Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Quality Report

2010/11

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Part 1: Statement on Quality from the Chief Executive of the NHS Foundation Trust

I am delighted to introduce the Trust's third Quality Report for the 2010/11 period, which highlights the work we have been doing over the past 12 months to ensure our patients receive the highest quality and safest care possible.

The Quality Report is aimed at assuring our patients, our commissioners, our stakeholders and our local population that we are focused on providing the highest level of clinical care, but also to show we are committed to continuously looking at ways of improving what we do.

We aim to provide services that consistently deliver the best clinical outcomes for our patients, which are safe, accessible and responsive to patients' needs. This Quality Report sets out how we are progressing with this ambition and where we are focusing our attention to make further progress.

During 2010/11 we made a number of improvements in key areas of quality and safety and received national recognition for some of our work.

For the third year running we were named in the CHKS Top 40 Hospitals, recognising our success as one of the best performing Trusts in the country in key areas such as waiting times, mortality, hospital readmissions and reducing infection rates.

Our drive to prevent and reduce hospital acquired infections has continued. We have maintained fantastic progress in reducing Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemias by 90% when compared to 2007/2008. We have also reduced the number of cases of Clostridium Difficile by 60% over the same time period as a result of clinical engagement, new ways of working and the commitment of all staff to make improvements in this important area.

Our hospital standardised mortality rate, an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect, has continued to improve and we have seen further reductions this year from 103 to 88 in comparison to our peers.

In recognition of our commitment to patient safety, our Trust was the only Trust in the country to be awarded two national awards in the Patient Safety Awards 2011. The awards were received for Education and Training in Patient Safety and Patient Safety in Maternity Care categories. The Trust has also seen significant reductions in patient falls, medication errors and pressure ulcers. These reductions demonstrate the Trust's high level of commitment to patient safety.

We have also made significant improvements in the areas of quality of care and patient experience with further improvements in our survey comments by patients in the 2010 National Inpatient Survey. Our own ward level patient surveys also indicate high levels of patient satisfaction. We could not deliver all of these improvements without the commitment and dedication of our staff and we work hard to ensure we develop our workforce and that the Trust is a great place to work. In recognition of this work we were awarded Investors in People Gold status for the second year running which is the highest rating possible in recognition of investing in our workforce.

This is just a flavour of some of the excellent work going on across the Trust to ensure we deliver 'Best in NHS Care' to our patients and you can now read about some of these initiatives in more detail within this Quality Report.

Our plans for continuing to improve and demonstrate quality in everything we do will evolve throughout the next financial year. We aim to work with our staff, patients, their families and carers, commissioners, stakeholders, Governors, members and the wider public in continually improving the quality of our services. Contributions to develop the Quality Report have been received from the Governors, Local Involvement Networks, and the Overview and Scrutiny Committee together with our Corporate Governance Team.

Our plans for 2011/12 aim to build on the excellent progress we have made as well as new improvement targets in relation to patient care. This report details the approach this work will take, the measures the Board of Directors have identified as being key to its delivery and how success in these areas will be measured.

Looking forward to the year ahead, we intend to increase our efforts even further towards driving quality and safety improvements across the organisation.

The Quality Report April 1st 2010 – March 31st 2011 to the best of my knowledge the information in the document is accurate.

Signed:.....

Date: 3rd June 2011

Aidan Kehoe
Chief Executive

Part 2 Priorities For Improvement And Statements Of Assurance From The Board

2.1 Priorities For Improvement

2.1.1 Performance In 2010/11 Against Each Quality Improvement Priority Identified In 2009/10 Report

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

- Patient safety
- Clinical effectiveness
- Patient experience

The following information provides an overview of the quality of care provided by the Trust based on the performance of each of the quality improvement priorities for 2010/11 as identified in the 2009/10 report against the indicators for patient safety, clinical effectiveness and patient experience. Wherever possible, the report will refer to historic data and benchmarked data, where available, to enable readers to understand progress over time and performance compared to other Trusts. Wherever possible, references of the data sources for the indicators will be stated, including whether the data is governed by national definitions.

Details of the priorities for quality improvement that were agreed by the Board of Directors as identified in the 2009/10 report are detailed in Table 1 below.

Table 1

Quality Improvement Priorities 2010/11		Quality Improvement Performance/Outcome Measures
Patient Safety	Improved Hospital Mortality Ratios	Continue to reduce the Trust's hospital mortality Continue to reduce MRSA and Clostridium Difficile infection rates as reflected by national targets
	Reducing Avoidable Harms	Reducing avoidable harms through the following strands of work: – Global Trigger Tool to be used to measure adverse events – Reduction of Falls by 30% – Reduction of Medication errors by 50% by 2011/12
Clinical Effectiveness	Conformance to Best Practice	Conformance to best practice through application of the following interventions to improve patient outcomes: Phase 1 site for the North West Advancing Quality initiative that seeks compliance with best practice in five clinical areas: – Acute Myocardial Infarction (Heart Attack) – Hip and Knee Replacement Surgery – Coronary Artery By-Pass Graft Surgery (CABG) – Heart Failure – Pneumonia Implementing 100,000 lives and Saving Lives Programme: – Rapid Response Team - Reducing Cardiac Arrest calls – Reducing the incidence of Surgical Site Infections – Embed implementation of Venous Thrombo Embolism (VTE) guideline Nursing care indicators used to assess and measure standards of clinical care and patient experience

Table 1		
Quality Improvement Priorities 2010/11		**Quality Improvement Performance/Outcome Measures**
Patient Experience	Improving Patient Quality	Improving the patient experience which will be measured through an improvement in the National Inpatient Survey results in the following three areas: – In your opinion, how clean was the hospital room or ward that you were in? – Were you given enough privacy when being examined or treated? – Overall, did you feel you were treated with respect and dignity while you were in the hospital? To improve National Outpatient Survey results in the following four key areas where the need for improvement was identified: – No copies of GP letters to patients – Poor information – Poor communication – staff not introducing themselves / Lack of information regarding waiting times and delays in clinic – Lack of time to discuss health issues Liverpool End of Life Care Pathway – Seeking patients and carers views to improve End of Life Care Patient Environment Action Team (PEAT) Survey – To improve PEAT Survey results/standards Ensure single sex accommodation to provide privacy and dignity for patients

The Trust has continued to work throughout the year to embed a culture of patient safety and deliver on the commitments made in our Quality Framework document. This has resulted in considerable progress and improvements in key quