Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Quality Account
2013/14

CLINICAL EFFECTIVENESS OF CARE

QUALITY OF THE PATIENT EXPERIENCE

PATIENT SAFETY

Blackpool Teaching Hospitals NHS
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Quality Account
2013/14

Presented to Parliament pursuant to Schedule 7,
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If you require any further information about the 2013/14 Quality Account please contact: The Corporate Affairs Team on 01253 655520 or email Judith Oates at judith.oates@bfwhospitals.nhs.uk

Part 1: Statement on Quality from the Chief Executive

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

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

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

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

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

The Quality Account for the 2013/14 period highlights the work we have been doing over the past 12 months to ensure our patients receive the highest quality and safest care possible. It includes a detailed overview of the improvements we have made during 2013/14 and sets out our key priorities for the next year 2014/15.

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

Infection rates have continued to fall and are now at their lowest levels with a 91% reduction in incidents of clostridium difficile over the last six years and 89% in Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteraemia when compared to 2007/08. We have also seen significant reductions in pressure ulcers and patient falls.

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

Once again we received national recognition for our work to improve patient safety and quality and the Trust's Maternity Substance Misuse team was recognised nationally, winning the Women's Health category at the National Care Integration Awards for its Integrated Care Pathway for Pregnant Women who misuse substances. The team has developed and improved the care and support given to pregnant women who misuse substances and this good practice has been recognised both inside and outside the Trust.

In June 2013 the Trust was selected for a review of Quality of Care and Treatment led by Sir Bruce Keogh, Medical Director, NHS England. We welcomed this review and the opportunity to demonstrate the quality of care and treatment provided by the organisation and to highlight many areas of improvement being undertaken. This visit linked well with our ongoing work to improve service quality and reduce mortality, which has seen average standardised mortality ratios for the Trust decreasing since July 2012.

We have continued to make progress on reducing mortality rates and this is something the Trust is totally committed to achieving. During the past 12 months our Summary Hospital – Level Mortality Indicator (SHMI) and Risk Adjusted Mortality Index (RAMI) have reduced significantly (SHMI 118-109 and RAMI from 102-87) and we confidently expect the data to be within the expected range by April 2014. On all (HSMR) mortality metrics the Trust's relative risk has reduced year-on-year following a number of operational and clinical quality initiatives

which have now resulted in substantial improvements in mortality figures. Our Better Care Now scheme has developed a number of clinical pathways that impact most on mortality and morbidity figures and are focusing particularly on the first 24-36 hours of patient care to standardise and improve the treatments they receive and this is providing excellent results.

Please note: SHMI and RAMI data taken from CHKS information website and is the 12 month rolling average figure taken as at 18.05.2014).

The Trust has also invested more than £1.5M in clinical staff with more than 180 qualified nurses and more than 40 doctors joining the organisation.

We have also been undertaking intensive work to deliver High Quality care within the community and developed a number of initiatives to provide care outside the hospital setting in particular for the frail elderly and those with long term conditions.

For example we are now able to offer intravenous therapy treatments in the home or community setting which allow long-term recipients of intravenous drugs to be allowed home from a hospital ward to continue their treatment.

Our Rapid Response Plus multi-disciplinary team, which is able to respond within two hours to an urgent health or social care need which does not require immediate hospitalisation, is also a great example of providing fast and efficient care in a safe and controlled way.

The Trust is also piloting a dedicated team working with 15 care homes across Blackpool. The team has worked with care home staff and other professionals to develop individual care plans for each resident which ensure they always receive appropriate treatment when needing medical intervention.

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

Our plans for 2014/15 aim to build on the progress we have made as well as new improvement targets in relation to patient care. In 2013 we launched our five strategic aims for 2020: 100% patients and carers included in decisions about their care, 100% compliance with agreed patient pathways, Zero inappropriate admissions, Zero patient harms and Zero delays. Whilst these targets are ambitious they will underpin everything we do.

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

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

To the best of my knowledge the information in the Quality Account 1st April 2013 – 31st March 2014 is a balanced and accurate account of the quality of services we provide.

Gary Doherty
CHIEF EXECUTIVE
21st May 2014

Part 2: Our Quality Achievements

In this section the Trust's performance in 2013/14 is reviewed and compared to the priorities that were published in the Trust's Quality Account in 2012/13. Priorities for improving the quality of services in 2014/15 that were agreed by the Board in consultation with stakeholders are also set out in this section. Legislated statements of assurance from the Board of Directors complete Section 2.

2.1 How we performed on Quality in 2013/14 against Priorities in 2012/13 Quality Account

This section tells you about some of the quality initiatives we progressed during 2013/14 and how we performed against the quality improvement priorities and aims we set ourselves last year.

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

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

The following symbols will tell you how we are performing and whether we met our aims. When we set our aims these were either set in year or to cover a three-year period. This was part of our quality journey. We are therefore pleased to report the significant progress made against our aims. An overview of performance in relation to the priorities for quality improvement that were detailed in the 2012/13 Quality Account is provided in Table 1. A more detailed description of performance against these priorities for clinical effectiveness of care, quality of the patient experience and patient safety will be reported on in detail in Part 3, section 3.4.

Table 1: Performance Against Trust Priorities

Key: Target Achieved/ On Plan | Close to Target | Behind Plan

Priority 1: Clinical Effectiveness of Care	2011/12	2012/13	2013/14	Actual Target 2013/14	Expected Score 2013/14
Reduce premature mortality from the major causes of death - Reduce 'preventable' mortality by reducing the Trust's Hospital Mortality Rates / Summary Hospital Mortality Indicators	Close to Target	Target Achieved	Target Achieved	< 1.18	Provisional 1.16 Results due October 2014
- The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust (See section 2.3.7 Core Clinical Indicators for results)	Not reported in 2011/12	Target Achieved	Target Achieved	1	1
- The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. (See section 2.3.7 Core Clinical Indicators for results)	Not reported in 2011/12	Target Achieved	Target Achieved	18.90%	10.57%
North West Advancing Quality initiative that seeks compliance with best practice to improve patient experience in six clinical areas:	2011/12	2012/13	2013/14	CQS Target 2012/13	Result Achieved 2012/13
- Acute Myocardial Infarction	Target Achieved	Target Achieved	Data not available until Sept 2014	95%	98.54%
- Hip and Knee Surgery	Target Achieved	Target Achieved		95%	95.54%
- Coronary Artery Bypass Graft Surgery	Target Achieved	Target Achieved		95%	98.19%
- Heart Failure	Target Achieved	Target Achieved		82.84%	91.14%
- Community Acquired Pneumonia	Target Achieved	Target Achieved		87.39%	90.77%
- Stroke	Target Achieved	Close to Target		90% / 50%	89.34% /57.74%
Enhancing quality of life for people with dementia:					
Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission	Not reported in 2011/12	Behind Plan	Behind Plan	68%	90%
Medical Care Indicators used to assess and measure standards of clinical care and patient experience	Target Achieved	Target Achieved	Behind Plan	82%	95%
Nursing Care Indicators used to assess and measure standards of clinical care and patient experience	Target Achieved	Target Achieved	Target Achieved	Acute 95%	95%
	N/A	N/A	Behind Plan	ALTC 58%	95%
	Target Achieved	Target Achieved	Behind Plan	Trust 87%	95%
Improving outcomes from planned procedures by Improving Patient Reported Outcomes Measure (PROMs) scores for the following elective procedures:		Provisional data			
i Groin hernia surgery	Target Achieved	Target Achieved	Data not available until Sept 2014	0.085	0.089
ii Varicose veins surgery	Target Achieved	Target Achieved		0.091	0.097
iii Hip replacement surgery	Close to Target	Target Achieved		0.405	0.366
iv Knee replacement surgery	Target Achieved	Target Achieved		0.298	0,297
Reduce emergency readmissions to hospital (for the same condition) within 28 days of discharge (See section 2.3.7 Core Clinical Indicators for results)	Not reported in 2011/12	12.04	Data not available	16+ -16.77%	Not available at this time
		10.73		< 16 -16.77%	Not available at this time

Priority 2: Quality of the Patient Experience	2011/12	2012/13	2013/14	2013/14	2013/14
Improve hospitals' responsiveness to inpatients' personal needs by improving the CQC National Inpatient Survey results in the following five areas:				National Picker average	BTHFT actual
• Were you involved as much as you wanted to be in decisions about your care and treatment?	●	●	●	88%	85% said definitely or to some extent
• Did you find someone on the hospital staff to talk to about your worries and fears?	●	●	●	44%	47.9% said definitely or to some extent
• Were you given enough privacy when discussing your condition or treatment?	●	●	●	91%	90% said always/ sometimes
• Did a member of staff tell you about medication side effects to watch for when you went home?	●	●	●	45%	44% said yes completely or yes to some extent
• Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	●	●	●	70%	73.7% said ye
Improve staff survey results in the following area:				National average	BTHFT actual
• Percentage of staff who would recommend their friends or family needing care	Not reported in 2011/12	Not reported in 2012/13	Not reported in 2013/14	To be the Best 20% of Trusts	Not yet reporting starts April 2014
• Report on Friend and Family Test and achieve above national target	Not reported in 2011/12	Not reported in 2012/13	Not reported in 2013/14	To be above national average	Not yet reporting starts April 2014
Improving the experience of care for people at the end of their lives:	2011/12	2012/13	2013/14	2013/14	2013/14
• Seeking patients and carers views to improve End of Life Care	●	●	●	Patient views to be sought	Patient questionnaire in place
• Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place across all services.	●	●	●	Facilitate preferred place	Identification of preferences for future care
Patient Led Assessment of the Care Environment (PLACE) Survey				Actual 2013/14	Expected Score 2013/14
• To improve PLACE survey results/standards	●	●	●	Excellent	Excellent
Priority 3: Patient Safety	2011/12	2012/13	2013/14	Actual 2013/14	Expected Score 2013/14
Achieve 95% Harm Free care to our patients by 2016 through the following strands of work:					
Risk-assessment for Thrombo-Embolism (VTE) - Improve the percentage of admitted patients who were risk- assessed for VTE; and - Compare the national average for the above percentage - (See section 2.3.7 Core Clinical Indicators for results)	97. 50% ●	99.40% ●	●	96%	99.5%
- Achieve a 10% reduction on the previous year in all VTE	●	●	●	10%	49.5%
Table 1: Performance Against Trust Priorities	2011/12	2012/13	2013/14	Actual Performance 2013/14	Expected Score 2013/14
Rates of Clostridium Difficile and MRSA - Reduce the incidence of Clostridium Difficile infection rates in the Trust as reflected by national targets	●	●	●	29	26
- Reduce the incidence of MRSA infection rates in the Trust as reflected by national targets	●	●	●	0	1

Priority 3: Patient Safety	2011/12	2012/13	2013/14	Actual 2013/14	Expected Score 2013/14
Reported Patient Safety Incidents - To monitor the rate of patient safety incidents and reduce the percentage resulting in severe harm or death				38	18
• Reduce the incidence of inpatient Falls by 30% resulting in moderate or major harm				25	39
• Reduce the incidence of Medication Errors by 50% resulting in moderate or major harm				17	15
- Reduce the incidence of new hospital acquired pressure ulcers stage 2 by 30%, stage 3 by 40% and stage 4 by 100%; and				Stage 2 – 30%	25%
				Stage 3-40%	60%
				Stage 4 -100%	100%
- Reduce stage 2, 3 and 4 community acquired pressure ulcers by 10% (see page 60 for definitions)				Stage 2 -10%	12%
				Stage 3-10%	59%
				Stage 4 -10%	0%
- Overall reduction in Hospital Acquired pressure Ulcers-				33%	33%
- Introduce the Think Glucose Programme	Not reported in 2011/12	Not reported in 2012/13		Pilot in progress	Pilot in progress

2.2 Selected Priorities for Quality Improvement in 2014/15

This section tells you about how we prioritised our quality improvements for 2014/15. This section also includes a rationale for the selection of those priorities and how the views of patients, the wider public and staff were taken into account. Information on how progress to achieve the priorities will be monitored, measured and reported is also outlined in this section.

2.2.1 How we Prioritised our Quality Improvements in 2014/15

The Board of Directors has developed an organisational Strategic Framework which underpins the quality programme set out in this Quality Account for 2013/14. We believe the quality programme will enable us to maintain a focus on the quality and safety agenda, whilst delivering our Strategic Framework to improve the health and outcomes of our local population based on the values and principles set by the Board of Directors.

2.2.2 Rationale for the Selection of Priorities in 2014/15

The Trusts priorities for 2014/15 in relation to the key elements of the quality of care for clinical effectiveness, quality of the patient experience and patient safety, and the initiatives chosen to deliver these priorities were established as a result of consultation with patients,

governors, managers and clinical staff. The Trust has shared its proposed priorities for 2014/15 with our Clinical Commissioning Groups, Blackpool Healthwatch, Lancashire Healthwatch, Blackpool Overview and Scrutiny Committee, Lancashire Overview and Scrutiny Committee and a sub group of the Council of Governors.

The Trust has taken the feedback received into account when developing its priorities for quality improvement for 2014/15 and after consultation at Board level, the following quality improvement priorities outlined in Table 2 were proposed and agreed by the Board of Directors which it believes will have maximum benefits for our patients.

These quality improvement priorities are also reinforced by the standards outlined in the NHS Outcomes Framework 2014/15 which set out the high-level national outcomes that the NHS should be aiming to improve. The priorities focus on 3 key elements in the quality of care. These are:

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

Four additional quality improvement priorities have also been selected by the Board of Directors as a priority in 2014/15 and are detailed in Table 2 in bold italics.

Table 2: Priorities for Quality Improvement			
National Level NHS Outcomes Framework (DH 2014/15) Quality Domain(s)	Trust Level	Key Elements in the Quality of Care	Description of Priority Indicators for Quality Improvement 2014/15
Domain 1: Preventing people from dying prematurely. Domain 2: Enhancing quality of life for people with long-term conditions.	To provide and maintain high quality and safe services. To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Clinical Effectiveness of Care	Reduce premature mortality from the major causes of death - Reduce 'preventable' mortality by reducing the Trust's hospital mortality rates - The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.
Domain 1: Preventing people from dying prematurely.	To provide patient centred care across integrated pathways with primary/ community/ secondary and social care.	Clinical Effectiveness of Care	Our strategic aim is 100% compliance with agreed pathways by 2016 through the following strands of work: - Sepsis - Pneumonia - Stroke - Cardiac Chest Pain - Acute Kidney Injury North West Advancing Quality initiative that seeks compliance with best practice to improve patient outcomes in eight clinical pathway programmes: - Acute Myocardial Infarction - Hip and Knee Surgery - Coronary Artery bypass graft surgery - Heart Failure - Pneumonia - Stroke - Patient Experience Measures - Acute Kidney Injury
Domain 2: Enhancing quality of life for people with long-term conditions.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based	Clinical Effectiveness of Care	Enhancing quality of life for people with dementia - Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission

Table 2: Priorities for Quality Improvement			
National Level NHS Outcomes Framework 2013/14 Domains of Quality	Trust Level	Key Elements in the Quality of Care	Description of Priority Indicators for Quality Improvement 2014/15
Domain 3: Helping people to recover from episodes of ill health or following injury.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Clinical Effectiveness of Care	Medical Care Indicators and Nursing Care Indicators used to assess and measure standards of clinical care. - Improving outcomes from planned procedures - Improve Patient Reported Outcomes Measure (PROMs) scores for the following elective procedures: i Groin hernia surgery ii Varicose veins surgery iii Hip replacement surgery iv Knee replacement surgery Emergency readmissions to hospitals within 28 days of discharge (Quality Accounts January 2014 DH) - The percentage of patients' of all ages and genders (aged 0 to14) and (15 or over) readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital; and - Compare the National Average for the above percentage
Domain 4 Ensuring that people have a positive experience of care.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based.	Quality of The Patient Experience	Improve hospitals' responsiveness to inpatients' personal needs by improving the CQC National Inpatient Survey results in the following five questions: - Were you involved as much as you wanted to be in decisions about your care and treatment? - Did you find someone on the hospital staff to talk to about your worries and fears? - Were you given enough privacy when discussing your condition or treatment? - Did a member of staff tell you about medication side effects to watch for when you went home? - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
			Improve staff survey results in the following area: - Percentage of staff who would recommend the Trust to friends or family needing care.
			- Report on Friends and Family Test

Table 2: Priorities for Quality Improvement			
National Level NHS Outcomes Framework 2013/14 Domains of Quality	Trust Level	Key Elements in the Quality of Care	Description of Priority Indicators for Quality Improvement 2014/15
Domain 4 Ensuring that people have a positive experience of care.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based.	Quality of The Patient Experience	Improving the experience of care for people at the end of their lives - Seeking patients and carers views to improve End of Life Care - Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place across all services.
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Patient Safety	Achieve 95% Harm Free Care to our patients by 2016 through the following strands of work: Risk-assessment for Thrombo-Embolism (VTE) - Improve the percentage of admitted patients who were risk- assessed for VTE; and - Compare the national average for the above percentage - Achieve a 10% reduction on the previous year in all VTE
			Rates of Clostridium Difficile and MRSA - The rate of Clostridium Difficile infections per 100,000 bed days amongst patients aged two years and over apportioned to the Trust; and - Compare the national average for the above rate. - Reduce the incidence of MRSA infection rates in the Trust as reflected by national targets
			Reported patient safety incidents - To monitor the rate of patient safety incidents the Trust have reported per 100 admissions; and - The proportion of patient safety incidents the Trust has reported that resulted in severe harm or death - Reduce the incidence of Falls resulting in patient harm by 30% at low, minor moderate and serious impact levels - Reduce the incidence of medication errors resulting in moderate or severe harm by 30% - Reduce the incidence of new hospital acquired pressure ulcers stage 2 by 50%, stage 3 by 100% and stage 4 by 100%; and - reduce stage 2, 3 and 4 community acquired pressure ulcers by 30%
			Continue to introduce the plan Think Glucose Programme
The Priority Indicators for Quality Improvement will be measured through the objectives and Strategic Aims that are identified within the Organisational Strategic Framework. The Priority Indicators for Quality Improvement will be monitored by the Board at each of its meetings through the Chief Executive Assurance Report, and a number of committees within the Board Committee Structure. Further information can be found in section 2.2.5 and in the Glossary of Terms			

2.2.3 Rationale for the Selection of Priorities to be removed in 2014/15

This section includes a list of priorities that have been chosen to be removed by the Board of Directors from the quality improvements priorities for 2014/15. The rationale for the de-selection of the following priorities is that considerable progress and improvements have been delivered or put in place and other improvements have become a priority.

Information regarding the improvements made to demonstrate evidence for their removal is outlined in Part 3. It has been agreed to remove the following quality improvement priority used in 2013/14. Although this will continue to be monitored by the relevant committee's detailed below, this will not be reported in the 2014/15 Quality Accounts:

- The one priority removed is in relation to improving Patient Led assessments of the Care Environment (PLACE) as the Trust constantly achieves high standards, and this will be continued to be monitored at the PLACE Committee.

2.2.4 Engagement with Patients, Public, Staff and Governors

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

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

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

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

2.2.5 How we will Monitor, Measure and Report ongoing Progress to Achieve our Priorities for Quality Improvement 2014/15

We use a number of tools to measure our progress on improving quality and these tools inform the reports we present to the Board and its Sub-Committees. The priorities for quality improvement in 2014/15 will continue to be monitored and measured and progress reported to the Board of Directors at each of its meetings as part of the Board Business Monitoring Report and the Quality and Safety Assurance Report. For priorities that are calculated less frequently, these will be monitored by the Board of Directors by the submission of an individual report. The Trust has well-embedded delivery strategies already in place for all the quality priorities, and will track performance against improvement targets at all levels from ward level to Board level on a monthly basis using the ward quality boards and the integrated divisional quality monitoring reports. The priorities for quality improvement will also be monitored through the high level Risk Register and Divisional Risk Register process and by the Sub-Committees of the Board.

The Trust will also report ongoing progress regarding implementation of the quality improvements for 2014/15 to our staff, patients and the public via the performance section of our website. You can visit our website and find up-to-date information about how your local hospitals are performing in key areas: infections, death rates, patient falls and medication errors. Improving patient safety and delivering the highest quality care to our patients is our top priority. We believe that the public have a right to know about how their local hospitals are performing in these areas that are important to them. As well as information on key patient outcomes, the website also includes data on our waiting times, length of stay, complaints, patient harms, cleanliness, hospital food, and patients and staff opinion of our hospitals.

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

2.3 Statements of Assurance from the Board of Directors

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

2.3.1 Review of Services

During 2013/14 the Blackpool Teaching Hospitals NHS Foundation Trust provided and/or subcontracted 49 relevant Health Services.

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

The income generated by the relevant Health services reviewed in 2013/14 represents 88 per cent of the total income generated from the provision of relevant Health services by the Blackpool Teaching Hospitals NHS Foundation Trust for 2013/14.

The quality aspirations and objectives outlined for 2013/14 reached into all care services provided by the Trust and therefore will have had impact on the quality of all services.

The data reviewed on various activities enables assurance that the three dimensions of quality improvement for clinical effectiveness, patient experience and patient safety is being achieved including:

- Divisional monthly performance reports
- Quality Boards based in our wards and departments
- Clinical audit activities and reports

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

2.3.2 Participation in Clinical Audits and National Confidential Enquiries

During 2013/14, 46 national clinical audits and 3 national confidential enquiries covered relevant Health services that Blackpool Teaching Hospitals NHS Foundation Trust provides.

During 2013/14 Blackpool Teaching Hospitals NHS Foundation Trust participated in 86% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries for which it was eligible. These are detailed in Column A of Tables 3 and 4.

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participated in during 2013/14, and for which data collection was completed during 2013/14, are listed in Column B of Tables 3 and 4 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry identified in Column C and D of Tables 3 and 4.

Table 3: National Clinical Audits					
List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2013/14					
Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
1	NNAP: neonatal intensive care	✓	✓	322	100%
2	ICNARC CMPD: adult critical care units	✓	✓	1048	100%
4	NJR: hip and knee replacements	✓	✓	440	100%
5	DAHNO: head and neck cancer	✓	✓	81	100%
6	MINAP (inc ambulance care): AMI & other Acute Coronary Syndrome	✓	✓	1448/1598	91%
7	Heart Failure Audit	✓	✓	334	115%
8	NHFD: hip fracture		X Not required for 13/14 QA		
9	TARN: severe trauma	✓	✓	158	100%
10	Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	358	100%
11	National Audit of Dementia: dementia care	NA	X Not required for 13/14 QA		
12	British Thoracic Society: National Bronchiectasis Audit	NA	BTS Not running this period 2013/14		
13	RCP: National Care of the Dying Audit	NA	X Not required for 13/14 QA		
14	National comparative audit of blood transfusion in adult cardiac surgery	✓	✓	309	100%
15	Coronary angioplasty	✓	✓	Awaiting confirmation	
16	Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	130	100%
17	CCAD: Adult Carotid interventions	✓	✓	1223	100%
18	CCAD :Heart rhythm management (pacing and implantable cardiac defibrillators (ICDS)	✓	✓	861	100%
19	CCAD: Congenital Heart Disease Paediatric Cardiac surgery	✓	✓	5	100%
20	Adult cardiac surgery: CABG and valvular surgery	✓	✓	1223	100%
22	NBOCAP: bowel cancer	✓	✓	219	100%
23	NLCA: lung cancer	✓	✓	293	100%
24	RCP: Audit to assess and improve service for people with inflammatory bowel disease	✓	✓	9/100	9%

Table 3: National Clinical Audits					
List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2013/14					
Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
25	Adult community acquired pneumonia (British Thoracic Society)	NA	BTS Not running this period 2013/14		
26	Emergency use of oxygen (British Thoracic Society)	✓	✓	29	100%
27	Renal colic (College of Emergency Medicine)	NA	X Not required for 13/14 QA		
28	Non-invasive ventilation - adults (British Thoracic Society)	NA	BTS Not running this period 2013/14		
29	Potential donor audit (NHS Blood & Transplant)	NA	X Not required for 13/14 QA	326	100%
30	National Cardiac Arrest Audit (NCAA)	✓	✓	388	100%
31	National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, AAA, NVD)	✓	✓		
32	Pulmonary hypertension (Pulmonary Hypertension Audit)	NA	X Not required for 13/14 QA		
33	Adult asthma (British Thoracic Society)	NA	BTS Not running this period 2013/14		
34	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	✓	✓	108	100%
35	Diabetes (Paediatric) (NPDA)	✓	✓	69	100%
36	National Review of Asthma Deaths (NRAD)	✓	✓	1	100%
37	Pain database	✓		Awaiting Confirmation	
38	Fractured neck of femur	NA	X Not required for 13/14 QA		
39	Elective surgery (National PROMs Programme)	✓	✓	NA	67.7
41	Epilepsy 12 audit (Childhood Epilepsy)	✓	NA	39	100%

Table 3: National Clinical Audits					
List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2013/14					
Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
42	"Maternal, infant and newborn programme (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical Outcome Review Programme) *This programme was previously also listed as Perinatal Mortality (in 2010/11, 2011/12 quality accounts)"	✓	✓	43	100%
43	Paediatric asthma (British Thoracic Society)	✓	✓	22	100%
44	Paediatric fever (College of Emergency Medicine)	NA	X Not required for 13/14 QA		
45	Paediatric intensive care (PICANet)	Not eligible at this Trust	X		
46	Paediatric pneumonia (British Thoracic Society)	✓	✓	10	100%
47	National audit of seizure management in Hospitals	✓	✓	30	100%
48	National emergency laparotomy audit (NELA)	✓	✓	54	100%
49	Paracetamol overdose (care provided in Emergency Departments - College of Emergency Medicine)	✓	✓	Awaiting confirmation	
50	Pleural procedures	Not eligible at this Trust	X		
51	Severe sepsis & septic shock (College of Emergency Medicine)	✓	Suspended due to Sepsis Pathway March 14		
52	Vital signs	NA	X Not required for 13/14 QA		
53	Intra thoracic transplantation (NHSVT UK transplant registry)	Not eligible at this Trust	x		
54	Liver transplantation (NHSVT UK transplant Registry)	Not eligible at this Trust	x		
55	Prostate Cancer	NA	X Not required for 13/14 QA		

Table 3: National Clinical Audits					
List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2013/14					
Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
56	COPD Discharge Audit	NA	X Not required for 13/14 QA		
57	National COPD Audit Programme (RCP)	✓		Awaiting confirmation	
58	Paediatric Bronchiectasis	✓	✓	Awaiting confirmation	
59	Renal Registry	Not eligible at this Trust	x		
60	Renal transplantation (NHSVT Transplant Registry)	Not eligible at this Trust	x		
61	Rheumatoid and early inflammatory arthritis	✓		Awaiting confirmation	
62	Learning disabilities/feasibility study	Not eligible at this Trust	X		
63	Mental health clinical outcome review programme NCEPOD into suicide and homicide with people with mental illness	Not eligible at this Trust	x		
64	National audit of psychological therapies	Not eligible at this Trust	x		
65	National audit of schizophrenia	Not eligible at this Trust	x		
66	Prescribing observatory for mental health	Not eligible at this Trust	x		
67	Falls and fragility fractures audit programme	✓		Awaiting confirmation	
68	National audit of memory clinics	Not eligible at this Trust	X		
69	Parkinson's Disease (Nationals Parkinson's audit)	NA	X Not required for 13/14 QA		
70	Familial Hypercholesterolaemia (National clinical audit management of FH)	NA	X Not required for 13/14 QA		
71	National audit of intermediate care	NA	X Not required for 13/14 QA		
72	National health promotion in hospitals audit	NA	X Not required for 13/14 QA		
73	Patient transport (National kidney care audit)	Not eligible at this Trust	X		

Table 3: National Clinical Audits					
List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2013/14					
Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
74	Fitting childcare in emergency departments	NA	X Not required for 13/14 QA		
75	Mental health care in emergency departments	NA	X Not required for 13/14 QA		
76	Older people care in emergency departments	NA	X Not required for 13/14 QA		
77	Speciality rehabilitation for patients with complex needs	NA	X Not required for 13/14 QA		
78	Child health clinical outcome review programme (CHR/UK)	NA	X Not required for 13/14 QA		
79	Heavy menstrual bleeding	NA	X Not required for 13/14 QA		
80	Paediatric Asthma audit	✓	✓	Awaiting confirmation	
81	Pain management (College of emergency medicine)	NA	X Not required for 13/14 QA		

✓ – Eligible to participate or actively participating
NA – Eligible to participate however not required for QA (Data collection dependent upon individual audit) or stage of audit with managing body for this time period
Not eligible at this Trust – The service to which this service relates to is not undertaken within the Trust

Table 4: National Confidential Enquiries					
List of National Confidential Enquiries that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2013/14.					
Number	National Confidential Enquiries	Column A Eligible to Participate In	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
1	Tracheostomy Care Study	Yes	Yes	17	100%
2	Lower Limb Amputation Study	Yes	Yes	7 Data collection not due to complete at time of report	100%
3	Gastro Intestinal Haemorrhage Study	Yes	Yes	Data collection not due to complete at time of repor	100%
4	Alcohol Related Liver Disease	Yes	Yes	7	100%

Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions

The reports of 2 National Clinical Audits (Confidential Enquiries) were reviewed by the provider in 2013/14 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take or has taken the following actions to improve the quality of healthcare provided as shown in Table 5.

Table 5: National Clinical Audits (Confidential Enquiries)	
National Clinical Audits (Confidential Enquiries) presented for assurance to the Board of Directors	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
Sub Arachnoid Haemorrage Study – Report issued Nov 2013 Managing the Flow? A review of the care received by patients who were diagnosed with an aneurysmal subarachnoid haemorrhage.	All patients presenting with acute severe headache in a secondary care hospital should have a thorough neurological examination performed and documented. • All patients presenting to the emergency department with acute severe headache have a GCS recorded in the observations section of the electronic patient record by the initial assessment nurse. Documentation of full neurological assessment by a doctor is recorded in the hospital notes • A full audit of all patients admitted with a suspected sun arachnoid haemorrage will be part of a clinical audit undertaken by the Lead Consultant to determine neurological assessment in A&E A CT- scan should be performed immediately in this group of patients as defined by the 'National Clinical Guideline for Stroke'. • The Trust provides 24 hr CT scanning In hours, • The PACS system at Blackpool Teaching Hospitals NHS Trust is linked directly to the PACS system at Central Lancashire Teaching Hospitals NHS Trust. The images are therefore immediately available for review by the neurosurgical on call at Royal Preston Hospital prior to transfer. The nationally-agreed standard ('National Clinical Guideline for Stroke') of securing ruptured aneurysms within 48 hours should be met consistently and comprehensively by healthcare professionals who treat this group of patients. This will require providers to assess the service they deliver and move towards a seven-day-service. • Neurosurgical services at Royal Preston Hospital conveniently located within15 minutes of a "blue light" ambulance transfer. • Critical care support is provided for transfer of patients intubated or with airway concerns. Organ donor policy in place within the Trust with appointed Specialist Nurse – Organ Donation (BVH)
Alcohol Related Liver Disease Study Report issued June 2013 Measuring the Units A review of patients who died with alcohol-related liver disease	• The Trust has appointed a multi disciplinary Alcohol Care Team that is led by a Consultant. • The Alcohol Specialist Nurse Service offers a 7 day service. • Policies are in place re the identification and management of alcohol misuse. • All patients are assessed on admission using an approved tool – (Audit – C) • Antibiotics and terlipressin are offered to all patients with a history of alcohol abuse and gastro intestinal haemorrhage until the results of endoscopy are reviewed. • Escalation of care is actively pursued based on renal function of individuals and need.

Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions

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

During 2013/14, 90 % (215) of audits were completed or are running according to schedule for completion. The number of audits being monitored by the Clinical Audit Department is 53 % (127). This includes all audits that have not been fully completed at end of Q4.

The reports of 113 local clinical audits were reviewed by the provider in 2013/14 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 6 below). Additional information can be found in the Annual Clinical Audit Report 2013/14 which is published on the Trusts website and is available via the following link: http://www.bfwh.nhs.uk/about/performance/. A copy of the Annual Clinical Audit report of is available on request.

Table 6: Local Clinical Audits

Local Clinical Audits presented for assurance to the Board of Directors	Details of actions taken to improve the quality of local services and the outcomes of care.
Ventilatory Associated Pneumonia (VAP) care bundles in ICU	CC1202 - Daily Ward Round Chart to check VAP / CPIS scores have been completed Bedside Nurses to complete VAP bundle on ICU day chart
Management of basal cell carcinoma with topical immiquimod	DER1101 The use of immiquimod in treatment of BCC will be constantly monitored.
Secondary prevention of Osteoporosis in patients with low trauma fracture neck of femur	GM092 - Size A4 flow chart developed. Discharge check list developed. Regular education to junior doctors ongoing.
Audit of diagnosis and management of inflammatory arthritis against NICE guidance	GM1032 - No change to MDT referral & assessment as better than regional ones but continuing to monitor. Recruitment of 2 specialist nurses underway for specific Early Arthritis Clinic incorporating urgent new patient slots & monthly follow up for newly diagnosed patients according to agreed protocols.
Drug errors in adult patients with diabetes	GM1118 - Plan to take up the 'Think Glucose' campaign is underway. Plans to make a separate insulin prescription with electronic prescribing tool can only be implemented when Vision is active.
30 day mortality and 8 day complications	GM1217 Patient leaflet has been updated. Coding problems have been addressed. Feedback process has been introduced for contact clinicians.
Colonic Biopsies for chronic diarrhoea	GM1210 - Action plan implemented. Ongoing education and information disseminated to all colonoscopists.
BTS National Emergency Oxygen Audit 2011 Continued from 12/13	GM1218 - Ongoing education of junior doctors, ward staff, and other Allied Health Professionals in drug chart inspection and importance of oxygen prescription. Oxygen therapy to be part of ward level indicators.
National Care of the Dying Acute Hospitals Audit (NCDAH) Interim audit Continued from 12/13	GM1219 - Continued rolling programme of training on all EOLC tools. Increased ward based training on LCP, communication, symptom management and best EOLC. Unable to implement recommendation of changing questions on NCI as request for this has been rejected at this time.
Adult Community Acquired Pneumonia Continued from 12/13	GM1226 - New pathway and checklist developed with real time feedback / accountability for performance. Education and communication on pathway ongoing. Information available on intranet.
Mortality review in the acute medical unit at BVH	GM1303 Continual education to improve documentation on AMU noting times, dates and clinician performing review.
Management of acute upper gastrointestinal haemorrhage (AUGH)	GM1306 - Early referral/discussion with Gastroenterologist/SpR of all acute upper gastrointestinal haemorrhage patients. AMU and A&E staff notified. Rockall/ Blatchford score to be a mandatory field in endoscopy e-request agreed with Vision & Alert.
Re-Audit of patient casenotes who have undergone peripheral blood stem cell transplantation	GM1307 - Introduction of orange casenote stickers to ensure all notes are returned to transplant coordinator for completion of casenotes.

Table 6: Local Clinical Audits	
Local Clinical Audits presented for assurance to the Board of Directors	Details of actions taken to improve the quality of local services and the outcomes of care.
Re-audit Assessment of compliance with NICE CG50 in Acutely ill patients in hospital	CC1204 - Ongoing education of nursing and medical staff regarding the need to use new POTTS charts and remove old versions. Monitor compliance with observation recording via NCI and spot checks by Matrons Full audit of 2222 calls to be undertaken in 2013
Audit of management of paediatric postoperative pain management	AN1207 - Discussed with ENT Surgeons who do not support the use of topical local anaesthetics for paediatric tonsillectomies.
Adequacy of medical records in Cardiothoracic surgical inpatients	CAR1203 - ITU round sheet introduced and in use. Medical staff more diligent to patient identifier details date and time.
The management of central venous catheter in surgical and medical wards	GS1206 Training to all staff at all levels in relation to completed daily reviews of patients being undertaken according to CVC care bundle and clear documentation on indication and on-going needs. Training to all health care professionals, junior doctors and nurses involved in the insertion and maintenance of cvc regarding central line associated infection.
NW Regional Bladder Cancer Audit	GS1204 Regular TRUS biopsy sessions introduced with extra sessions to accommodate peaks in demand. New standard letter introduced showing procedural steps. Fast track system developed for prostatic biopsies. Appointment of a further Consultant. All Consultants now have clinic slots reserved for giving positive results to cancer patients. Procedural operation note agreed that specifically requires the number of cores to be documented. Patients suitable for trials to be discussed at MDT and outcome of discussion to be documented.
DSE guided revascularisation	CAR1302 - Ongoing education/presentation to raise awareness of current ESC guidelines.
VTE prophylaxis in patients undergoing elective urological procedures	GS1302 Changes have been made to trust policy to reflect prescribing Dalteparin. Junior doctors advised in the increase in frequency of prescribing Dalteparin.
Diagnostic investigations in heart failure	CAR1306 - Ongoing education to doctors to refer all clinical suspicions of heart failure without requirement of an echo and echoes should include assessment of left ventricular diastolic function where possible.
Monitoring VTE prophylaxis in urology patients	GS1005 All surgical patients to have VTE assessment on admission Anaesthetists to consider regional anaesthesia to reduce risk of VTE Patients to be offered thromboprophylaxis to reduce VTE risk Minimise hospitalisation by considering minimal invasive procedures
Timeframe between listing for the laser treatment in Diabetic Retinopathy	OP1103 - New specific diabetic retinopathy clinic to be set up. Awaiting appointment of new consultant to oversee all ophthalmic diabetic patients.
Compliance with inpatient chart clinical verification audit	PH1215 Ensure all pharmacists obtain and have access to up to date standards
NPSA Alert - Loading Dose Audit	PH1214 - Trust policies to be amended to include critical care area procedures. Continue to educate newly qualified doctors to ensure awareness of importance of stopping the loading dose and continuing with maintenance dose. Warfarin posters on display throughout hospital to clarify policy. Disseminate policy to all nursing and medical staff.
Reducing harm from omitted and delayed medicines in hospital/ The correct use of omission codes	PH1211 Supply a critical drugs list to each ward, step by step easy to follow flow chart on how to obtain medication and the list of omission codes and what appropriate action needs to be taken to be placed in the drugs trolley on each ward.
Re-audit of Pharmaceutical Procurement Services	PH1212 - SOP116 has been reviews, policies covering how to deal with suppliers, reps and waste management have been written. Procedure for dealing with breaches of minimum and maximum specified temperatures and records reviewed. A documented training programme has been incorporated into training and competency records. A training record is now available for all staff working in procurement.
Clinical handover of care of neonates	CH1306 - Raise awareness of Baby transfer notification within Women's unit. Updated Baby Transfer Notification form to provide signature. Raise awareness of Baby transfer notification within Women's Unit.

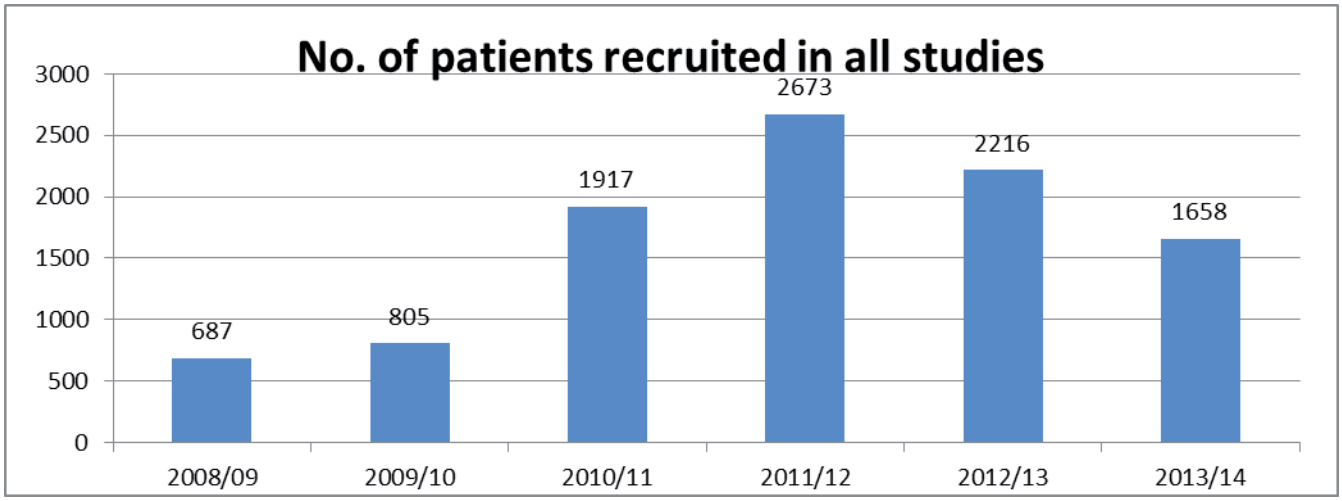
Table 6: Local Clinical Audits	
Local Clinical Audits presented for assurance to the Board of Directors	Details of actions taken to improve the quality of local services and the outcomes of care.
Discharge of babies from the Neonatal unit	OB1217 - Review of discharge plan: Health Visitor Liaison only to be phoned if Neonatal Nursing Unit discharge occurs at weekend. Otherwise Health Visitor Liaison will visit for discharge information during the week.
Venous thromboembolism (VTE)	OB1220 - Risk assessments for every woman to be completed. Women identified as intermediate or high risk of VTE following risk assessment by the obstetrician must be informed to carry out assessment and develop a management plan. Documentation reflects the advice and care provided.
Discharge	OB1221 - Comprehensive discharge documentation developed that includes antenatal record, discharge advice, prescription as required and post discharge care of mother and baby.
Handover of care	OB1222 - SBAR communication tool promoted for use of transfer of handover and care inter department. SBAR sticker proforma now includes information from the obstetrician St3 and the anaesthetist which details plan of care recorded in birth record.
Management of postpartum haemorrhage	OB1212 - Update current guideline to include pathway. Consider consultant baton bleep and inclusion 2222.
Obesity in Pregnancy	OB1210 - Improve communication with GP & Community Midwives regarding Folic Acid and Vitamin D. Improve documentation. Ongoing training.
North West Diabetes Pregnancy Audit	OB1207 - replaced by OB1302 ongoing audit
Actions noted in Health Action Plans; audit of record of action completion	C013 Provide Mandatory Training to Clinicians; Feedback to team managers and Clinicians; Evidence of meeting KPI's
Health Promotion in Hospitals	CG1213 - Results cascaded to relevant trust members, committees and external organisations. Ongoing training of staff in brief interventions for alcohol and tobacco use. Ongoing half day training in obesity.

2.3.3 Participation in Clinical Research in 2013/14

The number of patients receiving relevant health services provided or sub-contracted by Blackpool Teaching Hospitals NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 1,658*, identified in Graph 1, of which the number of patients recruited to National Institute of Health Research (NIHR) Portfolio Studies is 1,592*. This figure was less than the number recruited in 2012/13 due to a number of high recruiting studies closing during 2013/14.

* It should be noted that 2013/14 NIHR Portfolio Study data is not signed off nationally until 30th June 2014. We therefore estimate the total patient recruitment total to be higher than currently reported (as at 31st March 2014).

Graph 1: Participation in Clinical Research



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

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

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

Blackpool Teaching Hospitals NHS Foundation Trust was involved in conducting 140 clinical research studies during 2013/14. There were over 80 clinical staff participating in research approved by a research ethics committee at Blackpool Teaching Hospitals NHS Foundation Trust during 2013/14. These staff participated in research covering 19 medical specialties as outlined in Table 7 below. Please note the data on the Table 7 is provided by the NIHR whose figures are not finalised until 30th June 2014.

Table 7: Number of patients recruited to National Institute of Health Research Portfolio studies

Specialty	No. of Patients Recruited 2009/10	No. of Patients Recruited 2010/11	No. of Patients Recruited 2011/12	No. of patients recruited 2012/13	No. of patients recruited 2013/14
Age and Ageing	0	0	0	10	17
Cancer	111	140	419	303	197
Cardiovascular	223	275	449	549	353
Critical Care	25	963	359	8	6
Dementias and Neurodegenerative Diseases	5	11	6	0	9
Dermatology	0	21	10	9	23
Diabetes	0	6	150	702	307
Genetics and Congenital Dis	0	0	171	177	29
Health Services Research	2	7	133	4	2
Infection	3	24	6	26	42
Injuries and Emergencies	0	14	4	101	47
Meds for Children	30	43	24	15	6
Musculoskeletal	31	18	1	9	11
Neurological	0	0	0	0	6
Ophthalmology	0	1	0	0	22
Oral and Gastrointestinal	67	106	67	52	85
Paediatric	0	20	223	160	128
Paediatrics (non medicines)	10	10	32	66	11
Renal and Urogenital	114	90	0	0	0
Reproductive Health	88	54	41	35	26
Respiratory	13	19	22	20	20
Stroke	83	94	116	44	33

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

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

A proportion of Blackpool Teaching Hospitals NHS Foundation Trust's income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Blackpool Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: http://www.bfwh.nhs.uk/about/performance/

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

The total planned monetary value of income of CQUIN in 2013/14 conditional upon achieving quality improvement and innovation goals is £ 7,678,469; however, it is estimated that the Trust will achieve a monetary total value of £ 7,301,025 for the associated payment in 2013/14.

The main areas of risk are the Dementia (Screening, Assessment & Referral), Patient Experience and AQ (CABG, Stroke and Heart Failure), CQUIN themes; however performance against these measures will not be confirmed until August 2014.

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

Statements from the Care Quality Commission

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

The CQC has not taken enforcement action against Blackpool Teaching Hospitals NHS Foundation Trust during 2013/14.

Special Reviews/Investigations

In June 2013 the Trust had a visit from a team under the direction of Sir Bruce Keogh. The Trust was one of 14 Trusts identified as a persisting outlier on the national Summary Hospital Level Mortality Indicator (SHMI) measure based on data from pre 2012. We welcomed this opportunity to demonstrate the quality of care provided by the organisation and to highlight many areas of improvement being undertaken. This visit linked well with our ongoing work to improve service quality and reduce mortality, which has seen average standardised mortality ratios for the Trust decreasing since July 2012. The Trust was one of only three organisations not placed in special measures following the review.

The Trust has committed itself to improving the nurse and doctor to patient ratios over coming years and is spending over £1m new monies this year to reduce the number and severity of incidents that could result in patient harms and ensure high standards of clinical care are maintained.

Blackpool Teaching Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14. The Care Quality Commission has undertaken two visits during 2013/14 in relation to an unannounced visit in June 2013 and unannounced follow up visit in November 2013 to review the Trust's Complaints Service.

Unannounced Visit – Cardiac Directorate and Trust Complaints Service

On 11th June 2013 the Care Quality Commission carried out an unannounced visit to Blackpool Teaching Hospitals NHS Foundation Trust and reviewed the following standards:

Outcome 1: Respecting and Involving People Who Use Services
Outcome 2: Consent to Care and Treatment
Outcome 4: Care and Welfare of People Who Use Services
Outcome 16: Assessing and Monitoring the Quality of Service Provision
Outcome 17: Complaints

Following this visit the final report provided overall positive feedback, however the Trust was deemed to have not met the standard in respect of Outcome 17: Complaints, with moderate impact on patients using this service being identified.

Based on the final report the Trust developed an action plan and commenced implementation of the recommendations to address the areas for improvement detailed above.

Following a subsequent visit from the CQC in November 2013, the CQC confirmed that the Trust has demonstrated compliance with Outcome 17. This has been achieved by the following:

The Trust's Operation Procedure – Patient Relations Department (Corp/Proc/403) has been updated with regards to the investigation timescales to ensure they are manageable and fit for purpose. This has been undertaken in conjunction with a Non Executive Director. The Trust has also reviewed the Safeguard electronic system to ensure flexibility in date recording.

If a complaint is delayed a holding letter is sent to the complainant and a date identified of when the Division will have the final response mailed out to the complainant.

A Red Alert was developed by the Director of Nursing and Quality and the Medical Director. The Alert was sent out to all Ward Managers to present to staff at handover for a period of one week. An e-mail was also sent all Consultants regarding the contents of the red alert.

The completed action plan and progress report detailed above has been submitted to the Care Quality Commission in October 2013 following approval by the Board.

Unannounced Follow up Visit – Complaints Service

The Care Quality Commission carried out a second unannounced follow up visit on 26th November 2013 to review of the Trust's compliance against Outcome 17. The Trust was able to evidence that they were taking the improvement of complaints management very seriously and was found to be meeting the standard fully.

Chief Inspector of Hospitals inspection Visit

Announced visit to Blackpool Teaching Hospitals NHS

Foundation Trust by the Care Quality Commission (CQC)

In January 2014, Blackpool Teaching Hospitals acute services at Victoria Hospital, Clifton Hospital and Fleetwood Hospital were inspected as part of the Care Quality Commission's new national programme of inspections. This inspection was 6 months after the Keogh visit and subsequent report and action plan. The CQC inspected acute services covering; Accident and Emergency, Medical Care, Surgery, Intensive/critical care, Maternity and family planning, Children's care, End of Life Care and Outpatients. The CQC focused on five areas of inspection. These were: Are services safe, effective, caring, responsive to peoples needs and are they well-led.

The CQC's final report, published on 2 April, 2014 gave an overall rating to the Trust of "requires improvement" with the following ratings for each of the 5 key inspection questions:

Are acute services at this Trust safe?	Requires Improvement
Are acute services at this Trust effective?	Requires Improvement
Are acute services at this Trust caring?	Good
Are acute services at this Trust responsive?	Requires Improvement
Are acute services at this Trust well-led?	Requires Improvement

Of the 68 individual ratings given 42 were good, 2 were outstanding, 22 were requires improvement and 2 areas were deemed inadequate. Maternity Services were rated as 'inadequate' due to the ongoing review of PPH cases that had resulted in a hysterectomy, 5 cases in a 6 month period. The expected range for our Trust is 2 cases per year. The RCOG undertook their case review on 30th April and the CQC wish to receive a copy of this report and to agree with the Trust a date for re-inspection of the Maternity Service.

Following the Quality Summit on the 28th March it was agreed to formulate one quality improvement action plan following the CQC visit. The new CQC action plan and monitoring dashboard incorporates the main areas of continued focus from the Keogh Action plan e.g. monitoring mortality reduction, patient experience, incident reporting and staffing. The high level CQC action plan has been agreed with Commissioners and shared with Monitor. A detailed draft action plan has been developed and this has also been shared with Commissioners. The final action plan was returned to the CQC by 30th April 2014.

An action plan is currently being produced to ensure all matters requiring improvement will be attained. This plan will be agreed by the Trust Board and with our commissioners and with Monitor and will be implemented in 2014/15.

2.3.6 Information on the Quality of Data

Good quality information and data are essential for:

- The delivery of safe, effective, relevant and timely patient care, thereby minimising clinical risk
- Providing patients with the highest level of clinical and administrative information
- Providing efficient administrative and clinical processes such as communication with patients, families and other carers involved in patient treatment
- Adhering to clinical governance standards which rely on accurate patient data to identify areas for improving clinical care
- Providing a measure of our own activity and performance to allow for appropriate allocation of resources and manpower

- External recipients to have confidence in our quality data, for example, service agreements for healthcare provisions
- Improving data quality, such as ethnicity data, which will thus improve patient care and improve value for money

NHS Number and General Medical Practice Code Validity
Blackpool Teaching Hospitals NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was:
- 99.5% for Admitted Patient Care;
- 99.7% for Outpatient Care; and
- 98.6% for Accident and Emergency Care.

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

** based on provisional April 2013- February 2014 SUS data at the month 11 inclusion date

Information Governance Assessment Report 2013/14
Blackpool Teaching Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2013/14 was 82% and was graded Satisfactory (Green).

For 2013/14 the grading system is based on:

- Satisfactory - Level 2 or above achieved in all requirements
- Not Satisfactory - minimum Level 2 not achieved in all requirements

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

Blackpool Teaching Hospitals NHS Foundation Trust will continue to work towards maintaining and improving compliance standards during 2014/15 monitored by the Health Informatics Committee.

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

Payment by Results (PBR) Clinical Coding Audit
Blackpool Teaching Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were 6.7%. The results are detailed in Table 8 and demonstrate better than national average performance:

Table 8: Data Published by the Audit Commission

Clinical Coding	Percentages
Primary Diagnoses Incorrect	6.0%
Secondary Diagnoses Incorrect	9.4%
Primary Procedures Incorrect	4.5%
Secondary Procedures Incorrect	46.2%

Data source: External audit carried out by an approved auditor through the Audit Commission. This data is governed by standard national definitions

The following actions were identified to improve the quality of coding in the latest audit and are detailed below:

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

Please see explanatory note for clinical coding:

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

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

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

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

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

2.3.7 Core Quality Indicators

From 2013/14 all Trusts are required to report against a core set of Quality indicators, for at least the last 2 reporting periods, using the standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2013.

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

a) the national average for the same; and

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

Table 10: Core Quality Indicators

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

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

	SHMI				Palliative Care Coding			
Period	**Trust**	**England Average**	**England Highest**	**England Lowest**	**Trust**	**England Average**	**England Highest**	**England Lowest**
October 2012 to September 2013	117	100	118	63	0.86%	1.19%	14.09%	0.00%
July 2012 to June 2013	116	100	116	63	0.88%	1.23%	13.93%	0.00%
July 2011 to June 2012	126	100	126	71	0.92%	1.09%	15.51%	0.00%

***Internally calculated data suggests the Trust's SHMI score on next release will be 110.9*
**The palliative care indicator is a contextual indicator*

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

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

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

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

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

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

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
	2011/12	405	0.089	0.087	0.143	-0.002
Groin Hernia	2010/11	369	0.052	0.085	0.156	-0.02
	2009/10	360	0.06	0.082	0.136	0.011

***Provisional scores for 2012/13 show Trust position as 0.089 to be verified in September 2014*

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
	2011/12	269	0.366	0.413	0.499	0.306
Hip Replacement	2010/11	238	0.267	0.405	0.503	0.264
	2009/10	236	0.353	0.411	0.514	0.287

***Provisional scores for 2012/13 show Trust position as 0.366 to be verified in September 2014*

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
	2011/12	322	0.297	0.303	0.385	0.181
Knee Replacement	2010/11	323	0.231	0.298	0.407	0.176
	2009/10	251	0.279	0.294	0.386	0.172

***Provisional scores for 2012/13 show Trust position as 0.297 to be verified in September 2014*

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
	2011/12	443	0.097	0.095	0.167	0.049
Varicose Vein	2010/11	377	0.005	0.091	0.155	-0.007
	2009/10	341	0.058	0.094	0.15	-0.002

***Provisional scores for 2012/13 show Trust position as 0.097 to be verified in September 2014*

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

- The comparison data for internal PROMS between Blackpool Teaching Hospitals Provisional PROMs Data 2011-12 (April 2011 - March 2012) and Provisional PROMs Data 2012-2013 (April 2012 - March 2013) shows an improvement against the national scores, but reviewing the negative scores, the Trust has improved on previous data.

The Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by the following actions: Enhance our relationships with the provider, Capita, and work with clinicians essentially across the orthopaedic speciality to enhance the patients reported outcomes and provide greater information to clinicians on their feedback. See section 3.4.1 – For further information regarding improving outcomes from planned procedures - Patient Reported Outcome Measures (PROMS) and any actions taken to improve performance.

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

Age Group	2013/14	2012/13	2011/12	England Average
0 to 15; and	10.70	10.40	8.80	N/A
16 or over,	6.70	6.30	6.51	N/A

***Latest readmission percentages for 2013/14 show the Trust rate as – 7.00. However the English Average is not available until December 2014.*

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

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

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

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

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

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

Year	Trust	England Average	England Highest	England Lowest
2012/13	65.6	68.1	84.4	57.4
2011/12	67	67.4	85	56.5
2010/11	68.3	67.3	82.6	56.7
2009/10	66.1	66.7	81.9	58.3

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

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

- Developing training to assist team leaders to maximise and sustain the capacity and capability of individual team members.
- Developing a more robust Patient Relations Service and continuing to analyse concerns and complaint data to inform service improvement.
- Developing processes to gain more qualitative and quantitative feedback from patients.
- Planning services around the patient by working with the Trust's Patient Panel and local patient participation groups.
- Enhancing communication and providing treatment specific information to patients if appropriate, calling upon specialist nurses to assess patient's individual concerns around specific disease pathways.
- Encouraging patients to discuss any concerns they may have with staff at the time so they feel assured about their care plan.

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

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

Year	Trust	England Average	England Highest	England Lowest
2012	63	63	98	35
2013	65	65	94	40
2014	72	67	100	12

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

- Increased activity and demand on some services seeing an increase in hospitals admissions and pressures on discharges
- Staffing levels and agency and locum use, with some staff being moved from their own work area to cover staffing shortfalls
- Levels of sickness in some areas, increased levels of work related stress which also adds to the pressure on other staff to come to work despite not feeling well
- High levels of negative press reporting linked to patient mortality statistical reporting and regulatory reviews
- Levels of staff morale, pressure and conflicting demands placed on staff

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve the standard of care provided by this organisation by undertaking the following actions:

- Significant investment has been made in nurse and doctor staffing including increased levels of international recruitments and widening access secondments to increase supply of staff
- Better Care Now project to develop best evidence based care and pathways in key priority areas such as stroke, sepsis, pneumonia and cardiac chest pain
- Roll out of Targeted Support initiative that includes Patient Experience Revolution training aimed at helping staff to be at their best more of the time and improve their resilience and wellbeing as well as compassionate care – metrics link the numbers of staff trained and increased patient satisfaction levels
- TalkSafe project continues to be implemented with training for clinical staff to have conversations about safe and unsafe acts to help embed a safety culture through increased awareness and personal responsibility
- Development and launch of the Trust values to help support a culture of compassionate care
- Continued investment in our quality assured health and wellbeing services including therapies, mindfulness, fitness programmes, and in-house physiotherapist, etc.
- Increased visibility of the senior managers and leaders of the organisation including out of hours
- Review of the Whistleblowing Policy to make it easier for staff to raise a concern
- Recognition events taking place in each division to share good practice taking place across the Trust
- Investors In People (IIP) Gold interim review in preparation for a full reaccreditation
- Pilot of Aston University Team Based Working Pilot, with a research base that predicts that effective and high performing team will improve patient outcomes and reduce mortality

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

Quarter	Trust	England Average	England Highest	England Lowest
Q3 2013/14	99.81%	96%	100.00%	77.7%
Q3 2012/13	99.40%	94.10%	100.00%	84.60%
Q3 2011/12	97.50%	90.70%	100.00%	32.40%

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

- The Trust has aimed to implement current best practice guidelines in order to ensure that all adult inpatients receive a Venous Thrombo-Embolism Risk Assessment on their admission to the hospital, and that the most suitable prophylaxis is instituted. The Trust has embedded and improved the implementation of VTE guidelines within the Trust and has demonstrated this by achieving above the 90% compliance indicator. From 1st April 2011 to 31st August 2011 the Trust did not achieve the VTE target, however from 1st September 2011 - 31st March 2012 the Trust achieved above 90% compliance due to the hard work, commitment and the actions taken by staff. Since then we have been able to sustain this improvement as shown by latest figures from March 2012 to 31st March 2014.

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

- A senior clinician and a senior nurse have been identified to provide leadership to facilitate ongoing improvements in compliance with trust processes and consequently improvements in patient care with regards VTE. The National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92) has been incorporated into easy to follow risk assessment forms across various specialties and is an integral part of clerking documents. This will not only ensure that VTE risk assessments are undertaken and embedded permanently in the admission pathway but also facilitates its documentation for subsequent analysis. The Thrombosis Committee monitors performance of individual clinical areas.
- Since December 2013, the clinical audit department have collected real time VTE data to give feedback to individual areas and address poor performance pro- actively.

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

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

Year	Trust	England Average	England Highest	England Lowest
2012/13	10.4	16.1	30.8	0
2011/12	20.4	21.8	51.6	0
2010/11	38.9	29.6	71.8	0

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

- Following the significant reductions in Clostridium Difficile Infection (91% for the last six years for the Acute Trust from 2007/2008) the Trust has continued to embed measures to reduce levels further within the organisation.
- There have been 26 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2013 and March 2014, in comparison to 28 for the period April 2012 to March 2013, demonstrating a reduction of 7%. The Trust was required to achieve a trajectory of 29, a reduction of 24%, based on the 38 incidences of Clostridium Difficile between October 2011 and September 2012 by March 2014. Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms.

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

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

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

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

Please note that the data supplied by HSCIC is provisional.

	Incidents				Resulting in Severe Harm or Death			
Period	Trust Rate per 100	England Rate per 100 (Average)	England Rate per 100 (Highest)	England Rate per 100 (Lowest)	Percentage of Total (Trust)	Percentage of Total (England)	Percentage of Total (Highest)	Percentage of Total (Lowest)
01/04/2013 to 30/09/2013	3.99	N/A	N/A	N/A	0.347	N/A	N/A	N/A
01/04/2012 to 30/09/2012	8.3	6.7	13.61	1.99	0.1	0.7	2.5	0
01/04/2011 to 30/09/2011	5.92	5.99	10.08	2.75	0.2	0.8	2.9	0.1

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

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

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

- It is essential that lessons are learned from Serious Untoward Incident's in order to mitigate the risk of reoccurrence, these lessons are fedback to staff within the Divisions through training, ward meetings, SUI reports being uploaded onto the Risk Management site of the Intranet, the bi-monthly LIRC Committee meetings and the Trust wide monthly "lessons learned" newsletter.
- Engagement with the patient and their relatives is very important to the Trust to embed an open and honest culture, and to the patient and their family as a healing tool. Patients and relatives are informed when an incident has occurred and that an investigation is to be undertaken. They are also offered feedback in relation to the investigation findings.

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

Part 3: Other Information - Review of Quality Performance

The Quality Account has provided an overview of the Quality Improvement work which has taken place across the organisation. There are a number of projects which we will be taking forward into the coming year and focusing our attention upon them. We would however, like to highlight the following projects as key priorities for 2013/14:

3.1 An Overview of the Quality of Care Based on Performance in 2013/14 with an Explanation of the Underlying Reason(s) for Selection of Additional Priorities

Table 1 in Part 2 sets out the priorities for improvement which were identified in the 2012/13 report and none of these priorities changed in 2013/14 because they were all considered to be of importance by the Board of Directors. Additional information regarding the rationale for the priority selection is detailed in 2.2.2 and 2.2.3. We also identified four additional priorities for quality improvement for monitoring in 2013/14 in relation to improving patient pathways with our service users. The additional priority has been identified and included and monitored during the reporting period 2013/14 for the following reasons detailed below:

Improving Patient Pathways in: –

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

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

- Pathways
- Waits
- Workforce

It has been proven that the use of clinical pathways supports standardised management and delivery of patient care, improves patient outcomes, and can contribute to a reduction in mortality, hospital complications and length of stay.

The pathways identified and developed to date are for conditions that impact most on our mortality and morbidity. Five pathways have been implemented to date and a work plan for 2014/15 agreed to address other high mortality areas.

Data is collected real time and fed back to clinicians and teams to allow immediate improvements to be made. All pathways have seen an improvement in compliance with the mission critical points of the pathways, and there has been a downward trend in mortality for pneumonia, sepsis and stroke.`

Many complaints and negative feedback comments are related to poor communication or lack of information. The Foundation Trust is constantly seeking to

establish the most effective way of communicating with patients and exploring new ways to address communication barriers faced by patients using our services. The following developments highlight our commitment to improving the pathway of care with all our service users and are very focussed on providing clearer information and improving the pathway of care with all our service users.

100 Day Pathway Campaign
The Fylde Coast Scheduled Care vision is committed to introducing end-to-end pathways for specific conditions to maximise convenience and safety for patients and overall efficiency. Over 20 local pathways relating to the high demand procedures undertaken by the hospital in 2012 in areas such as general surgery, gynaecology and orthopaedics were launched in December 2013. These not only provide clear guidance to GP's, Practice Nurses, Consultants and other clinical staff but have been made available for patients on the Fylde Coast to access through the Trust's web site so they can see the care they can expect to receive.

Enhanced Recovery Pathways
Enhanced Recovery is an approach to elective surgery based on the principles that patients are in the optimal condition for treatment, have different care during their operation and experience optimal post-operative rehabilitation. A number of patient pathways have been developed and are in use in Gynaecology, Cardiology, Orthopaedics and Urology. As well as a reduction in length of stay these pathways improve communication between clinical staff and patients by providing them with a recovery diary to update daily on their recovery.

3.2 Performance Against Key National Priority Indicators And Thresholds

The NHS Outcomes Framework for 2013/14 sets out high level national outcomes which the NHS should be aiming to improve. The Board of Directors monitors performance compliance against the relevant key national priority indicators and performance thresholds as set out in the NHS Outcomes Framework 2013/14. This includes performance against the relevant indicators and performance thresholds set out in the Risk Assessment Framework 2013/14 which can be accessed via the following link: **http://www.monitor-nhsft.gov.uk/sites/default/files/publications/RAF_Update_AppC_1April14.pdf**

Monitor uses a limited set of national measures of access and outcome objectives as part of their assessment of governance at NHS Foundation Trusts. Monitor uses performance against these indicators as a trigger to detect potential governance issues.

NHS Foundation Trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action. Except where otherwise stated, any trust commissioned to provide services will be subject to the relevant governance indicators associated with those services.

Part 3, Section 3.2 and detailed in table 11 sets out the relevant indicators and performance thresholds outlined in Appendix A of Monitors Risk Assessment Framework. Unless stated in the supporting notes, these are monitored on a quarterly basis. Please note: where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they will not be repeated here. Only the additional indicators which have not already been reported in part 2 will be reported here to avoid duplication of reporting.

Please note: there will be some overlap with indicators set out in part 2 which are now mandated by the Quality Accounts Regulations. Only the additional indicators which have not already been reported in part 2 will be reported here to avoid duplication of reporting.

Performance against the key national priorities is detailed on the Business Monitoring Report to the Board of Directors each month and is based on national definitions and reflects data submitted to the Department of Health via Unify and other national databases.

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

Table 11: Performance against Relevant Key National Priority Indicators and Thresholds				
Quality Standard	Trust Self Assessment 2010/11	Trust Self Assessment 2011/12	Trust Self Assessment 2012/13	Trust Self Assessment 2013/14
All Cancers: one month diagnosis to treatment:				
First Treatment (target >= 96%)	Achieved	Achieved Q1 99.5% Q2 99.6% Q3 99% Q4 99.8%	Achieved Q1 99.3%, Q2 99.4%, Q3 98.5%, Q4 98.9%	Achieved: Q1 98.9% Q2 98.9% Q3 99.8% Q4 99.3%
Subsequent Treatment – Drugs (Target >=98%)	Achieved	Achieved Q1 100% Q2 100% Q3 99.3% Q4 99.3%	Achieved Q1 100%, Q2 100%, Q3 99.2%, Q4 98.6%	Achieved: Q1 99.2% Q2 100% Q3 100% Q4 100%
Subsequent Treatment – Surgery (Target >=94%)	Achieved 100% for all 4 quarters	Achieved Q1 100% Q2 100% Q3 100% Q4 100%	Achieved Q1 100%, Q2 95.8%, Q3 96.7%, Q4 100%	Achieved: Q1 100% Q2 98.7% Q3 96.3% Q4 97.3%
Subsequent treatment – Radiotherapy (Target >=94%)	Not applicable	Not applicable	Not applicable	Not applicable
All Cancers: two month GP urgent referral to treatment:				
62 day general (target >=85%)	Achieved	Achieved Q190.8% Q2 87.2% Q3 92.3% Q4 87%	Achieved Q1 85.1%, Q2 89.5%, Q3 85.5%, Q4 83%	Achieved: Q1 86.6% Q2 89.4% Q3 85.2% Q4 86.6%
Annual percentage Excluding rare cancer 86.5%				
62 day general (target >=85%) Including Rare Cancers	Not applicable	Not applicable	Not applicable	Achieved: Q1 86.8% Q2 89.4% Q3 85.4% Q4 86.7%
Annual percentage 87.1%				
62 day screening (target >=90%)	Achieved	Achieved Q1 90.5% Q2 93.7% Q3 86.8% Q4 96.7%	Achieved Q1 94%, Q2 91.3%, Q3 98%, Q4 96.6%	Achieved: Q1 89.1% Q2 91.7% Q3 90.1% Q4 94.7%
62 day upgrade (Target TBC)	Achieved greater than 95% in all 4 quarters	Achieved greater than 94% in all 4 quarters	Achieved Q1 91.4%, Q2 90.9%, Q3 92.2%, Q4 95.6%	Achieved: Q1 85.4% Q2 95.9% Q3 93.6% Q4 92.6%

Table 11: Performance against Relevant Key National Priority Indicators and Thresholds				
Quality Standard	Trust Self Assessment 2010/11	Trust Self Assessment 2011/12	Trust Self Assessment 2012/13	Trust Self Assessment 2013/14
Breast Symptoms – 2wk wait (Target 93%)	Achieved Q1, 93.7%; Q2, 95.7%; Q3, 94.9%; Q4, 96.2%	Achieved Q1 94.1% Q2 94.7% Q3 93.2% Q4 96.4%	Achieved Q1 93.8%, Q2 96.5%, Q3 97.2%, Q4 93.4%	Achieved: Q1 94% Q2 94.8% Q3 96.7% Q4 93%
Reperfusion – Primary PCI	Achieved	Achieved	Achieved	Achieved
Delayed Transfers of Care (target <3.5%)	Achieved	Achieved	Achieved	Achieved
Percentage of Operations Cancelled (target 0.8%)	Achieved 0.6%	Achieved 0.56%	Achieved 0.45%	Under Achieved 0.92%
Percentage of Operations not treated within 28 days (target 0%)	Achieved 0%	Achieved 0%	Achieved 0%	Achieved 0%
National In-Patient Experience Survey	Achieved	Under-achieved	Under-achieved	Achieved
Quality of Stroke Care	Achieved	No longer measured	No longer measured	No longer measured
Ethnic Coding Data quality	Achieved	Achieved	Achieved	Achieved
Maternity Data Quality	Achieved	Achieved	Achieved	Achieved
Staff Satisfaction	Achieved	Achieved	Achieved	3.70 (Highest best 20% nationally)
18 week Referral to Treatment (Admitted Pathway) (target >=90%)	Achieved 94.08%	Achieved 91.89%	Achieved 94.66%	Achieved 92.02%
18 week referral to treatment Open Pathways (Target >+92%)	Not Applicable	Not Applicable	Achieved 94.37%	Achieved 94.78%
18 week Referral to Treatment (Non-Admitted Pathways [including Audiology]) (Target >=95%)	Achieved 96.46%	Achieved 95.76%	Achieved 97.51%	Achieved 96.78%
18 week Referral to Treatment (non admitted pathways) 95th percentile (target 18.3 weeks)	Not Applicable	Achieved	No longer measured	No longer measured
18 week Referral to Treatment (admitted pathways) 95th percentile (target 23 weeks)	Not Applicable	Achieved	No longer measured	No longer measured
Incidence of MRSA	4 (target <=3)	2 (target <=3)	3 (target <=3)	1 (target 0)
Incidence of Clostridium Difficile	101 (target <=152)	53 (target <=86)	28 (target <=51)	26 (target <=29)
Mixed Sex Accommodation (Target 0)	2 breaches	5 breaches	12 breaches	15 breaches
Total time in A&E (target 95% of patients to be admitted, transferred or discharged within 4hrs)	Achieved 97.69%	Achieved 95.93%	Achieved 96.61%	Not updated on National website as yet
Total time in A&E (95th percentile) (Target 240 minutes)	Not applicable	Under-achieved	Under-achieved	Under-achieved

Table 11: Performance against Relevant Key National Priority Indicators and Thresholds				
Quality Standard	Trust Self Assessment 2010/11	Trust Self Assessment 2011/12	Trust Self Assessment 2012/13	Trust Self Assessment 2013/14
Total time to initial assessment (95th percentile) (Target 15 minutes)	Not applicable	Under-achieved	Under-achieved	Under-achieved
Time to treatment decision (median) (Target 60 minutes)	Not applicable	Under-achieved	Achieved	Under-achieved
Unplanned re-attendance (Target 5%)	Not applicable	Achieved	Achieved	Not updated on National website as yet
Left without being seen (Target 5%)	Not applicable	Achieved	Achieved	Not updated on National website as yet
Ambulance Quality (Category A response times)	Not applicable	Not applicable	Not applicable	Not applicable
Waiting times for Rapid Access Chest Pain Clinic	100%	100%	100%	100%
Access to healthcare for people with a learning disability	Achieved	Achieved	Achieved	Achieved
Participation in heart disease audits	Achieved	Achieved	Achieved	Achieved
Smoking during pregnancy	Under-achieved 26.99%	24.59%	24.56%	23.2%
Breast-feeding initiation rates target (average rate within 48 hrs)	Under-achieved 63.14%	60.47%	56.35%	65.7%
Emergency Preparedness	**	**	**	**
Where needed the criteria for the above indicators has been included in the Glossary of Terms				

*** The Pandemic Influenza Plan (Version 8) was reviewed in April 2014 and ratified by the Board of Directors.*

This document defines the key pandemic influenza management systems and responsibilities of staff**. The suite of emergency plans are all to be reviewed in early 2014 due to the release of new national guidance in November 2013 and the Emergency Preparedness, Resilience and Response Core Standards being issued which have been reviewed and are to be approved by the Trust Board in January 2014.

The Major Incident Plan (Version 6) and Decontamination Plan (Version 5) were reviewed in March 2014 and ratified by the Board of Directors. These documents define the key roles and responsibilities of staff during those incidents and the management systems.

Decontamination training is undertaken every 6 weeks with the responding departments. A regional major incident exercise was hosted by NHS England in October 2013 with all NHS organisations in Lancashire taking part.

To support these arrangements the Trust has a Trust wide Business Continuity Plan (Version 3) which was reviewed and ratified by the Board of Directors in March 2013. Beneath the Trust Business Continuity Plan are 9 Corporate, 19 CSFM, 3 Scheduled Care, 4 Unscheduled Care, 26 Adults and 8 Families Business Continuity Plans (total 69) with operational information on alternative options to deliver their services.
The Emergency Planning Manager and Local Security Management Specialist continue to undertake group training sessions for the seventy eight on call or duty staff, this includes Duty Directors, Duty Managers (Acute and Community Health Services), members of the Acute Response Team, Associate Directors of Nursing, Senior Nurses covering bleep 002, On Call Consultant Haematologists and Loggists.

The Emergency Planning Manager and Local Security Management Specialist also deliver quarterly lockdown and silver command activation exercises for on call staff to rehearse their roles.

Readmissions within 30 days
The Trust has been working with its health economy partners to implement strategies to reduce readmissions. Overall the percentage of all readmissions 2013/14 was above peer average; however for readmissions following non-elective admissions the Trust was above peer average as shown in Table 12. Work continues to improve the performance of patients readmitted following an elective procedure.

Table 12: 28 Day Readmissions

Indicator	Trust 2011/12	Peer 2011/12	Trust 2012/13	Peer 2012/13	Trust 2013/14	Peer 2013/14
All Admissions	6.9%	6.9%	6.4%	6.8%	6.8%	6.6%
Non-elective	11.5%	10.8%	10.8%	10.7%	11.2%	10.4%
Elective	2.9%	3.2%	3.3%	3.1%	3.2%	3.1%

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

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

62 day Cancer Waiting Time Standard
Delivery of the 62 day Waiting Time standards for both GP urgent and screening programme referrals continued to require significant work and pathway development across the Trust, the local health economy and wider Cancer Network during 2013/14 and the year end figure was 86.50% (excluding Rare Cancers) The overall annual performance figure increases to 87.1% when Rare Cancers are included (as required by Monitor). A significant amount of work was undertaken to understand and address the issues within pathways and across organisations for the benefit of patients. Information on the criteria for this indicator is detailed in the Glossary of Terms.

Learning from Patients
We encourage patients to give us feedback, both positive and negative, on their experiences of our hospital services so that we can learn from them and develop our services in response to patients' needs.
During the financial year 1st April 2013 to 31st March 2014 we received 3794 thank you letters and tokens of appreciation from patients and their families.
The number of formal complaints received by the Trust during the same period was 506 this includes 395 written complaints registered via the Trust and 32 Community formal complaints. There were also 79 verbal complaints made. The numbers of formal complaints received shows an overall increase of 49 cases compared to the previous year as shown in the Table 13 below.

Table 13: Complaints	
Date - Financial Year	Complaints
2013/2014	506 Total (439 Trust + 67 Community)
2012/2013	457 Total (376 Trust + 81 Community)
2011/2012	483 Total (399 Trust + 84 Community)
2010/2011	347 (Trust only)

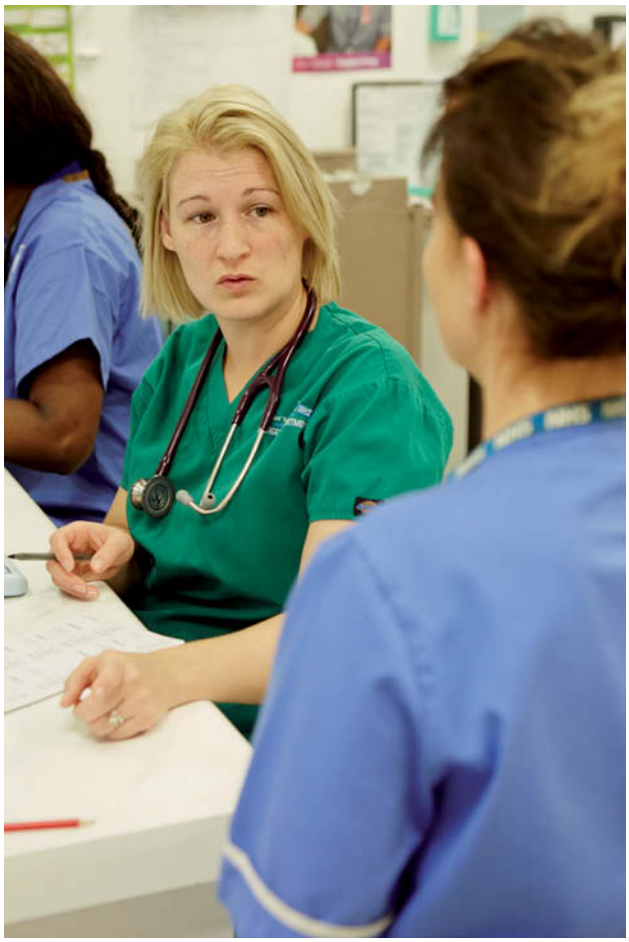
The main categories of complaints are related to:

- Treatment Issues 263
- Communication 42
- Staff Attitude 56
- Waiting Times 48
- Administration 51

Once the complaint has been acknowledged by the Trust, it is sent to the appropriate Division for local investigation. Once this investigation has been completed, their response is compiled and, following quality assurance checks, the response is signed by an Executive Director and posted to the complainant. Divisions are actively encouraged to arrange face to face meetings with complainants and during 2013/14, 63 meetings were held in order to resolve a complaint in a more timely manner (9 after a final response and 54 before a final response), a decrease of four from the previous year.

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

Following recommendations in the Keogh Report, the Trust holds a monthly Complaint Review Panel to discuss 'upheld' formal complaints. The panel address if the divisions complaints have been managed in line with agreed timeframe, investigated thoroughly and proportionally and the response is appropriate. Evidence is reviewed and lessons learned discussed to discover emerging themes and trends arising from complaint investigations. The panel will also review complainants that are deemed vexatious and agree a suitable response.



Once local resolution has been exhausted the complainant has the right to contact the Health Service Ombudsman for a review of the complaint. During 2013/14, 16 complaints were considered by the Ombudsman. Of these, the Ombudsman has decided 'no further investigation' is required, 2 have been reported as 'not upheld', one 'partially upheld' and 10 are still under consideration and classed as being 'referred to the second stage'.

Informal Complaints

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

Table 14 below shows the number of issues dealt with by the by PALS team over the last four years.

Table 14: Informal Complaints		
Date - Financial Year	Number of Cases	Number of Issues
2013/2014	2,284	4,307
2012/2013	2,496	2,702
2011/2012	3,124	3,508
2010/2011	2,609	2,887

The number of cases handled by the Patient Experience Team this year has decreased by 212 cases in comparison to the previous year. Out of the 2,284 cases 2,182 have been resolved and 102 cases are ongoing or require final closure. The main themes that have emerged from the cases recorded are:

- Administration (476 issues)
- Staff Attitude (158 issues)
- Treatment Issues (466 issues)
- Waiting Times (449 issues)
- Communication (198 issues

To help reduce the number of complaints within the Trust, lessons learned are discussed within the Divisional Governance meetings, whilst lessons that can be learned across the organisation and trends in the number of category of complaints are discussed at the Learning from Incidents and Risks Committee and the weekly complaints meeting to ensure learning is across the organisation. Following recommendations in the Keogh Report, the Trust holds a monthly Complaint Review Panel to discuss 'upheld' formal complaints. The panel address if the divisions complaints have been managed in line with agreed timeframe, investigated thoroughly and proportionally and the response is appropriate. Evidence is reviewed and lessons learned discussed to discover emerging themes and trends arising from complaint investigations. The panel will also review complainants that are deemed vexatious and agree a suitable response.

3.4 Detailed Description of Performance on Quality in 2013/14 against Priorities in 2012/13 Quality Accounts

This section provides a detailed description regarding the quality initiatives that have been progressed by the Trust including both hospital and community services information based on performance in 2013/14 against the 2012/13 indicators for the following priorities:

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

3.4.1 Priority 1: Clinical Effectiveness of Care

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

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

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

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

ensure information is available to attribute accurate clinical codes
- Engagement with Northwest area AQUA team to develop a definitive action plan for mortality improvement
- Development of enhanced informatics tools for early identification of mortality issues
- Initiated a review of the compliance with agreed care pathways and care bundles within clinical areas
- Detailed review of all mortality indicators with Chief Executive involvement

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

The Trust has shown a significant and sustained improvement in not only Risk Adjusted Mortality Index (RAMI) over the last three years but has also since July 2012 shown marked improvements in SHMI.

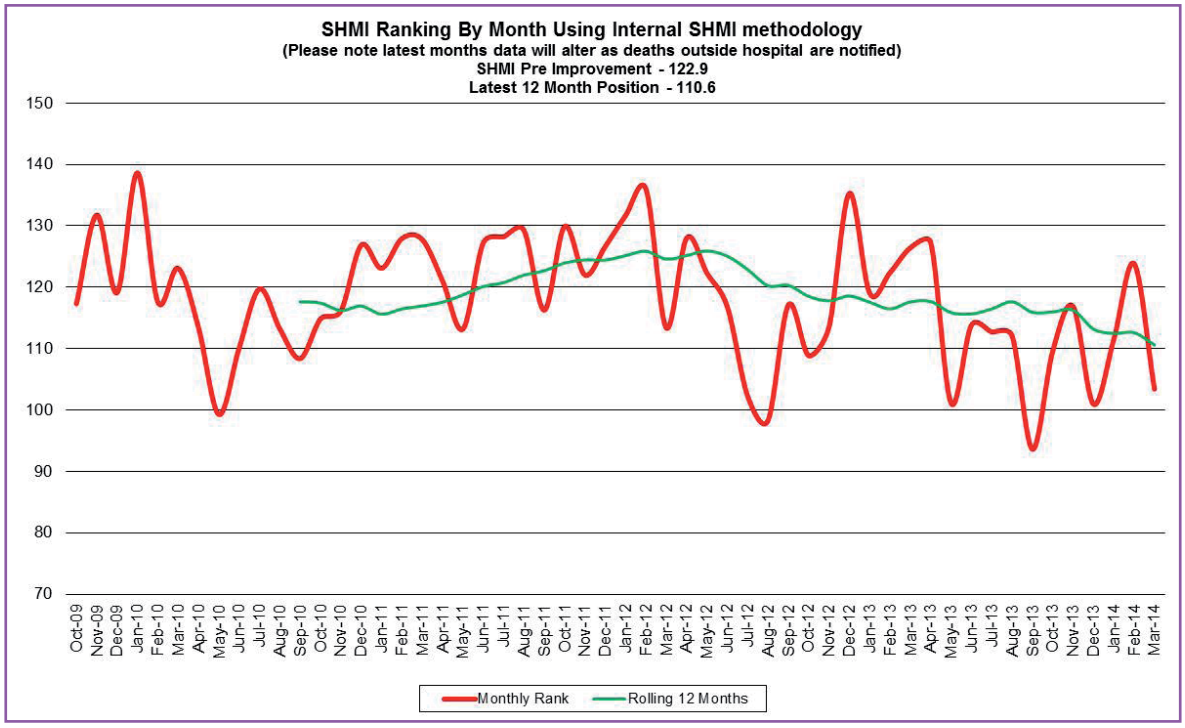
The Trust continues to be part of a North West Collaborative Programme for mortality reduction and has implemented programmes specifically around the care of patients with pneumonia and patients with severe sepsis. In addition to this work hospital mortality has been improved by the implementation of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

Blackpool Teaching Hospitals was one of the 14 Trusts identified for review by Sir Bruce Keogh as a persisting outlier on the national SHMI measure based on data from pre March 2012. The Trust welcomed this review and was one of only three organisations not placed in special measures following the review.

The Trust has also recently been inspected by the CQC where its work on reducing mortality and improving care pathways was commended.

These reviews have helped the organisation in creating a focused action plan for improving patient care around the key themes of Governance and Leadership, Mortality, Patient Experience and Workforce and Safety.

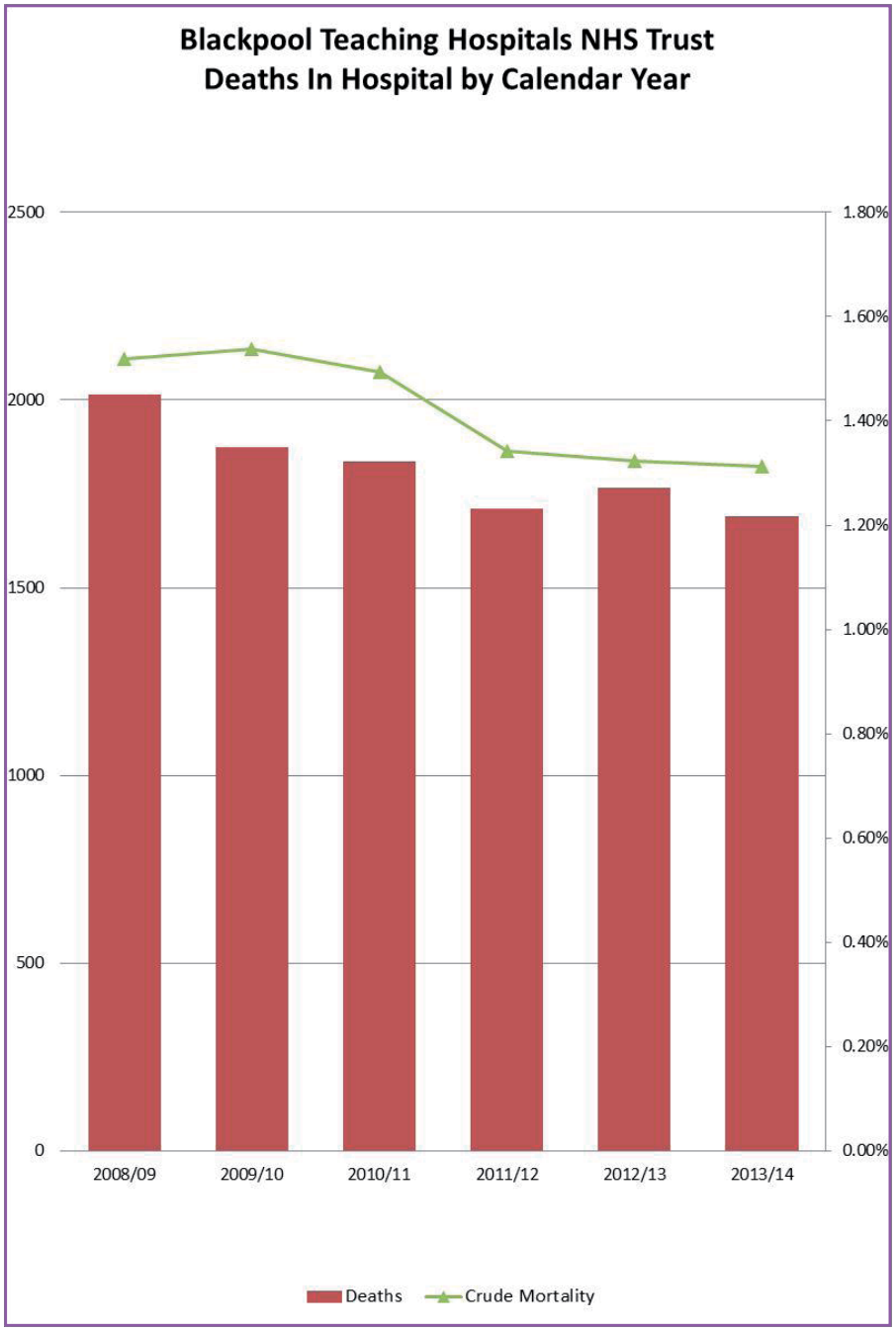
Graph 2: SHMI Ranking by month



Data source: HED data evaluation tool and Trust SHMI Calculation Tool. This data is governed by standard national definitions

Since commencement of work in July 2012 the Average Summary Hospital Mortality Indicator (SHMI) as produced by the Healthcare Evaluation Data Tool (HED) and internal calculations has fallen by over 12 points compared to the period from June 2010 to commencement of work.

Graph 3: Deaths in Hospitals by Calender Year



Data source: Trust Patient Administration System (PAS). This data is governed by standard national definitions

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

North West Advancing Quality Initiative

The Trust participates in the NHS North West (Strategic Health Authority) Advancing Quality Programme, which focuses on the delivery of a range of interventions for each of the following conditions listed in Table 15. Examples of the interventions can be found in the following information and Tables overleaf:

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

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

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

Table 15 : Commissioning for Quality and Innovation		
Commissioning for Quality and Innovation (CQUIN) and the respective Targets For The Trust		
Scheme	Threshold	Collection Period
Acute Myocardial Infarction (Heart Attack)	88.08%	Discharges which occur between 1st April 2013 and 31st March 2014
Hip and Knee Replacement Surgery	83.17%	
Coronary Artery By-pass Graft (CABG)	95%	
Heart Failure	77.85%	
Community Acquired Pneumonia	64.58%	
Stroke	54%	
Patient Experience Measures (PEMs)	N/A	

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

Comparison of Data

For each of the key areas a series of appropriate patient care measures has been determined, known as the Composite Quality Score (CQS). Data is collected to demonstrate if these measures are being met and a Composite Quality Score for each key area is derived for every Trust in the programme. Performance thresholds have been agreed using this data which, whilst challenging, are aimed at each Trust having the opportunity to be awarded the full amount retained through the Commissioning for Quality and Innovation (CQUIN) framework. The percentage levels which would generate a CQUIN payment for each organisation and the data collection periods for each scheme are slightly different, and therefore each CQUIN and the respective targets for the Trust are detailed in Table 15 above.

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

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

Please note: The 2013/14 data cannot be published until Grant Thornton have completed their audit to validate the data, which is anticipated to be September/ October 2014.

Acute Myocardial Infarction (Heart Attack)

The Trust has always performed well against the advancing quality measure for Acute Myocardial Infarction (Heart Attack). A number of measures have been introduced to ensure compliance with all performance measures. The Trust achieved the Composite Quality Score (CQS) of 98.54% as shown in Table 16.

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

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

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

Table 16: Acute Myocardial Infarction				
Acute Myocardial Infarction (Heart Attack)	Trust Performance			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	Apr 12 – Mar 13
Aspirin at arrival	100.00%	100.00%	99.78%	99.65%
Aspirin prescribed at discharge	100.00%	100.00%	100.00%	99.74%
ACEI or ARB for LVSD	100.00%	100.00%	100.00%	98.91%
Adult smoking cessation advice/counselling	96.00%	96.61%	95.12%	96.73%
Beta Blocker prescribed at discharge	100.00%	98.79%	99.54%	99.01%
Beta Blocker at arrival				
Fibrinolytic therapy received within 30 minutes of hospital arrival				66.67%
Primary Coronary Intervention (PCI) received within 90 minutes of hospital arrival	100.00%	95.12%	91.50%	92.88%
Survival Index	99.00%	90.80%	96.52%	98.52%
Acute Myocardial Infarction (AMI) Composite Quality Score (CQS)	99.62%	97.98%	98.17%	98.54%
Top 25% CQS Threshold	99.04%			
Top 50% CQS Threshold	98.00%			
CQUIN Threshold	87.35%	95.00%	95.00%	95%
The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 98.54% (green)				

Hip and Knee Replacement Surgery

Both antibiotic and Venous Thrombo-Embolism prophylaxis is the subject of a set of departmental protocols. Compliance with the Venous Thrombo-Embolism prophylaxis protocol is 98% or better. With regard to antibiotic prophylaxis we have developed a system, involving both Flucloxacillin and Gentamicin antibiotics as a first line for patients without Penicillin/ Cephalosporin antibiotic allergy, and are compliant in this area. The Trusts performance is shown in Table 17.

Table 17: Hip and Knee Replacement Surgery				
Hip and Knee Replacement Surgery	Trust Performance			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	Apr 12 – Mar 13
Prophylactic antibiotic received within 1 hour prior to surgical incision	88.14%	97.96%	94.97%	93.13%
Prophylactic antibiotic selection for surgical patients	97.36%	99.59%	97.18%	91.06%
Prophylactic antibiotic discontinued within 24 hours after surgery end time	98.31%	96.64%	95.63%	97.13%
Recommended Venous Thrombo-Embolism prophylaxis ordered	99.66%	100.00%	99.11%	98.73%
Received appropriate Venous Thrombo-Embolism (VTE) prophylaxis w/I 24 hrs prior to surgery to 24 hrs after surgery	99.66%	100.00%	98.96%	98.73%
Readmission (28 Day) avoidance index	94.02%	92.50%	91.98%	94.78%
Hip and Knee Composite Quality Score (CQS)	96.19%	97.78%	96.25%	95.54%
Top 25% CQS Threshold	96.89%			
Top 50% CQS Threshold	94.27%			
CQUIN Threshold	75.67%	95.00%	95.00%	95.00%
The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 95.54% (green).				

Coronary Artery Bypass Graft (CABG) Surgery

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

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

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

All data is shared with the Consultant Team and Health Professionals at the monthly Directorate meeting and in the Divisional Governance meeting. The Trust achieved the Composite Quality Score (CQS) of 98.19% as shown in Table 18.

Table 18: Coronary Artery Bypass Graft Surgery				
Coronary Artery Bypass Graft Surgery	Trust Performance			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	Apr 12 – Mar 13
Aspirin prescribed at discharge	98.54%	98.68%	99.30%	100%
Prophylactic antibiotic received within 1 hr prior to surgical incision	87.89%	95.59%	99.68%	98.52%
Prophylactic antibiotic selection for surgical patients	94.88%	98.30%	99.68%	99.59%
Prophylactic antibiotic discontinued within 24 hrs after surgery end time	89.82%	93.62%	90.42%	94.52%
Coronary Artery Bypass Graft Composite Quality Score (CQS)	92.73%	96.54%	97.23%	98.19%
Top 25% CQS Threshold	97.75%			
Top 50% CQS Threshold	97.73%			
CQUIN Threshold	95.00%	95.00%	95.00%	95.00%
Year 3 - The Trust had to achieve the CQUIN Threshold of 95%. *The Trust met the CQUIN Threshold – we scored 98.19% (green)*				

Heart Failure

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

All data is shared with the Consultant Team and Health Professionals at the monthly Directorate meeting and in the Divisional Governance meeting. The Trust achieved the Composite Quality Score (CQS) of 91.14% as shown in Table 19.

Table 19: Heart Failure				
Heart Failure	Trust Performance			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	Apr 12 – Mar 13
Discharge instructions	18.42%	34.43%	76.79%	81.01%
Evaluation of LVS function	84.62%	87.70%	96.40%	96.18%
ACEI or ARB for LVSD	81.37%	84.84%	92.88%	97.65%
Adult smoking cessation advice / counselling	53.85%	28.13%	76.79%	97.50%
Heart Failure Composite Quality Score (CQS)	59.10%	65.94%	88.37%	91.14%
Top 25% CQS Threshold	77.60%			
Top 50% CQS Threshold	72.19%			
CQUIN Threshold	65.34%	65.34%	75.08%	82.24%
The Trust had to achieve the CQUIN Threshold of 82.24%. *The Trust met the CQUIN Threshold – we scored 91.14% (green)*				

Community Acquired Pneumonia

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

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

Performance of Blackpool Teaching Hospitals NHS Foundation Trust shows the Composite Quality Score (CQS) to be 90.77% as shown in Table 20.

Table 20: Community Acquired Pneumonia

Community Acquired Pneumonia	Trust Performance			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	Apr 12 – Mar 13
Oxygenation assessment	100.00%	99.81%	100.00%	100%
Blood Cultures performed in A&E prior to initial antibiotics received in hospital	41.60%	80.35%	77.82%	81.97%
Adult smoking cessation advice / counselling	39.62%	39.26%	50.00%	58.67%
Initial antibiotic received within 6 hrs of hospital arrival	64.94%	79.24%	83.60%	87.53%
Initial antibiotic selection for Community Acquired Pneumonia in immune-competent patients	97.32%	99.68%	100.00%	99.48%
CURB-65 score			75.63%	87.25%
Community Acquired Pneumonia Composite Quality Score (CQS)	76.28%	86.29%	85.74%	90.77
Top 25% CQS Threshold	84.03%			
Top 50% CQS Threshold	82.24%			
CQUIN Threshold	78.41%	78.41%	84.81%	87.39%

The Trust had to achieve the CQUIN Threshold of 87.39%.
The Trust met the CQUIN Threshold – we scored 90.77% (green)

Stroke
Performance of Blackpool Teaching Hospitals NHS Foundation Trust shows the Composite Quality Score (CQS) to be 89.34% and Appropriate Care Score (ACS) as 57.74% as shown in Table 21.

Table 21: Stroke			
Stroke (New Target Introduced October 2010)	Trust Performance		
Measure	(1.10.2010 – 31.3.2011)	(Apr 11 – Mar 12)	Apr 12 – Mar 13
Stroke Unit Admission	41.92%	74.19%	66.67%
Swallowing Screening	97.77%	97.96%	95.73%
Brain Scan	68.15%	84.41%	95.21%
Received Aspirin	90.71%	99.09%	96.32%
Physiotherapy Assessment	98.48%	96.69%	95.81%
Occupational Assessment	97.01%	95.47%	92.88%
Weighed	98.15%	98.49%	95.99%
Stroke Composite Quality Score (CQS)	83.65%	92.07%	89.34%
Stroke Appropriate Care Score (ACS)	34.27%	68.11%	57.74%
CQS - CQUIN Threshold	90%	90%	90%
ACS - CQUIN Threshold	50%	50%	50%
Year 1 – The Trust had to achieve two CQUIN Thresholds – CQS target of 90% and ACS target of 50% *The Trust did not achieve the CQUIN Threshold – we scored 83.65% (CQS) and 34.27% (ACS) (red = no payment received). This was due to patient's not being admitted to the Stroke Unit within 24 hours of suffering a TIA and not having a brain scan within the appropriate timescale.*			
Year 2 – The Trust met the CQUIN Threshold – target 90% / 50% and we scored 92.07% / 68.11%.			
Year 3 – The Trust achieved the ACS CQUIN target but failed the CQS CQUIN target.			

Enhancing quality of life for people with dementia –Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission
Dementia is a significant challenge for the NHS with it estimated that 25% of general hospital beds in the NHS are occupied by people with dementia, rising to 40% or even higher in certain groups such as elderly care wards or in people with hip fractures. The Dementia Project – Large Scale Change is led by two Associate Directors of Nursing and was introduced within the Trust to implement the Dementia Quality Standard and further raise awareness of dementia. The project is divided into five main work-streams each with a lead person responsible. The work-streams are: 1. CQUIN and pathways; 2. Safety and environment; 3. Pharmacology; 4. Education and training and specialist nurses; 5. Volunteers and Partnership. The Dementia Advisory Board continues to meet regularly and significant improvement to all aspects of dementia care is demonstrated within each of the ongoing work -streams.

- A successful bid to the Blue Skies Charity fund has meant that plans have now been drawn up for the development of a memory walk. The location and members of a project team have been identified and discussions have taken place with local businesses and artists who have kindly donated picture boards and local artefacts. The memory walk will be fully operational by June 2014.
- Distraction/comfort boxes have been introduced to try to engage our patients more effectively. These boxes contain familiar everyday items such as buttons, clothes pegs, and a wide range of 'sensory' materials such as crinkly, furry fabrics or items with lights that flash and twinkle. The aim is to stimulate a range of senses and help staff to engage with the patients, whilst also helping to relieve the anxiety felt by patients in an unfamiliar setting.
- Development of a Dementia Pathway is now completed and the launch of this will coincide with "Dementia Awareness" week.
- The butterfly scheme has been

re-launched this last month and work continues to ensure the principles of this approach are embedded within the organisation.

- Dementia Training and education continues to be improved. Opportunities for staff now include dementia awareness full day for all staff, Best Practice module in Dementia care, Level 3 course at UCLAN, Caring for people with Dementia, Delirium Awareness and risk assessment for junior doctors.
- Guidelines have been implemented for the prescription of antipsychotic medications.

A national target of 90% of patients admitted to hospital as an emergency aged over 75 years, will receive screening, assessment and onward referral for further memory assessment if indicated. After engagement with clinical staff and working with the NHS Institute, a Care Bundle Approach, which is a process where printed checklist paper forms of accepted clinical guidelines are introduced to relevant wards and made conveniently available to all clinicians, was agreed as the best way for doctors to screen patients for dementia and ensure that a proper assessment and appropriate referral took place.

The Initial Dementia Assessment

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

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

Despite the introduction of the Dementia Care Bundle and a mechanism to audit, the Trust was unable to meet the 90% national target in 2012/13. Further improvements were made during quarter 4 of 2013/14 through the introduction of dedicated audit staff to collect data and feedback compliance real time. This has shown some improvement (17% in quarter), and it is envisaged that the Trust will build on this over the coming year, but the Trust did not meet the 90% national target overall as shown Table 22. The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

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

Table 22: Monthly Trust-wide performance – Dementia Screening

Target 90%	Nov 2012	March 2013	June 2013	September 2013	December 2013	April 2014
Screening Question	29%	73%	52%	57%	70%	59%
Assessment	39%	75%	61%	52%	71%	59%
Referral	0%	0%	0%	20%	0%	54%

Data source: Internal data system and data submitted to the Department of Health. This data is governed by standard national definitions. Please note: data has not been signed off for the April 2014 data or submitted to the Department of Heath

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

- A daily alert email is sent to Ward Managers and Ward Clerks that alerts them to patients that need to have their assessment completed within 24 hours in order to meet the 72 hour criteria.
- A weekly performance report is now available that breaks down ward compliance and identifies which consultants were in charge at the time.
- Practice Development Sisters offer additional training on dementia for clinical staff that will include content on how to complete the bundle particularly the Dementia Assessment.
- Since December 2013, clinical audit assistants have collected data and provided real time feedback to clinicians to identify areas where improvements can be made to patient care relating to dementia screening and care planning

Medical Care Indicators Used to Assess and Measure Standards of Clinical Care and Patient Experience

The framework for the medical care indicators was designed to support medical staff to understand how they deliver specific aspects of their care. As with the nursing care indicators, our overall aim when introducing these performance measures is to reduce harm and improve patient outcomes and experience. The metrics are visible and therefore by using this system we can ensure that accountability is firmly placed on the medical teams providing the bedside care.

The results are obtained from a monthly spot prevalence audit, and the Indicators are based on questions relating to medical documentation, antibiotic prescribing, DNARCPR, Consultant review and care planning, VTE risk assessment and mortality

Reports are circulated to identify the following:

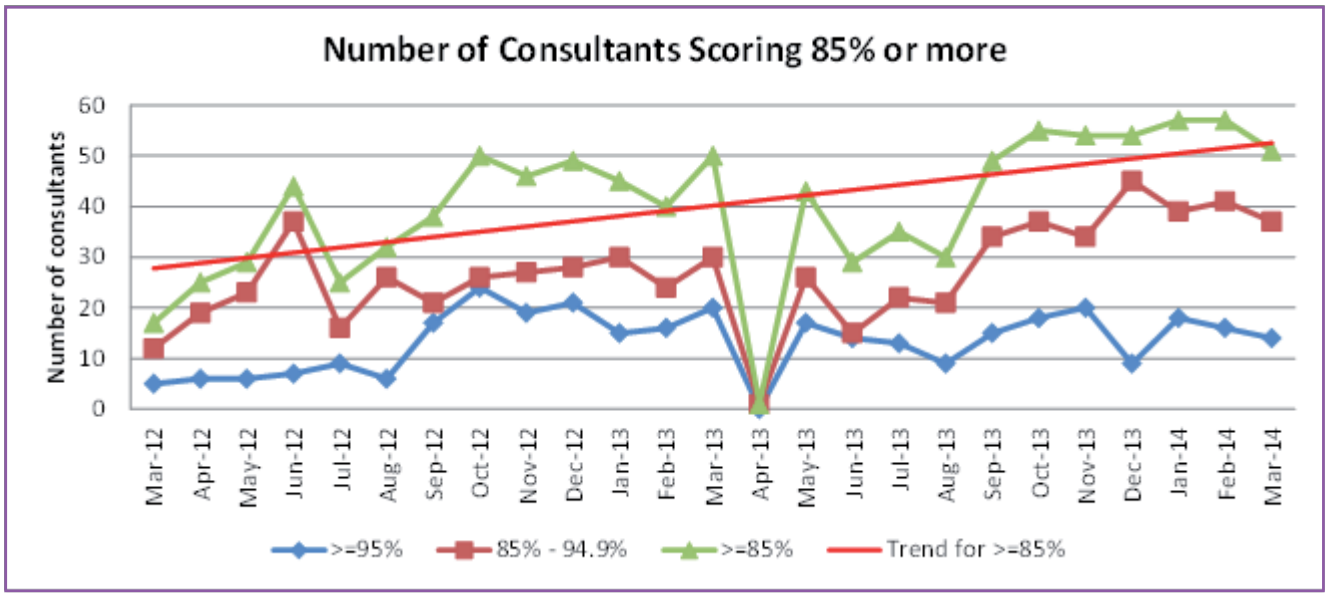
- Overall Trust Results
- Divisional Results
- Ward Level results
- Consultant level results

Between March 2012 and March 2014 the three month average number of consultants who achieved 85% compliance or better increased from 24 (Mar 12 to May 12) to 55 (Jan 14 to Mar 14) and the three month average number of consultants who achieved 95% compliance or better increased from 6 (Mar 12 to May 12) to 16 (Jan 14 to Mar 14)

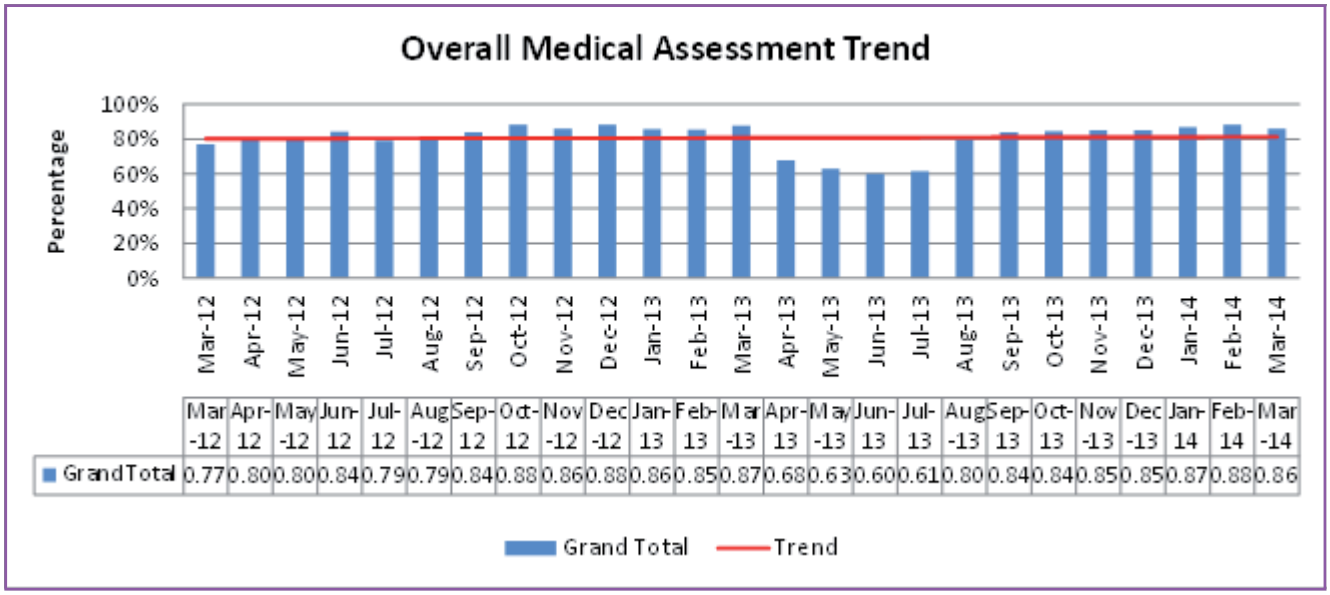
In April 2013 new criteria were added to the audit which led to the average consultant score falling from 87% to 68% and no consultants achieving a score for that month above 85%. By September 2013 the scores had recovered to the levels seen just prior to the introduction of the new criteria.

These indicators are shown in Graph 4 and Graph 5. The overall Medical Assessment Trend is shown in Graph 6.

Graph 4: Medical Care Indicators

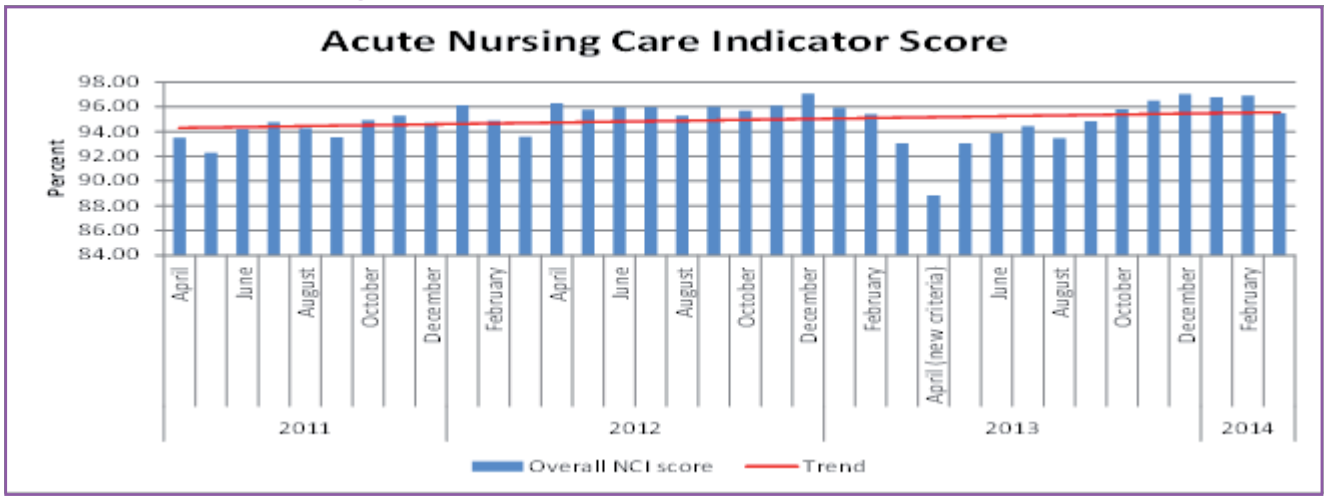


Graph 5: Medical Care Indicators



	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Grand Total	0.77	0.80	0.80	0.84	0.79	0.79	0.84	0.88	0.86	0.88	0.86	0.85	0.87	0.68	0.63	0.60	0.61	0.80	0.84	0.84	0.85	0.85	0.87	0.88	0.86

Graph 6: Acute Nursing Care Indicator Score



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

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

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

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

In the development of the Nursing Care Indicators, key themes for measurement were identified from complaints, the Patients' Survey, the Trust documentation audit, the benchmarks held within the essence of care benchmarking tool, and assessments against Trust nursing practice standards.

Measurement of the Nursing Care Indicators is an evolving process and is subject to annual internal review to ensure the indicators reflect current best practice and they are expanded into non ward based areas. In 2013 the criteria for all the indicators was reviewed and amended to reflect changing best practice. An additional indicator, 'Management of Patient property' was also added.

The following themes are measured monthly:

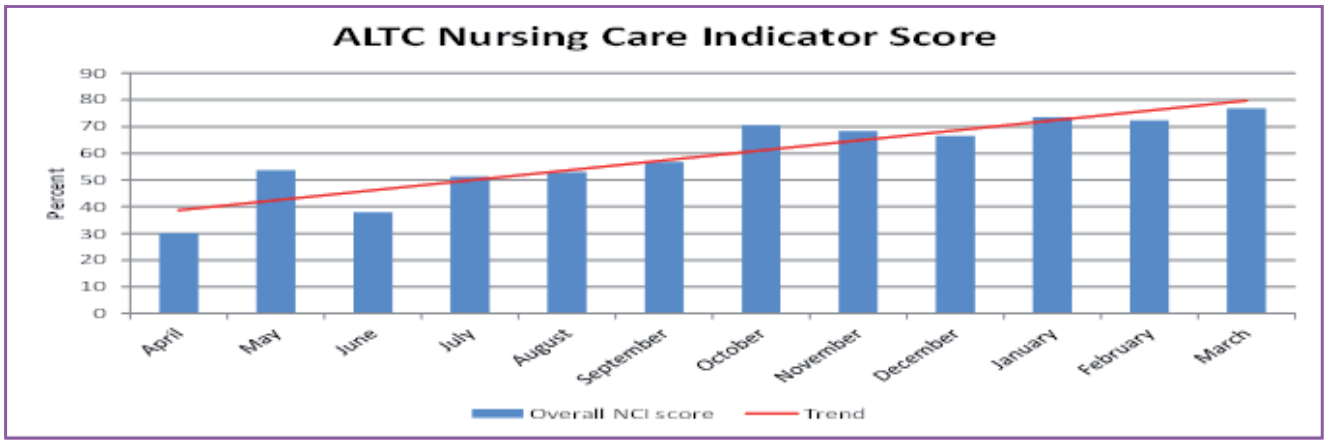
- Patient Observations
- Pain Management
- Falls Assessment
- Tissue Viability
- Nutritional Assessment
- Medication Assessment
- Infection Control
- Privacy & Dignity
- Care of the Dying
- Continence Care
- Management of patient property

Graph 7 shows the overall Trust performance, expressed as an average percentage of all 11 nursing care indicators, for 2013/14. The variation in scores seen is the type expected in a normal process. The trend clearly shows an overall improvement over the year.

In April 2013, Nursing Care Indicators were introduced into the community setting. Five indicators are being measured:

- Nutritional Assessment
- Pain Management
- Falls Assessment
- Tissue Viability
- Care of the Dying Patient

Graph 7: Adult and Long Term Conditions Nursing Care Indicator



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

Improving outcomes from planned procedures

- Patient Reported Outcome Measures (PROMS)

Improve the scores for the following elective procedure

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

Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective, it is a national programme organised by the Department of Health. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre and post operative surveys. The Trust Participation rates are as shown in Table 23.

Table 23: Participation Rates	
Date	Participation rate (full year)
2011/2012	75.7%
2012/2013	73.7%
2013/2014	76.5%

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The comparison data for PROMS between Blackpool Teaching Hospitals Provisional PROMs Data 2011 -12 (April 2011 - March 2012) and Provisional PROMs Data 2012-2013 (April 2012 - March 2013) is shown in Table 24. The data shows an improvement against the national scores, the positive scores are highlighted in green but reviewing the negative

scores, the Trust has improved on previous data. In regard to varicose vein PROMS the Trust scores against national scores appear to have slightly decreased, but in reviewing the scores comparing full year 2011/12 data to part year April to December 2012 data all scores have seen an increase in value.

Table 24: Provisional PROMs Data

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2011 -12 (April 2011 - March 2012) and Provisional PROMs Data 2012 - 2013 (April 2012 - March 2013)

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2011 -12 (April 2011 - March 2012) and Provisional PROMs Data 2012 - 2013 (April 2012 - March 2013)

Percentage Improving	Measure									
	EQ-5D Index 2011-12	EQ-5D Index 2012-13	Variance	EQ-VAS 2011-12	EQ-VAS 2012-13	Variance	Condition Specific 2011-12	Condition Specific 2012-13	Variance
Groin Hernia	48.8%	44.8%	-4.0%	41.5%	39.0%	-2.5%	N/A	N/A	N/A
Hip Replacement	88.8%	86.0%	-2.8%	61.3%	65.4%	4.1%	96.8%	95.50%	-1.3%
Knee Replacement	80.1%	79.6%	-0.5%	60.3%	58.2%	-2.1%	95.3%	89.40%	-5.9%
Varicose Vein	54.9%	50.0%	-4.9%	49.0%	38.9%	-10.1%	80.4%	88.20%	7.8%

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2011 -12 (April 2011 - March 2012) and Provisional PROMs Data 2012 - 2013 (April 2012 - March 2013)

Percentage Getting Worse	Measure									
	EQ-5D Index 2011-12	EQ-5D Index 2012-13	Variance	EQ-VAS 2011-12	EQ-VAS 2012-13	Variance	Condition Specific 2011-12	Condition Specific 2012-13	Variance
Groin Hernia	14.0%	19.8%	5.8%	35.8%	42.6%	6.8%	N/A	N/A	N/A
Hip Replacement	7.0%	2.8%	-4.2%	28.5%	22.6%	-5.9%	2.6%	4.50%	1.9%
Knee Replacement	6.6%	10.8%	4.2%	30.5%	27.8%	-2.7%	3.7%	9.00%	5.3%
Varicose Vein	14.4%	11.6%	-2.8%	40.0%	47.8%	7.8%	19.6%	11.80%	-7.8%

Data source: Health and Social Care Information Centre (HSCIC). This data is governed by standard national definitions

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

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

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

The Trust has been working with its health economy partners to implement strategies to reduce readmissions. Overall the percentage 28 day readmissions in 2013/14 was below peer average as shown in Table 25.

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that it shows that the work being undertaken across the health economy has started to impact on the percentage of readmissions seen at the Trust as shown in Graph 8.

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

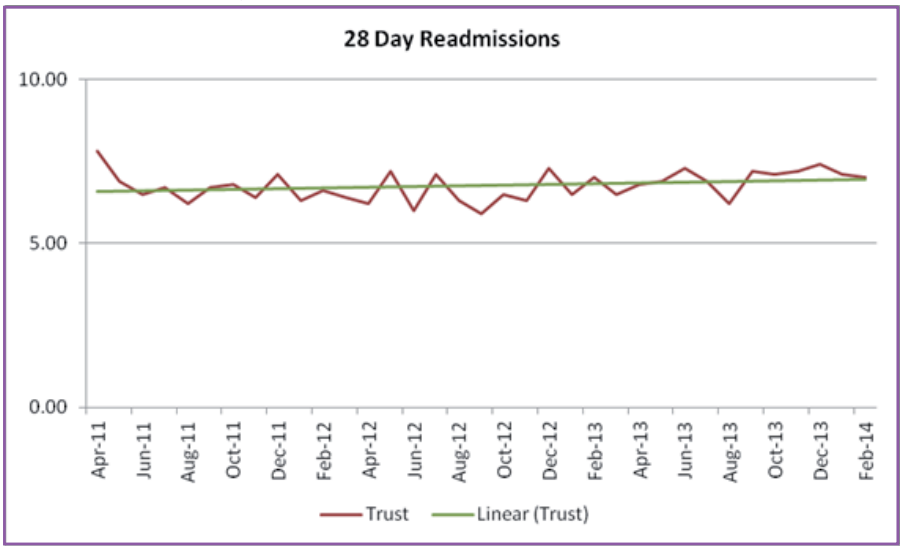
- A clinically led review of readmissions to identify/ implement actions required to reduce the number of avoidable admissions
- Joint work with Clinical Commissioning Groups to identify and implement health economy wide readmission avoidance schemes, including single point of access services to ensure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

Table 25: 28 Day Readmissions						
Indicator	Trust 2011/12	Peer 2011/12	Trust 2012/13	Peer 2012/13	Trust 2013/14	Peer 2013/14
All Admissions	6.9%	6.9%	6.4%	6.8%	6.8%	6.6%
Non-elective	11.5%	10.8%	10.8%	10.7%	11.2%	10.4%
Elective	2.9%	3.2%	3.3%	3.1%	3.2%	3.1%

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

NB: No exclusions are made from the CHKS data and therefore includes (day cases, obstetrics, cancer patients, etc). The Trust is unable to replicate the national methodology in full. The Trust has reviewed its raw data (not standardised as in national data) and non elective readmissions for the Trust equates to 16.77% for 2013/14.

Graph 8: 28 Day Readmissions



3.4.2 Priority 2: Quality of the Patient Experience

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

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

The CQC National Inpatient Survey is undertaken on an annual basis by the Picker Institute, an independent organisation. Between the period October 2013 and January 2014 a questionnaire was sent to 850 recent inpatients. 369 patients responded. Table 26 shows a comparison of data for five indicators from 2011 to 2014 and progress remains consistent.

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

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

Table 26: Care Quality Commission National Inpatient Survey				
Indicator	2011/12 Results	2012/13 Results	Comparison to last year's results	2013/14 Results
Were you involved as much as you wanted to be in decisions about your care and treatment?	87.3% said yes often or yes sometimes	82.6% said yes often or yes sometimes	↑	84.8% said yes often or yes sometimes
Did you find someone on the hospital staff to talk to about your worries and fears?	52.2% said yes definitely or yes to some extent	75.4% said yes definitely or yes to some extent	↑	76.9% said yes often or yes sometimes
Were you given enough privacy when discussing your condition or treatment?	89.2% were always or sometimes	91.3% were always or sometimes	↓	89.9% were always or sometimes
Did a member of staff tell you about medication side effects to watch for when you went home?	55.7% said yes completely or yes to some extent	51.5% said yes completely or yes to some extent	↑	57.4% said yes completely or yes to some extent
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67.3% said yes	66.7% said yes	↑	73.7% said yes

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

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

The Trust is in the process of improving the score in relation to the question "Were you given enough privacy when discussing your condition or treatment?". The Patient Experience Team are conducting regular spot audits to identify areas where patients feel they are not given enough privacy, informing divisional leads of their findings so action can be taken in real time.

The clinical divisions are also looking at what actions are needed to ensure information relating to medication side effects is discussed with the patients on discharge. The pharmacy team are developing information to enable patients' to be aware of the use of community pharmacists in medication reviews or any issues relating to medications.

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

Improve Staff Survey Results in the Following Area

- **Percentage of Staff Who Would Recommend Their Friends or Family Needing Care**

The National Staff Survey is undertaken on an annual basis by the Picker Institute, an independent organisation. Between the period October 2012 and January 2013 a questionnaire was sent to 1996 staff. 938 staff responded. Table 27 shows the result for the indicator.

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

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

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

Table 27: National Staff Survey Results		**Comparison to last years results**
Indicator	2012 Result	2013 Result
Percentage of staff who would recommend their friends or family needing care	89% of staff would be happy to recommend their friends or family needing care	86% of staff would be happy to recommend their friends or family needing care

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

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continuing to roll out the patient experience training to clinical staff and complete the actions as described above. In addition the Trust has updated its Strategic Aims and is consulting on new values and behaviours to ensure we each provide a consistent level of care to all our patients and service users and their families. We continue to invest in development of staff at the front line and to review performance. The Trust has

updated its Whistle blowing Policy which is currently being consulted on in order that it can be launched by the Chief Executive. The Trust will also implement a range of recommendations from the Francis, Keogh and CQC reports as it deems necessary.

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

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

Report on Friends and Family Test

The Friends and Family Test (FFT) has been implemented within the inpatient areas and accident and emergency dept from 1st April 2013 and across Maternity Services from October 2013.

The test will provide us with a simple, easily understandable headline matric which combined with other information, patient feedback and follow up questions can support the trust in pinpointing areas for improvement, and will inform and empower the ward, and the board, to tackle areas of weak performance and enhance areas of excellent practice.

The test will be designed to be a single matric and we will still need to supplement this with other methods of capturing, responding and understanding the patients experience data.

Why the test is important for our patients?

Patients will be able to use this information to make decisions about their care and also to challenge us in improving services as well as celebrating areas of good care.

Why the test is important for our staff?

Sharing this data with staff will increase the transparency of our Trust and empower all levels of staff to target and carry out improvements. Along with tracking the test results staff will also be able to see where targeted improvements have been effective and sustained. Staff being engaged in this process will be key to its success and data collection.

Expected requirements for the Test

We use the test to survey patients after they have experienced an episode of care, therefore participants are those adult patients at the point of discharge from acute inpatient care (with an overnight stay) and all patients who have attended A&E and from October 2013 this also included maternity services including ante natal, delivery, home birth and post natal care.

The aim of the test is to promote a responsive, patient led NHS. Ideally all patients in the target group should be given the opportunity to take part, so the Trust has been collecting data every day, not just on selected dates. We survey as many patients as possible as well as monitoring and reporting on the number of responses along with local reports.

The Friends and Family Test is simple and centred around one question:

- How likely are you to recommend our (ward name/ A&E Department) to friends and family if they needed similar care or treatment?

Respondents can respond by ticking:

- Extremely likely
- Likely
- Neither likely or unlikely
- Unlikely
- Extremely unlikely
- Don't know

We also asked a small number of additional questions find out what influenced their decision and gain deeper understanding of thier patient experience.

The Trust is marked according to the net promoter score based on the Department of Health scoring methodology. Scores are calculated based on the following calculation:

- Proportion of respondents who would be extremely likely to recommend minus proportion of respondents who would not recommend (response categories neither likely nor unlikely, unlikely and extremely unlikely)

The net promoter score is marked from plus 100 to minus 100. The Trust scores and response rates are detailed in Table 28 overleaf:

Table 28: Friends and Family Test					
Month	Trust Overall score	Responses	Inpatient Response Rate	Emergency Department Response Rate	Maternity Response rates
April 2013	72	453	19.7%	0.1%	Not surveyed
May 2013	74	724	25.7%	1.5%	Not surveyed
June 2013	76	877	32%	2.5%	Not surveyed
July 2013	72	1021	37.7%	7.4%	Not surveyed
August 2013	73	938	29.4%	4.1%	Not surveyed
September 2013	76	814	25.60%	3.10%	Not surveyed
October 2013	74	1128	30.70%	6.50%	9.7%
November 2013	70	1521	41.2%	13.4%	8.6%
December 2013	73	1816	44%	17.7%	9.8%
January 2014	66	2005	43.4%	21.7%	7.9%
February 2014	71	1611	41.8%	15.4%	12%
March 2014	72	1636	37%	14.1%	19.45%

Data obtained from Health and Social Care Information Centre

Improving the Experience of Care for People at the End of Their Lives

- Seeking Patients and Carers Views to Improve End of Life Care

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

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

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

The Trust End of Life Care Team continues to promote the tools available to enable patients to have choices in where they are cared for at end of life. A local family have worked with the team to share their experience of choice and preferences for care at end of life. Their daughter participated in a poster campaign, which received television and radio coverage. The aim of the campaign is to encourage patients, carers and staff to have discussions about their wishes and choices. These posters were launched throughout the Trust in May 2013 and were again supported with media coverage. The Trust continues to support same day or next day rapid discharges for those patients who wish to be cared for outside hospital in their last few weeks of life.

Based on the national Route to Success 'How to' guide on Transforming end of life care in acute hospitals, a ward based training programme has been developed and 3 senior nurses appointed to the Transform Training Team. The aim of the Transform Project is to increase the quality of end of life care in the Trust for patients and their carers and promote earlier identification of end of life with the opportunity for advance care planning discussions, realistic treatment choices and reduced emergency admissions at end of life. It will enhance communication, documentation, training and patient choice to improve the overall journey and experience.

Patient Led Assessment of the Care Environment (PLACE)

- **To Improve PLACE Survey Results/Standards**

Our aim is to deliver the best environment for our patients to ensure that the patient experience exceeds the standards set by the National Patient Safety Agency. Providing a clean and

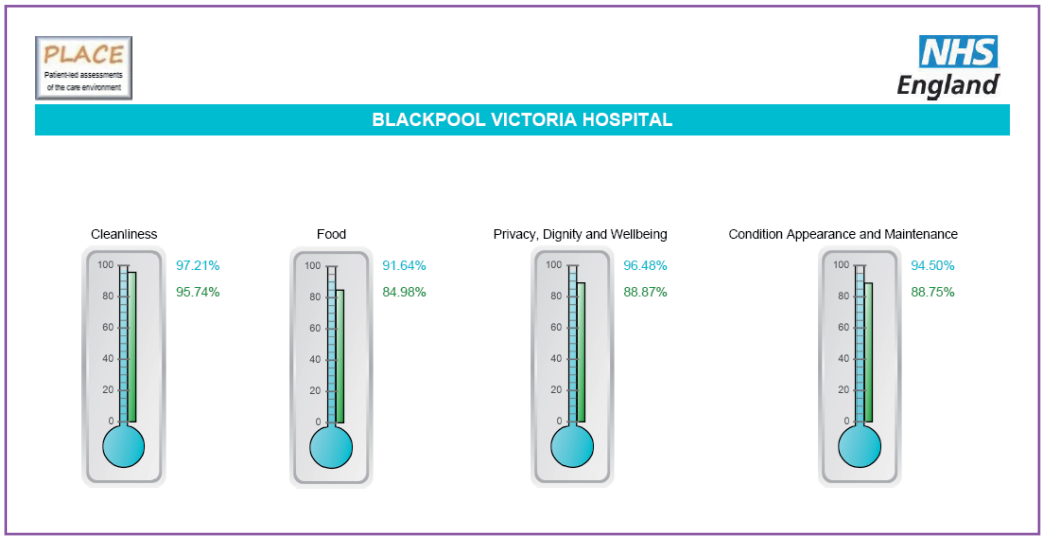
safe environment for our patients is extremely important to the Trust. We monitor this through the Patient Led Assessments of the Care Environment (PLACE) annual audits across all hospital sites.

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

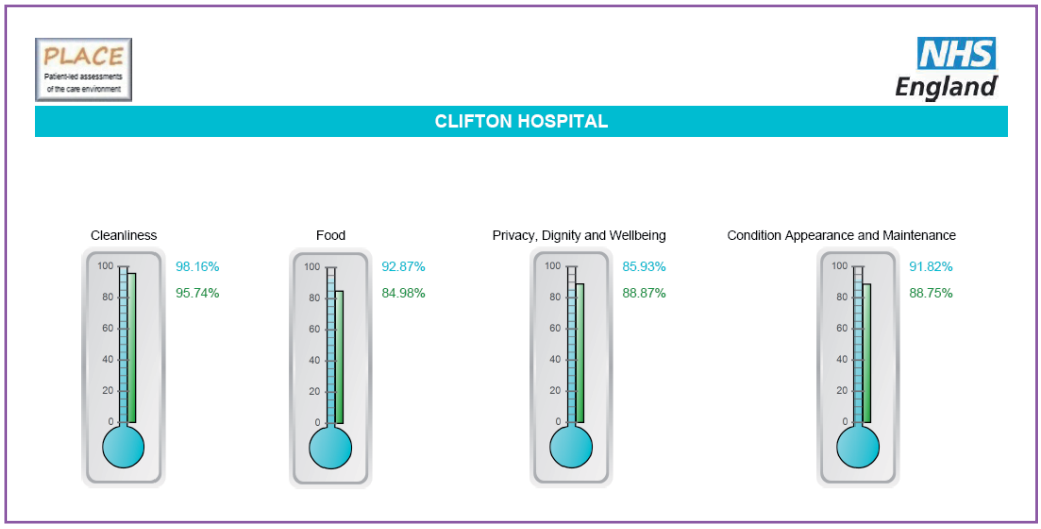
- Cleanliness
- Specific bathrooms/toilet cleanliness
- Catering Services
- Environment
- Infection Prevention
- Privacy and Dignity
- Access all external areas

The audit follows guidelines set by the National Patient Safety Agency and the results are publicised nationally on an annual basis. In 2013/14, PLACE audits were extremely encouraging across all hospital sites resulting in excellent standards achieved. The results in Graph 9 and Graph 10 demonstrate the commitment and dedication of all staff within the Trust who strive to ensure that the patient experience is met or exceeded during their stay in our hospitals.

Graph 9: Patient Led Assessment of the Care Environment (PLACE)



Graph 10: Patient Led Assessment of the Care Environment (PLACE)



Key: Blue data indicates Trust scores, green data indicates National Average.

Data source: Local data from the Patient – Led Assessment Care Environment survey. This data is governed by standard national definitions set by the Health and Social Care Information Centre

3.4.3 Priority 3: Patient Safety

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

Achieve 95% Harm Free Care to Our Patients by 2016 through the following strands of work

Improve the Percentage of Admitted Patients Risk Assessed for Venous Thrombo-Embolism (VTE) -

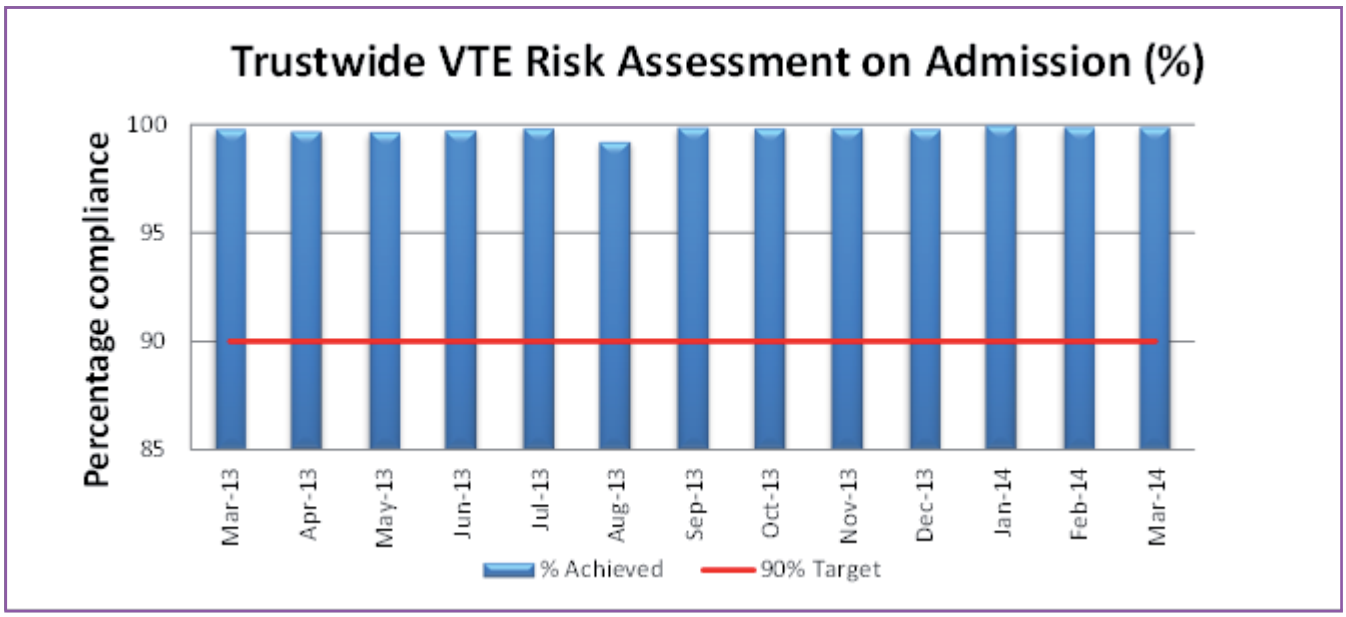
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has aimed to implement current best practice guidelines in order to ensure that all adult inpatients receive a Venous Thrombo-Embolism Risk Assessment on their admission to the hospital, and that the most suitable prophylaxis is instituted. The Trust has embedded and improved the implementation of VTE guidelines within the Trust and has demonstrated this by achieving above the new 95% compliance indicator. We have been able to sustain previous improvement as shown by latest figures from March 2013 to 31st March 2014 as shown in graph 11.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this 95% percentage compliance indicator and so the quality of its services, by undertaking the following actions:

- A senior clinician and a senior nurse have been identified to provide leadership to facilitate ongoing improvements in compliance with trust processes and consequently improvements in patient care with regards VTE. The National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92) has been incorporated into easy to follow risk assessment forms across various specialties and is an integral part of clerking documents. This will not only ensure that VTE risk assessments are undertaken and embedded permanently in the admission pathway but also facilitates its documentation for subsequent analysis. The Thrombosis Committee monitors performance of individual clinical areas.
- Since December 2013, the clinical audit department have collected real time VTE data to give feedback to individual areas and address poor performance pro- actively.

Graph 11: Trustwide Venous Thrombo-Embolism Risk Assessment



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

- **Compare the VTE national average for the above percentages**
  The average proportion of acute patients reported as having any type of VTE form the national Safety Thermometer (February 2013 to February 2014 inclusive) is 2.89%

- **Achieve a 10% reduction on the previous year in all VTE**
  In 2012/13, based on Safety Thermometer data, 563 out of 9030 hospital in-patients were reported as having a VTE. This represents a proportion of 6.23%. In 2013/14, 285 out of 9054 hospital in-patients were reported as having a VTE. This represents a proportion of 3.15%. The reduction in the proportion of patients reported as having a VTE from last year to this year is therefore 49.51%. The average proportion of acute patients reported as having any type of VTE form the national Safety Thermometer (February 2013 to February 2014 inclusive) is 2.89%

Reduce the Infection Rate of Clostridium Difficile and MRSA Bacteraemia

Reduce the rate of Clostridium Difficile Infections per 100,000 bed days amongst patients aged two years and over apportioned to the Trust, and compare the national average for the above site

Clostridium Difficile is an organism which may be present in approximately 2% of normal adults. This percentage rises with age and the elderly have colonisation rates of 10-20%, depending on recent antibiotic exposure and time spent in an

institution. Symptomatic patients are those whose stools contain both the organism and the toxins which it produces, and have diarrhoea. Those patients who are most at risk of acquiring Clostridium Difficile diarrhoea are the elderly, those on antibiotic therapy and surgical patients. Antibiotic administration is the most important risk factor for Clostridium Difficile diarrhoea, which is also known as Antibiotic Associated Diarrhoea. The clinical features of Clostridium Difficile infection can range from diarrhoea alone, to diarrhoea accompanied by abdominal pain and pyrexia to Pseudo Membranous Colitis (PMC) with toxic megacolon, electrolyte imbalance and perforation.

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

- Following the significant reductions in Clostridium Difficile Infection (91.95% for the last six years for the Acute Trust from 2007/2008) the Trust has continued to embed measures to reduce levels further within the organisation. There have been 26 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2013 and March 2014, in comparison to 28 for the period April 2012 to March 2013, demonstrating a reduction of 7%. The Trust was required to achieve a trajectory of less than 29 cases. Clostridium Difficile rates for April 2013-March 2014 as shown in Graph 12. Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to decrease the levels of Clostridium Difficle and improve the quality of its services:

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

significant impact on the rates of C.difficile and on trust antibiotic compliance rates. This is provided by regular ward rounds by the consultant microbiologist.

ii. Introduction of probiotics drinks for patients considered to be at high risk for C.difficile by consultant microbiologists

iii. Decontamination of patient environment and equipment as and when possible by using hydrogen peroxide fogging system.

iv. Ensuring cleaniliness of patient environment by ATP bioluminescence testing.

v. Proactive management of GDH positive, who are likely colonised with C.difficile by the infection prevention team.

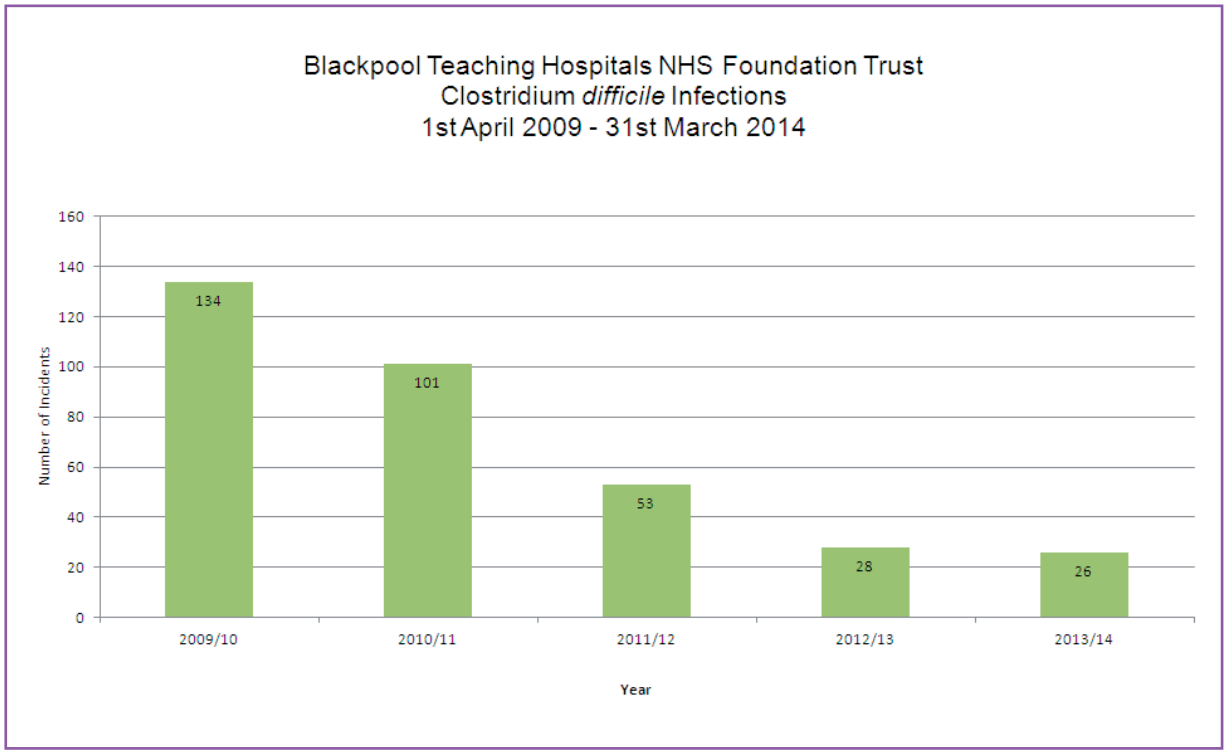
vi. Continuing to raise awareness and leading by example;

vii. Ongoing audits of compliance to ensure all infection prevention measures and control policies and procedures continue to be implemented, including in particular hand hygiene, environmental and decontamination standards; and

viii. Training on all aspects of infection prevention continues to be delivered;

ix. Outcomes were assessed by reviewing progress with the C.difficile target, and auditing compliance with national standards/ regulations

Graph 12: Clostridium difficile Infection Rates



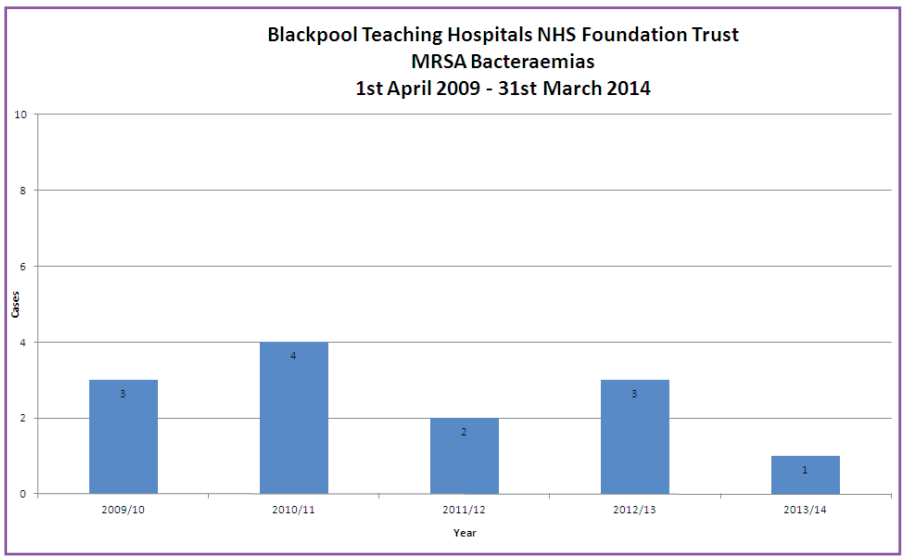
Data source: Department of Health M.E.S.S. This data is governed by standard national definitions

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

Following the significant reductions in Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia by 96.42% for the Acute Trust when compared to 2007/08, the Trust has continued to make tremendous progress in the last few years and embed Infection Prevention principles across the organisation, ensuring that the risk of acquiring an infection for patients is further reduced as shown in Graph 9 and 10.

The delivery of the MRSA Bacteraemia target remains a clinical risk, in relation to Monitor's Compliance Framework which identifies an MRSA trajectory of 0 cases for the reporting period. The Trust has reported 1 case for this year, which is above trajectory and against Monitor's Compliance Framework target, as detailed in Graph 13 Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms.

Graph 13: MRSA Bacteraemias Rate



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

To Monitor the Rate of Patient Safety Incidents the Trust have reported per 1000 admissions and the proportion of Patient Safety Incidents the Trust has reported that resulted in Severe Harm or Death

An analysis of patient safety incidents is undertaken by the Trust on a monthly basis. Incidents are coded based on the potential harm to the patient and on the actual harm to the patient. Incidents coded as severe involve any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving care in the Trust. Incidents resulting in death relate to those incidents where the incident directly resulted in the death of one or more persons receiving care in the Trust. Further information can be found in the Glossary of Terms

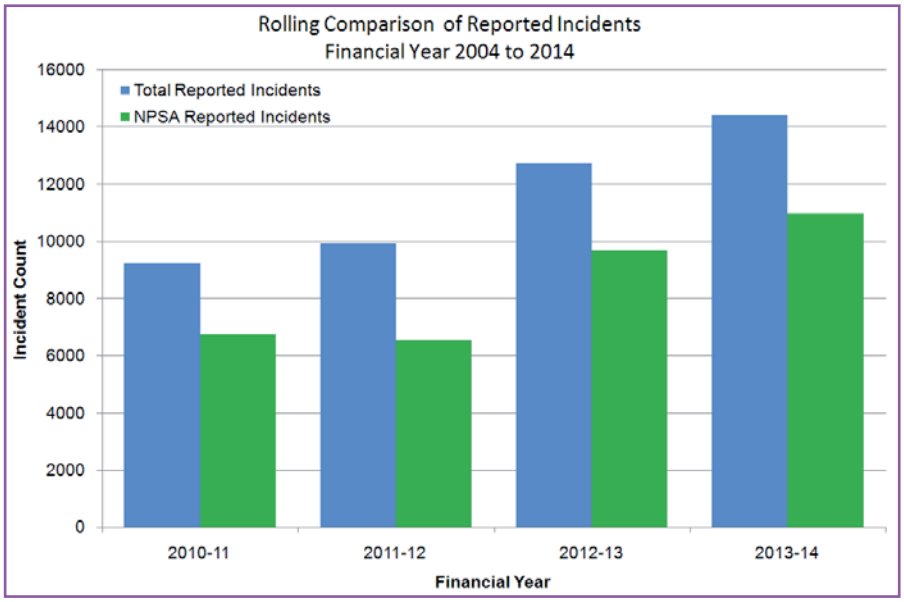
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- There has been a steady increase in the number of untoward incidents reported over the past 4 financial years (Graph 14). Patient Safety Incidents account for approximately 76% of all reported untoward incidents. In the year 2013/2014 there have been 14414 untoward incidents reported and of these 10957 were patient safety incidents and as such were reported to the National Patient Safety Agency. Of these 10957 patient safety incidents, 2,821 or 25.7% resulted in harm to the patient and in comparison to the number of attendances at the Trust (556,994) there is a patient safety incident reported for every 1 in 51 patients.

However only one patient safety incident resulting in harm was reported for every 205 patients during 2013/14.

Since 2011/2012 there has been an increase in the number of patient safety incidents that have resulted in severe patient harm (Graph 15 and Table 29). This continues to be monitored through analysis of trends and themes, lessons being learned and actions being taken at lower level incidents. The Trust has a policy of reporting incidents within 24 hours of occurrence, 71% of severe harm or death incidents were reported within 24 hours of occurrence. In order to address this shortfall all

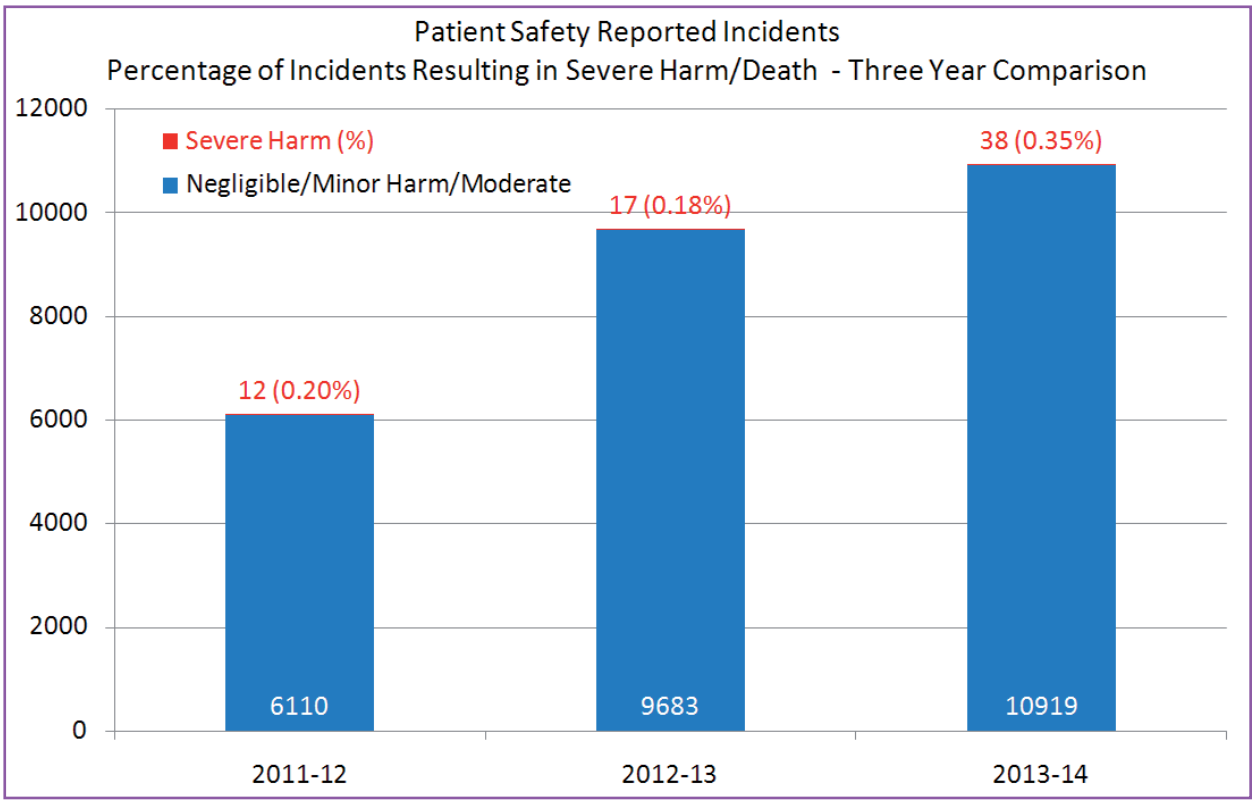
Graph 14: Rolling Comparison of Reported Incidents



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

induction, clinical mandatory and specific incident reporting and investigation training includes the importance of contemporaneous reporting. The message being communicated is that if an incident has occurred action needs to be taken promptly to prevent a reoccurrence especially if the incident has resulted in severe harm or death. The Trust is currently reviewing its policies and procedures in relation to holding staff accountable for actions or omissions in care which may impact on patient safety.

Graph 15: Patient Safety Reported Incidents



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

Table 29: Patient Safety Incidents That Resulted In Severe Patient Harm/Death

Financial Year	Severe/Major Harm	Disaster/Death	Total
2004-05	22	5	27
2005-06	6	3	9
2006-07	10	2	12
2007-08	8	1	9
2008-09	7	2	9
2009-10	8	4	12
2010-11	24	0	24
2011-12	12	0	12
2012-13	13	4	17
2013-14	28	10	38

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

In 2013/14 there have been 0 incidents where following a serious untoward investigation it has become evident that the cause of death was as a direct consequence of the incident.

There was one 'Never Event' incident reported at the end of the 2013/14 year which is being investigated under the Serious Untoward Incident investigation process.

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

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

- It is essential that lessons are learned from SUI's in order to mitigate the risk of reoccurrence, these lessons are fedback to staff within the Divisions through training, ward meetings and the Trust wide monthly "lessons learned" newsletter. Lessons learned are also discussed at the bi-monthly Learning from Incidents and Risks Committee. All completed SUI reports are published on the Trust's Risk Management site on the intranet so that any member of staff can access and use it as a learning tool. Links with the Learning and Development Team have been adopted so that training and development can be tailored around real life incidents and patient experiences. The Trust's simulation centre has undertaken several sessions where staff who were involved in an incident have the opportunity to re-enact the scenario, reflect on the events and evaluate what went wrong and why. Feedback from staff has been extremely positive especially with those staff who have been involved in an incident where the patient was severely harmed or died.
- Engagement of the patient and their relatives/carers is very important to the Trust not only in developing an open and honest culture, but as a healing tool. Patients and

relatives are informed when a serious incident has occurred and that an investigation is to be undertaken. In some cases they are asked for their version of events and this has been reflected within the report. Following completion of the investigation report they are given the opportunity to discuss the findings and any actions taken to prevent further occurrence. A section entitled Duty of Candour has been added to the SUI report template to ensure that communication with the patient/family/carer is captured and monitored.

Reduce the Incidence of Inpatient Falls by 30% at low, minor and Serious Impact levels – Resulting in Patient Harm

Patient falls are one of the most common patient safety incidents reported. The majority of slips, trips and falls result in low or no harm to patients physically. However, any slip, trip or fall can result in the patient losing their confidence. There have been significant improvements within all areas of the Trust in reducing the numbers of falls as shown in Graph 18 and 19 below. There have been a number of initiatives introduced during 2013/14 to promote the reduction in falls resulting in harm.

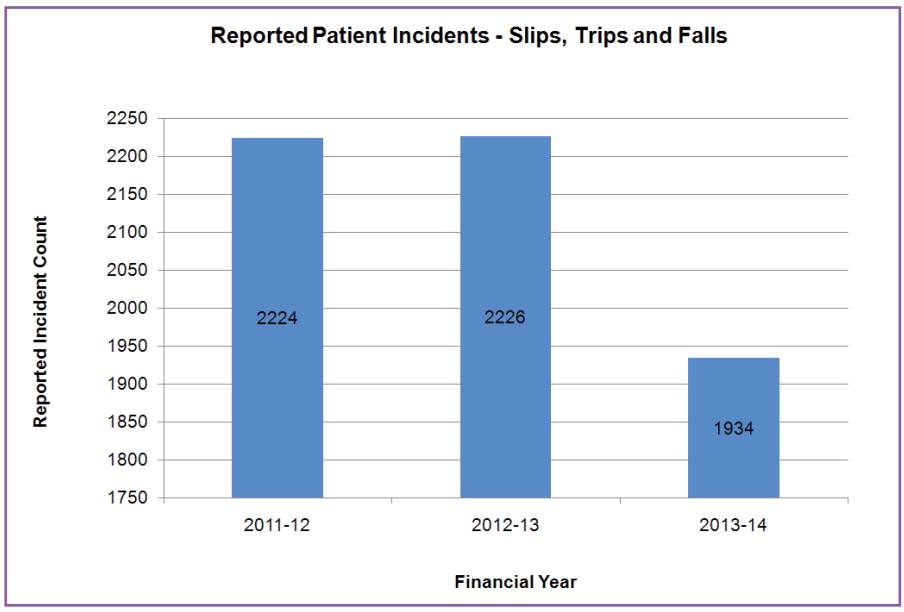
- There has been targeted support and training given to wards within both the Scheduled and Unscheduled Divisions to improve the staffs understanding in relation to bone health and falls risks. This included education around the falls risk assessment and the formulation of a care plan for patients at risk of falling.
- Introduction of movement sensors in all the clinical divisions, both on the acute wards and in the community hospitals, for patients who are identified to be at high risk of falling. The sensors are discreet and can be placed either under the mattress of the bed, or on the chair if the patient is sitting out of their bed. The sensors alert the ward nurses via a pager system if a patient attempts to get out of bed or move from the chair unaided. The sensors have already helped prevent potential injury to patients as the nursing staff have been alerted swiftly and assistance given.
- Low beds have been introduced across the Trust to prevent falls for those patients at higher risk.
- A footwear trial has been completed and we have changed the products used across the Trust
- We have developed a slipper exchange scheme in the care of the older adult wards
- Greater cross boundary working with colleagues working in the community.
- The Trust Falls Steering Group has been re-invigorated and is now multi-disciplinary and includes voluntary agencies.
- A falls prevention workbook has been developed and rolled out across the organisation to improve education of staff. This is currently being reviewed following feedback to simplify it for staff.
- Falls prevention leaflets have been developed to improve patient education.
- Ward level standards have been introduced in Scheduled Care.
- A trial of green wrist bands to identify patients at risk of fall is taking place in unscheduled care.
- Falls exercise programmes have been introduced within all localities of the community setting
- The current falls prevention policy is under review to incorporate community requirements and make it more robust
- A falls RCA template was being introduced in the New Year 2014, to support effective analysis of incidents and dissemination of lessons learned.
- Monthly falls data is now made available at trust, divisional and ward level, for interrogation and identification of trends/issues in order to implement quality improvements where required.

In 2012/13 there were 2,226 falls with harm compared with 1,934 in 2013/14 as demonstrated in Graph 16. This represents a reduction of 13.12%. However, the Trust recognises that there has been improved reporting of falls.

Please note that the data for the last two months of the year is unvalidated and all falls totals are liable to change.

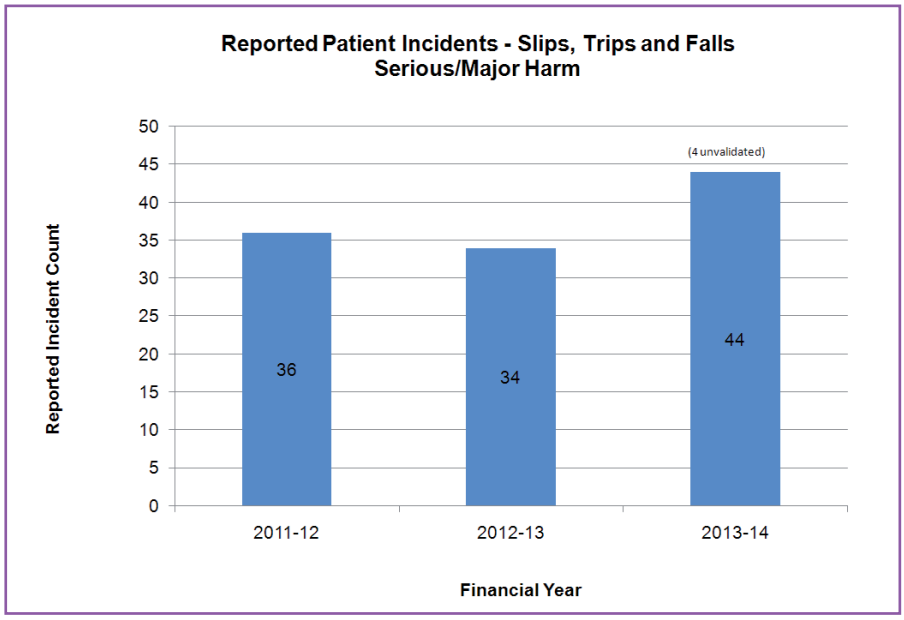
1,934 falls resulted in low or minor harm being experienced by the patient and there were 44 (2.3%) patients who experienced a fall that resulted in a moderate/serious harm. This is a 0.74% increase on the number of patients who experienced serious harm or above in 2012/13 (34), but only a 0.1% increase on the 2011/12 figure of 36. Measures have been put into place as outlined above to ensure that the Trust will see a downward trend for patient falls in 2014/15. As seen in Graph 17.

Graph 16: Patient Slips, Trips and Falls



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

Graph 17: Patient Slips, Trips and Falls (Serious/Major Harm)



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

Reduce the Incidence of Medication Errors by 30% Resulting in Moderate or Severe Harm

Medicines and medicine safety are an integral part of care provision within the Trust. The Trust continues to engage both staff and patients in the safe usage of prescribed medicines within all Specialities. Medicines are the most frequently and widely used NHS treatment and account for over 12% of NHS expenditure.

The Trust maintains current and coherent medicines policies, protocols and guidance that aim to increase patient access to medicines and safety. The Trusts policies on medicines and medicine safety cover every step of the journey from the development of medicines to their use by the patient.

The provision of Medicines Management Mandatory training continues to re-inforce the safe management of medicines within the Trust for all professionals to reduce the risk of medication errors. Medication incidents / errors are reported through the Trust Ulysses system which is fed into the National Reporting and Learning System. Currently medication errors reported by the Trust are identified in Graph 18.

Medication errors can occur anywhere within the care pathway including dispensing, preparing, administering, monitoring, storing or communication. The number of medication process errors are identified in Graph 18. The Medicines Management Team continue to ensure that the principles, safety and recommendations from all the National Patient Safety Agency Alerts are firmly embedded and maintained within all clinical areas. A robust and comprehensive audit process assures the Trust that standards are sustained on an annual basis.

The Medicines Management Committee meets bi-monthly. A report is supplied by the risk department which details all medication errors, drug type, level of harm to the patient, cause group and area. A trend

and theme analysis is completed with the aim that target areas can be highlighted and action plans devised to mitigate the risk. Several areas now have dedicated pharmacist cover, this has been found to reduce medication errors in these areas, it is hoped that this service will be extended over the coming year. The Trust has introduced Specialist Nurse Practitioners who are able to prescribe a set group of medications; this has been shown to reduce prescription errors and waiting times for discharge medication. Drug administration has been shown to be consistently the highest cause group as demonstrated in Graph 19, further analysis of the incidences indicated that many of these incidences were as a result of staff being interrupted whilst completing drug rounds, all nurses are now required to wear 'do not disturb' tabards when completing drug rounds.

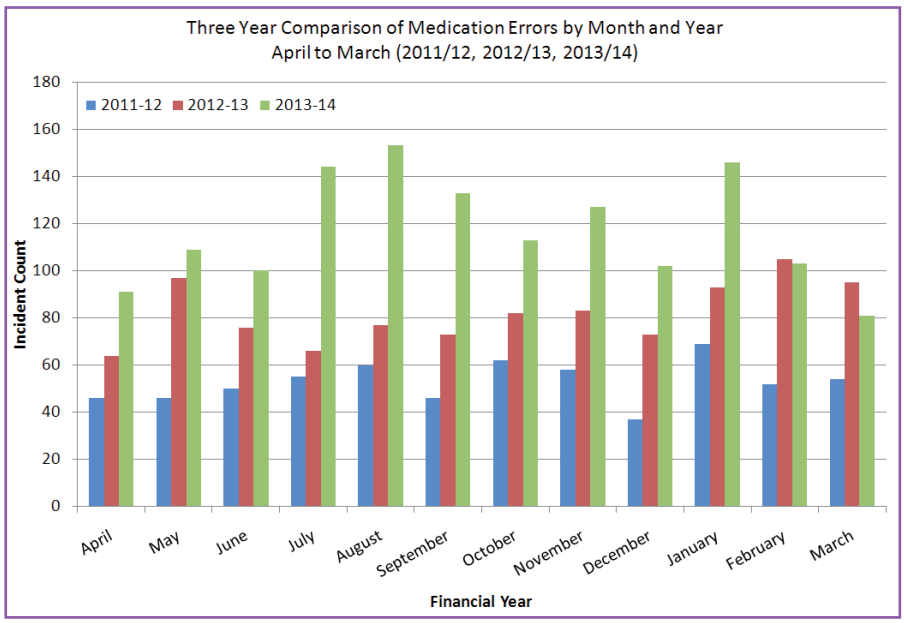
The September 2013 report published by the National Patient Safety Agency (NPSA) is based on incidents which occurred between 1st October 2012 and 31st March 2013 and were reported to the National Reporting and Learning System (NRLS) by the 31st May 2013.

Medication incidents

A total number of 10957 incidents were reported by the Trust. 1304 were medication errors and this equates to 11.9% of all incidents. The total number of medication errors was 52% higher in 2013/14 than 2012/13. The number of drug administration errors with serious and above harms was 17 in 2012/13 and this fell to 10 in 2013/14, a reduction of 41%, though the number of drug administration errors with minor or less serious harms increased by 81.6% over the same period. (It should be noted that the data for February and March are yet to be validated at the time of writing and may change).

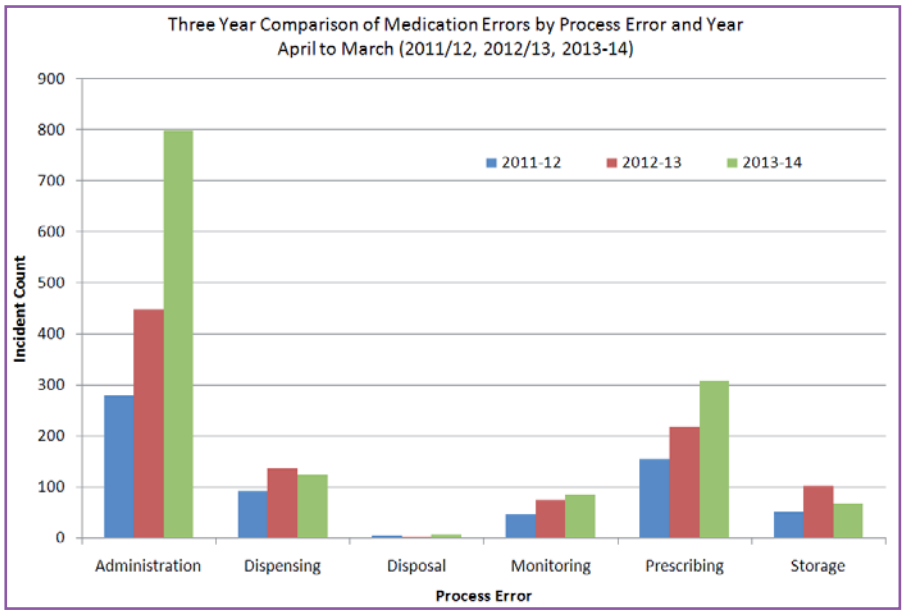
The Trust is able to report an improvement in the number of incidents reported by staff and a reduction in the level of serious patient harm. This emphasises the improvement in safety and medication awareness within clinical areas.

Graph 18: Medication Errors



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

Graph 19: Medication Errors



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

Reduce the Incidence of New Hospital Pressure Ulcers stage 2 by 30%, stage 3 by 40% and stage 4 by 100%.

A definition of pressure ulcers: Pressure ulcers are localised injuries to the skin and/or underlying tissue as a result of pressure. They are sometimes known as bedsores. They can be classified into four grades, with one being the least severe and four being the most severe.

The reduction of pressure ulcers has also been identified as a priority indicator to enable the Trust to meet national healthcare directives and current local quality improvement priorities for 2013/14. To improve the quality of care provided, the Trust made a commitment to ensure that all patients who suffered a hospital acquired pressure ulcer stage 2, 3 or 4 would have a root cause analysis undertaken.

Through the implementation of a quality improvement initiative programme the Trust has demonstrated how pressure ulcers have been reduced and targets met due to the initiative being implemented over the last twelve months as shown in Graph 20.

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

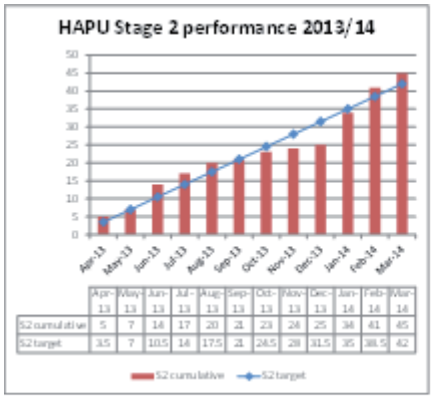
Work will continue to ensure that changes are embedded into practice and the improvements in performance are sustained. During 2013, the Acute site integrated with Community Health Services. Collaborative working between the staff has seen an improvement in the reporting of pressure ulcer incidents in the community setting and the implementation of improvement processes has commenced.

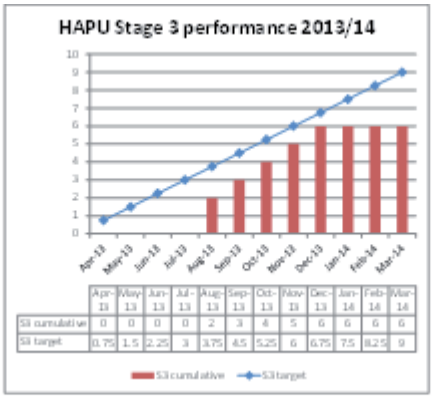
The Trust is delighted that it continues to see a significant and sustained year on year reduction in the number of hospital acquired pressure ulcers. Since March 2009, hospital acquired pressure ulcers have reduced by 84.34%. The last 12 months since

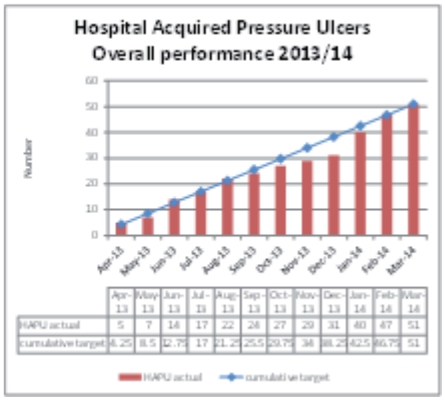
April 2013 have seen a 32.89% reduction in the number of hospital acquired pressure ulcers.

Although the number of Stage 2 hospital acquired pressure ulcers slightly exceeded trajectory (45 reported against a trajectory of 42), the number of Stage 3 hospital acquired pressure ulcers was lower than trajectory (6 reported against a trajectory of 9) and there were zero Stage 4 hospital acquired pressure ulcers; hence overall the Trust met the overall target for its reduction in hospital acquired pressure ulcers.

Graph 20: Hospital Acquired Pressure Ulcers (HAPU) - Acute







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

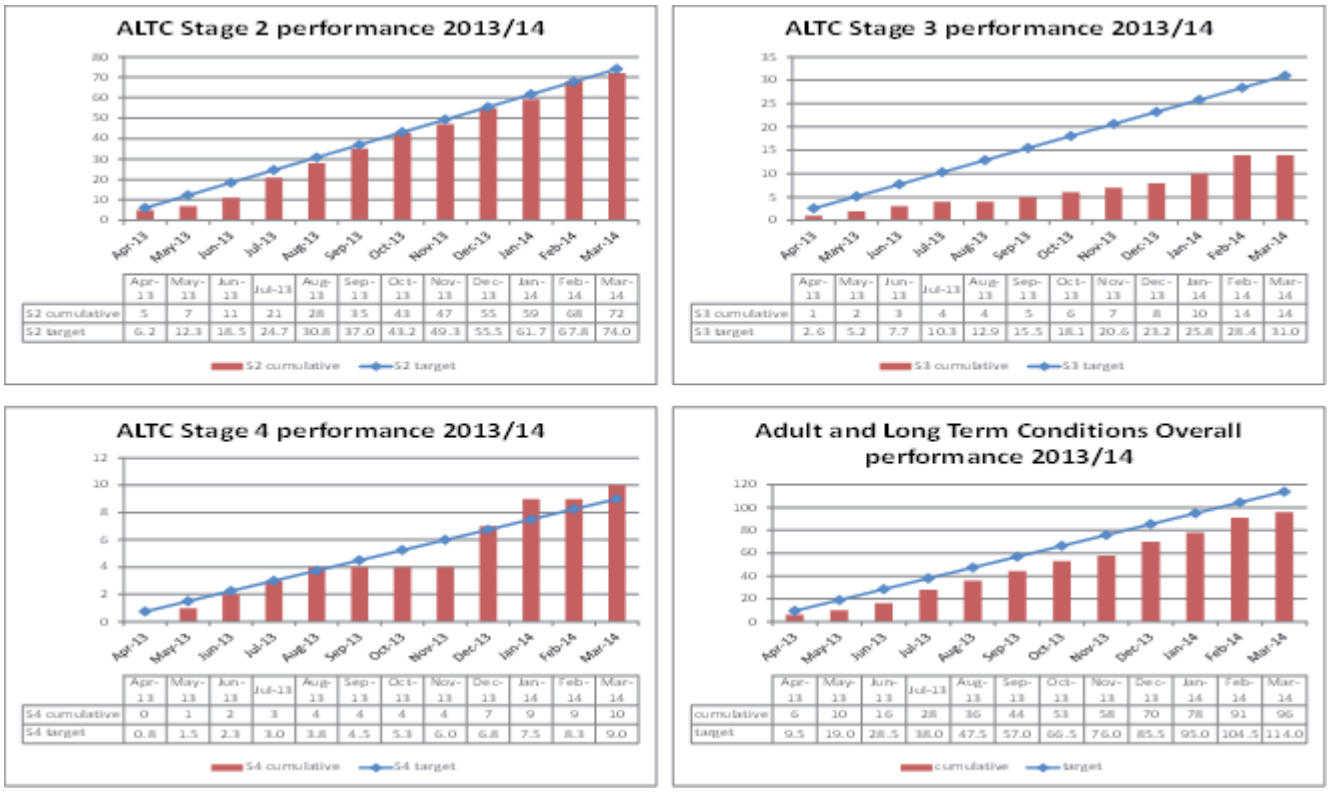
Reduce stage 2, 3 and 4 Community Pressure Ulcers by 10%

Target - Reduce stage 2, 3 and 4 pressure ulcers acquired whilst the patient is under the care of the community services by 10%.

In the Adult and Long Term Condition (ALTC) community setting the aim was to reduce the number of new pressure ulcers by 10% across all Stages of pressure ulcers. Although the number of Stage 4 pressure ulcers slightly exceeded trajectory (10 reported against a trajectory of 9), the number of Stage 3 ulcers was much lower than trajectory (14 reported against a trajectory of 31) and the number of Stage 2 ulcers was below trajectory (72 reported against a trajectory of 74); This means that since April 2013, the trust has seen a reduction of 26.67% in pressure ulcers acquired whilst the patient was under the care of the community services, hence overall the Trust met the overall target for its reduction in new pressure ulcers in the community setting.

In addition, 93% of community based staff completed Pressure Ulcer Prevention training workbooks.

Graph 21: Hospital Acquired Pressure Ulcers (HAPU) - Adult and Long Term Conditions



To Introduce the Think Glucose Programme

Plans to take up the 'Think Glucose' campaign is underway. It is a new project that due to be launched in April 2014, which will highlight the needs and care for patients with diabetes. The aim of the "Think Glucose" project is to improve patient care by promoting proactive care for patients who have diabetes as a secondary diagnosis. The project will also introduce a new referral system, as well as a rolling education programme and there will be a link nurse in place on each ward. This will improve staff knowledge on diabetes, reducing insulin errors and providing a better patient experience.

The project is due to be piloted on Wards 11 and 18 over the next month, and further information will be available on the intranet in due course; details of which are still being finalised. Last week, the "Think Glucose" Clinical Nurse Specialist lead commenced the pre-audits on how diabetes is being managed on the wards and is ongoing with this. Both pre and post audits are undertaken to monitor the impact the project has. Staff will then be educated on diabetes management over a series of weeks and another audit will be performed post training to measure the level of improvement that has been made.

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

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

3.5 Quality Account Production

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

The Quality Account was discussed with the Council of Governors which acts as a link between the Trust, its staff and the local community who have contributed to the development of the Quality Account.

3.6 How to Provide Feedback on the Quality Account

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

Telephone: 01253 655520
Contact us on: www.bfwh.nhs.uk

3.7 Quality Account Availability

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

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

3.8 Our Website

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

Part 4: Appendices

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

1.1 Statement from Blackpool Clinical Commissioning Group and Fylde & Wyre Clinical Commissioning Group – 16.05.14

Re: Blackpool Teaching Hospitals NHS Foundation Trust Quality Account for 2013/14

Blackpool CCG as Lead Commissioner together with Fylde and Wyre CCG as Associate Commissioners welcome the opportunity to appraise the content of the Quality Account for 2013-2014 and are pleased to acknowledge that there is a clear focus on the key quality elements and Blackpool Teaching Hospital NHS Foundation Trust has clearly referenced its organisational objectives, focusing on the five key domains of quality as outlined in Planning for Patients 2013/14.

The Quality Account is concise given the breadth of information it is required to reference, well-presented and reflects the new requirements to benchmark against peers.

The Quality and Engagement Committee of the CCG noted that due to the complexity of the information reported, consideration could be given to producing a précis of the report with the focus on patients and the public as the key audience.

Quality Priorities 2013/14

Blackpool Teaching Hospital NHS Foundation Trust continues to be an outlier for hospital mortality. The CCG are pleased to note the reductions in hospital mortality rates reported under Standardised Hospital Mortality Index (SHMI) and Risk Adjusted Mortality Indicator (RAMI) during the year however, a continued focus on mortality should be maintained in order to see the Hospital Standardised Mortality Rate achieve a reduction. As lead commissioner, Blackpool CCG monitors actions to achieve this reduction.

Blackpool Teaching Hospital NHS Foundation Trust continues to participate in 86% of National Clinical Audits and 100% of National Confidential Enquiries and this is a clear indication of an organisation with a commitment to delivery of evidence based and safe care. However, the CCG would like to see participation in 100% of eligible National Clinical Audits for 2014/15.

Blackpool CCG notes that Blackpool Teaching Hospital NHS Foundation Trust has rated themselves green against the requirements of the Information Governance Toolkit with and overall rating of satisfactory with no serious breaches in data security and as such patients and the public can be assured that data held is stored, used and transferred securely and confidentially. Blackpool CCG however, note the high % of secondary procedures coded

incorrectly at 46.2%, as clinical coding supports clinical care, treatment and outcomes and is directly linked to payment and costs we would welcome sight of the associated action plan for improvement.

Research is well supported at Blackpool Teaching Hospital NHS Foundation Trust Blackpool CCG confirm that a research active provider demonstrates a strong commitment to clinical effectiveness in support of improving the quality of care delivered.

Core Quality Indicators identified to be progressed 2014/15

Blackpool CCG is pleased to note improvement in Patient Reported Outcome Measures particularly in relation to groin hernia procedure which has identified that patients level of comfort has increased. The Trust is also to be commended for the sustained reduction in HCAI with a continued commitment to zero tolerance for MRSA bacteraemia in 2014/15. Clostridium Difficile Infections (CDI) attributed to the Acute Trust shows a 7% reduction from the previous year and both commissioners and provider agree that there needs to be continued focus on reduction.

Blackpool Teaching Hospital NHS Foundation Trust continues to see an increase in the number of patient safety incidents reported together with an associated decrease in reported level of harm and view this as a positive indicator that demonstrates an organisation with an open and transparent reporting mechanism and a robust patient safety process and culture.

Of significant note and commendation is Blackpool Teaching Hospital NHS Foundation Trust commitment to participation in the Patient Safety and Quality visits and in particular the recent Maternity review visit. The Trust welcomed representation from the CCG, LCSU, Health Watch, Non Executives and Ley Members and details of the full report have been shared with the Trust who are responding to the outputs.

We can confirm that Blackpool Teaching Hospital NHS Foundation Trust has achieved targets for the majority of the national performance measures but diagnostic waiting times for cystoscopy rates are showing above the threshold as a result of national screening campaigns with an action plan in development.

Patient and Public Initiatives to be progressed 2014/15

In accordance with the NHS Outcomes framework privacy

and dignity continues to be a priority area for both provider and commissioners and we note that 91% of those surveyed said they were treated with dignity and respect. However Blackpool Teaching Hospital NHS Foundation Trust has notified 6 breaches in mixed sex accommodation and we would anticipate a reduction in 2014-15.

Dementia care was noted to be rated red with the expected score for assessing and treat patients at 75% against a target of 90%. The Nursing Care Indicators have achieved green for the Trust but red for delivery in the Community Services at only 58% against a 95% target. As such the CCG would like to see a significant improvement in scores for both Dementia Care and Nursing Care Indicators specifically in Community Services for 2014/15.

Blackpool CCG look forward to seeing the improvements to the quality of services provided as outlined in this Trust Quality Account.

1.2 Statement from Governors – 16-05-2014

Creation of the Quality Accounts is a vital process in the yearly activity of an NHS Trust. The document, by its nature, contains a huge amount of data and information and is a reflection of the complex nature of providing quality care to a large and diverse population. Whilst this is a report as to what happened in the previous year, it should be noted that Governors were able to provide input and support, as well as to question various quality aspects in "real time" during the year. In respect, it should be noted that the Council of Governors has had a positive impact on a number of reported areas.

Here is some feedback on the Quality Accounts, provided by Governors:-

"As and elected Governor for the Fylde, we feel assured that there is significant progress against these objectives in the Acute and Community services:-

- Infection rates have continued to fall.
- Significant reductions in pressure ulcers and patient falls.
- Improvements in our local results of the national patient survey in areas such as; privacy and dignity, cleanliness, waiting times and communication between staff and patients.
- National recognition for our work to improve patient safety and quality and the Trust's Maternity Substance Misues Team.
- Continued to make progress on reducing mortality rates.
- Invested more than £1.5M in clinical staff with more than 180 qualified nurses joining the organization and more than 40 doctors"

"Some form of measurement on volunteer/member/patient involvement/engagement & contribution. Involvement and engagement in my opinion are good quality indicators."

In response to a question about what are some of the priorities for quality improvement for the coming year:-

- "Provision of adequate levels of trained competent staff who are responsible about providing outstanding patient treatment and care".
- "Full staff buy in and implementation of pathways".
- "Faster implementation of technology to assist staff with accurate record keeping and reduce uneccessary paper crunching".
- "We also wish to see actions from the CQC report achieved and the CQC CQUINN threshold targets improved".

Do not be put off by the length and complex nature of this report; there is a lot of valuable information and extremely useful insight contained within its pages. That information and insight highlight the striving for Excellence and the Trust's aim to be the "safest organization within the NHS".

1.3 Statement from Local Healthwatch Blackpool - 12-05-2014

A comprehensive document detailing the many quality issues being addressed by the Trust both mandatory and in-house.

However, the sheer volume of the issues being addressed makes the Quality Account a not very user- friendly publication and in its present form it is not ideal for distribution to the general public as a whole. Its use of technical and medical terms would make it difficult to interpret by many. Couple this with the fact that the visually impaired would require the QA to be available in

an alternative format as would certain ethnic minorities who do not have English as a first language. A separate publication, perhaps a 6 fold document, highlighting the salient points for public consumption could be produced and made available in patient/public areas, such as GP surgeries and libraries.

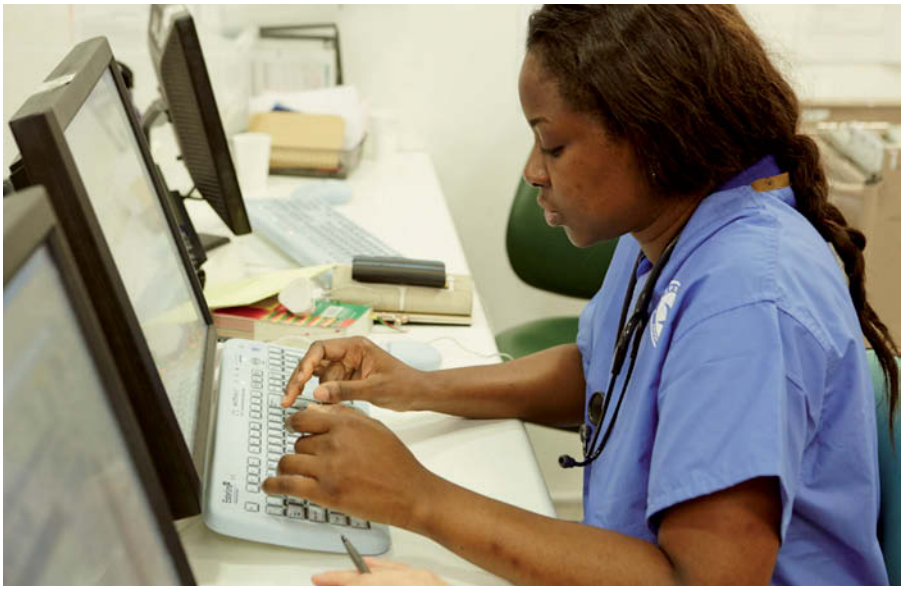
The Trust's comprehensive Clinical Audit and Research programmes ensure that BTHFT participates in identifying improvements in treatments and care in the national picture, and it is good to see that the Trust complies with the CQC and CQUINN standards.

However, it is concerning that the Trust has fallen behind plan (Red-lighted) in two important points in its Priority 1, namely medical and Nursing care indicators used to assess and measure standards of clinical care and patient experience, which should be at the fore-front of any Quality Account.

We would like to see more evidence of the use of the Family and Friends Test in future Quality Accounts.

1.4 Statement from Local Healthwatch Lancashire – 20.05.2014

We welcome the efforts of the Trust to deliver fit for purpose services for local people. Based on the information we have gathered during the year, the Quality Accounts broadly reflect what we know and what we have been told about the Trust. We have no reason to doubt their



accuracy. The comments we have received from the public during 2013/14 do not indicate particular trends in care provision – positive or negative. The Quality Accounts appear to provide evidence of an organisation that is focused on service improvement.

We are pleased to see the commitment to engaging with patients, public, staff and governors. We would encourage a systematic approach to this with some clarity on shared expectations of what the Trust is trying to find out, what will change as a result of the engagement and how people will find that out.

It would have been useful to know what the reasons were for the Trust failing to meet the complaints outcome 17 when the CQC visited in June 2013. It is encouraging that the Trust was subsequently deemed to be fully meeting the standard, but we have some concerns about the decision to introduce a holding letter when the response to a complaint is delayed. This seems quite reasonable, but the risk is that it becomes the norm, not the exception and that complaints take longer as a result. For example, the introduction of the 20 day maximum response time limit for public organizations was done for positive reasons - to make the public sector more responsive and accountable. Over time many organizations have come to see 20 days noat as the maximum standard but just as the standard. We are sure the Trust is aware of this issue and will take steps to monitor the use of holding letters.

We would welcome sight of the improvement action plan referred to in 2.3.5 and also information on the outcome of the RCOG case review.

The progress on reducing mortality rates is welcome, although more still needs to be done. It is to be welcomed that in the four areas - Groin Hernia, Hip & Knee Replacement and Varicose Vein - all of the average health gain numbers show improvement. We do not yet know how these compare to the national averages, but it is encouraging.

We would welcome an explanation in the "steady increase in the number of untoward incidents reported in the past four financial years". Is this because there are more

such incidents or because the reporting culture has improved?

In "Learning from patients" in section 3.3, we fully support the Trust capturing and reporting on the positive things said by patients. However the tendancy of Trusts generally to present this information as it it is a counterbalance to complaints is not particularly helpful. We know that people do not complain for well documented reasons and that as result, the number of recorded complaints is always lower than the number of people who later feel that they should have complained. For this reason we are also not persuaded that seeking to reduce complaints as a target is necessarily a positive thing. The issue should be about the Trust's culture being open to complaints, seeing them as an important quality improvement tool and applying the learning.

Some brief points about some of the reported outcomes:

- We strongly support the work being undertaken to achieve the Dementia Screening Targets. The current scores are unacceptably low.
- The CQC's National Inpatient Survey information presented in Table 28 shows that a very low number of patients reported that staff told them about medication side effects to look out for at home. Although this is an improvement on the previous year, we welcome the fact that clinical divisions and pharmacy are looking at how this number can be increased.
- The Trust is to be congratulated on the high number of staff who would recommend the Trust to friends and family needing care. Hopefully this is also an indicator of the state of staff morale, which is a key part of delivering good quality services.
- We are concerned about the numbers of Medication Incidents where errors were made. There appears to have been a very large increase in these during 2013/14 and it would be helpful to get more information about why this is and what is being done about it.

We would like to make a general point about the presentation of the Quality Accounts, which applies to most of the ones that we have read. It is not totally clear who the target audience for the document is. We would have thought that a basic test would be that a member of the public, sitting in a waiting area at the Trust, should be able to read this document and understand how well the Trust is doing. Realistically this document does not pass that test. This is not just an issue for theis Trust and from Healthwatch Lancashire's perspective there is a question about what purpose of the Quality Account is.

1.5 Statement from Lancashire Health Overview and Scrutiny Committee - 14-05-2014

The Committee notes the progress that the Trust has made over the past 12 months and looks forward to effective engagement around their plans for 2014/15.

The Trust states that it 'will continue to listen to patients, staff, stakeholders, partners and Foundation Trust members' and the Committee will maintain an oversight of how the Trust will evidence this and takes on board the views provided in the shaping of their priorities for the future.

1.6 Statement from Blackpool Health Overview and Scrutiny Committee - 13-05-2014

"The Health Scrutiny Committee would like to thank Blackpool Teaching Hospitals NHS Foundation Trust for the opportunity to view and comment on the Trust's 2013/14 Quality Account. The Committee is satisfied with the level of engagement and information it has received from the Trust throughout the year and is pleased with the way that the Trust has dealt with queries, requests for information and attendance at Committee meetings. In relation to the Account document, the Committee expressed the view that from the perspective of the general public, it was a lengthy document and could be difficult to interpret. It would therefore be in favour of the production of a document that summarised the main content and findings of the Account.

The Committee looks forward to working with the Trust during the coming year, particularly in the areas of scrutinising quality, safety and patient care".

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

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

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

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

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

- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 – March 2014
  - Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
  - Feedback from the commissioners - Blackpool Clinical Commissioning Group and Fylde & Wyre Clinical Commissioning Group – dated 16/05/2014;
  - Feedback from Governors dated 17/03/2014 and 16/05/2014;
  - Feedback from Local Healthwatch organisations – Local Healthwatch Lancashire – 20.05.2014
  - Feedback from Local Healthwatch organisations – Local Healthwatch Blackpool dated 12.05.2014
  - Feedback from the Blackpool Council's Health Scrutiny Committee dated 13.05.2014
  - The Trusts Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16/05/2014;
  - The 2013 national patient survey published February 2014;
  - The 2013 national staff survey published February 2014;
  - The Head of Internal Audits annual opinion over the Trust's control environment approved 16/04/2014;
  - Care Quality Commission quality and risk profiles dated 31.05.2013, 30.06.2013 and 31.07.2013;
  - The CQC Intelligent Monitoring Report dated 21.10.2013, 13.03.2014.

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

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

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

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

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

By order of the Board:

Signed: **Date:** 21st May 2014

Ian Johnson
CHAIRMAN

Signed: **Date:** 21st May 2014

Gary Doherty
CHIEF EXECUTIVE

Appendix C: Glossary of Abbreviations And Glossary Of Terms

Table 35: Glossary of Abbreviations	
Abbreviation	Meaning
ALTC	Adult and Long Term Conditions
AMI	Acute Myocardial Infarction
AQ	Advancing Quality
ACEI	Angiotension Converting Enzyme Inhibitors
ARB	Angiotension Receptor Blocker
BVH	Blackpool Victoria Hospital
CABG	Coronary Artery Bypass Graft
CAP	Community Acquired Pneumonia
CC	Clinical conditions.
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile Infection
CDU	Clinical Decisions Unit
CEMACH	Confidential Enquiry into Maternal and Child Health - This is a national enquiry to improve the health of mothers, babies and children by carrying out confidential enquires on a nationwide basis and by disseminating the findings and recommendations as widely as possible.
CHKS	Name of the Company which is used for benchmarking
CHP	Combined Heat and Power
CRC	Carbon Reduction Commitment
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQS	Composite Quality Score
CQUIN	Commissioning for Quality and Innovation
DoH	Department of Health
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
ERIC	Estates Returns Information Collections
GHG	Green House Gas
GP	General Practitioners
HAPU	Hospital Acquired Pressure Ulcers
HCAI	Healthcare Acquired Infection

Table 35: Glossary of Abbreviations	
Abbreviation	Meaning
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HRG	Healthcare Resource Group
HSMR	The Hospital Standardised Mortality Ratio
IRMER	Ionising Radiation Medical Exposure Regulations 2000
LAC	Looked After Children
LSCB	Local Safeguarding Children's Board
LVSD	Left Ventricular Systolic Dysfunction
LVS	Left Ventricular Systolic Function Assessment
Medusa	Electronic version of the Injectable Medicines Guide
MRSA	Methicillin Resistant Staphylococcus Aureus
NCEPOD	National Confidential Enquiries into Perinatal Outcomes of Death
NICE	National Institute for Health and Clinical Excellence
NCI	Nursing Care Indicators
NHSLA	National Health Service Litigation Authority
NIHR	National Institute for Health Research
NHS OF	The NHS Outcomes Framework
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
PbR	Payment by Results
PCI	Primary Coronary Intervention
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
RAMI	Risk Adjusted Mortality Index
SBAR	Situation Background Assessment Recommendations
SHMI	Summary Hospital Level Mortality Indicator
SUS	Secondary Uses System
TIA	Trans Ischemic Attack
VTE	Venous Thromboembolism

Table 36: Glossary of Terms	
Abbreviation	Glossary of meaning
Antibiotic Prophylaxis	Antibiotic Prophylaxis is preventive treatment given to patients in order to protect them from developing an infection.
Cardiac Arrest	Cardiac arrest, (also known as cardiopulmonary arrest or circulatory arrest) is the cessation of normal circulation of the blood due to failure of the heart to contract effectively.
Clinical Commissioning Group	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in NHS England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs will operate by commissioning (or buying) healthcare services including: • Elective hospital care • Rehabilitation care • Urgent and emergency care • Most community health services • Mental health and learning disability services
Clinical Conditions	JD042: Minor Skin Disorders category 3 without CC "CC" means clinical conditions. Therefore in this context the patient had no other clinical conditions or co-morbidities.
Clinical Divisions	Unscheduled Care Division comprises of Medicine, Adult Medical Assessment Unit, Intensive Therapy Unit and Accident and Emergency Department and Community Team Adult Long Term Conditions. Scheduled Care comprises of the Cardiac Unit and the Surgical Unit Women's Health comprises of the Women and Children's unit, Paediatric Unit, Community Midwives, School Nurses and Health Visitors.
Clostridium Difficile	Clostridium Difficile (C. diff) is a bacterium that is present naturally in the gut of around two thirds of children and 3% of adults. C. diff does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. diff bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. At this point, a person is said to be 'infected' with C. diff.
Endoscopy Accreditation	Accreditation within Endoscopy is enabling the Trust to prove that all processes around the use of endoscopes within Gastroenterology, Cardiac Directorate and ENT are conducted to the highest standard. Systems are now in place to prove that all areas, within the Trust, conform to the same standards and Trust has passed the second stage which shows that we do what we have documented. Extremely good feedback was received during all visits by the inspector.
Evidence Based Practice	Evidence based practice (EBP) is: "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research"

Table 36: Glossary of Terms	
Abbreviation	Glossary of meaning
Friends and Family Test	The test will provide us with a simple, easily understandable headline matrix which combined with other information, patient feedback and follow up questions can support the trust in pinpointing areas for improvement, and will inform and empower the ward, and the board, to tackle areas of weak performance and enhance areas of excellent practice. The test will be designed to be a single matrix and we will still need to supplement this with other methods of capturing, responding and understanding the patients experience data. It is not designed to replace more local operational level information, yet will be designed to act as an opener for deeper organisational work across all patients pathways. The test will help us quickly flag issues, which will be easily responded to. Effective, targeted improvements will quickly show up as the score will improve, validating and incentivising further improvements across the Trust. Further information can be located at the following link: http://transparency.dh.gov.uk/2012/11/28/nhs-friends-and-family-test
Healthcare Resource Groups	Developed by The Case mix Service, Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource. Healthcare Resource Groups offer organisations the ability to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time. Healthcare Resource Groups are currently used as a means of determining fair and equitable reimbursement for care services delivered by Health Care Providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the NHS. They improve the flow of finances within - and sometimes beyond - the NHS. HRG4 has been in use for Reference Costs since April 2007 (for financial year 2006/7 onwards) and for Payment by Results (PbR) since April 2009 (for financial year 2009 onwards). HRG4 was a major revision that introduced Healthcare Resource Groups to new clinical areas, to support the Department of Health's policy of Payment by Results. It includes a portfolio of new and updated HRG groupings that accurately record patient's treatment to reflect current practice and anticipated trends in healthcare.
Hospital Standardised Mortality Ratio	The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death for example, heart attacks, strokes or broken hips. For each group of patients we can work out how often, on average, across the whole country, patients survive their stay in hospital, and how often they die.
Investors In People Gold Standards	Investors in People is all about business improvement to help transform the organisation's performance by targeting chosen business priorities
JACIE Accreditation	The Joint Accreditation Committee is a non profit body established in 1998 for the purpose of assessment and accreditation in the field of haematopoietic stem cell (HSC) transplantation. JACIE's primary aim is to promote high quality patient care and laboratory performance in haematopoietic stem cell collection, processing and transplantation centres through an internationally recognised system of accreditation.

Table 36: Glossary of Terms	
Abbreviation	Glossary of meaning
Joint Advisory Group (JAG) Accreditation on our Endoscopy Unit	Joint Advisory Group (JAG) Accreditation and Global Rating Score (GRS) The Endoscopy Global Ratings Scale (GRS) is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. Accreditation definition: Usually a voluntary process by which an independent agency grants recognition to organisations which meet certain standards that require continuous improvement in structures, processes and outcomes. Quality improvement and accreditation offers a risk reduction strategy that an endoscopy service is doing the right things and doing them well; thereby significantly reducing the risk of error in the delivery of services. What is JAG Accreditation intended to accomplish? Stimulate continuous improvement in processes and patient outcomes Strengthen endoscopy services Provide a knowledge base of best practices Increase patient confidence in services Improve the management and efficiency of services Provide education on better/best practices The GRS & accreditation pathway will assist you to both achieve and demonstrate this
Methicillin Resistant Staphylococcus Aureus	MRSA stands for Methicillin-Resistant Staphylococcus Aureus. It is a common skin bacterium that is resistant to some antibiotics. Media reports sometimes refer to MRSA as a superbug. Staphylococcus Aureus (SA) is a type of bacteria. Many people carry SA bacteria without developing an infection. This is known as being colonised by the bacteria rather than infected. About one in three people carry SA bacteria in their nose or on the surface of their skin. MRSA bacteraemia – An MRSA bacteraemia means the bacteria have infected the body through a break in the skin and multiplied, causing symptoms. If SA bacteria.
Microbial Contamination	Inclusion or growth of harmful microorganisms (such as clostridium botulinum) in an item used as food, making it unfit for consumption.
NHS Outcomes Framework	The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on: • Domain 1 Preventing people from dying prematurely • Domain 2 Enhancing quality caring of life for people with long-term conditions • Domain 3 Helping people to recover from episodes of ill health or following injury; • Domain 4 Ensuring that people have a positive experience of care; and • Domain 5 Treating and caring for people in a safe environment • Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance
Risk Adjusted Mortality Index	Risk Adjusted Mortality Index – is a measure of the outcomes of care for patients. Risk Adjusted Mortality compares us to what is expected from the types of cases we manage and compares us to other similar hospitals in the country.
Summary Hospital Level Mortality Indicator	The Summary Hospital-level Indicator (SHMI) reports mortality at trust level across the NHS in England using standard and transparent methodology. The Summary Hospital Level Mortality Indicator measures whether mortality associated with hospitalisation was in line with expectations. http://www.ic.nhs.uk/CHttpHandler.ashx?id=10664&p=0
Trans Ischemic Attack	Trans Ischemic Attack – A transient stroke that lasts only a few minutes. It occurs when blood to the brain is briefly interrupted

Table 36: Glossary of Terms	
Abbreviation	Glossary of meaning
Venous Thrombo embolism (VTE)	Venous Thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and Pulmonary Embolism (PE). A DVT is a blood clot that forms in a deep vein, usually in the leg or the pelvis. Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE).We can avoid many VTEs by offering preventative treatment to patients at risk.
VTE Prophylaxis	Venous Thromboembolism (VTE) Prophylaxis is preventive treatment given to patients in order to protect them from developing a blood clot that forms in a deep vein.
62 day cancer screening waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days referral from the screening programme as a percentage of the total number of patients receiving first definitive treatment for cancer following a referral from the screening programme.
Mortality Rate	Location of the latest published data can be accessed from: http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/summary-hospital--level-mortality-indicator-shmi
Patient Reported Outcome Scores	The patient reported outcome scores are for i) groin hernia surgery, ii) varicose vein surgery, iii) hip replacement surgery, and iv) knee replacement surgery http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/patient-reported-outcome-measures-proms
Emergency readmissions to hospital within 28 days of discharge	Location of the latest published data can be accessed from: http://www.ic.nhs.uk/pubs/hesemergency0910
National Patient Survey Results	The patient survey question to be monitored by the Trust is in relation to 'Responsiveness to inpatients' personal needs' http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_126972
National Staff Survey Results	The staff survey question to be monitored by the Trust is in relation to the 'Percentage of staff who would recommend the provider to friends or family needing care'. Location of the latest published data can be accessed from: http://www.nhsstaffsurveys.com/
Percentage of admitted patients risk-assessed for Venous Thrombo-Embolism	Location of the latest published data can be accessed from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539
Clostridium. Difficile Target	Number of patients identified with positive culture for C. Difficile
Rate of Clostridium Difficile	Location of the latest published data can be accessed from: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/MandatorySurveillance/cdiffMandatoryReportingScheme/ The following information provides an overview on how the criteria for measuring this indicator has been calculated: • Patients must be in the criteria aged 2 years and above • Patients must have a positive culture laboratory test result for Clostridium Difficile which is recognised as a case • Positive specimen results on the same patient more than 28 days apart are reported as a separate episode • Positive results identified on the fourth day after admission or later of an admission to the Trust is defined as a case and the Trust is deemed responsible
MRSA Target	Number of patients identified with positive culture for MRSA bacteraemia

Table 36: Glossary of Terms	
Abbreviation	Glossary of meaning
Rate of MRSA	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • An MRSA bacteraemia 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.

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Quality Account
2013/14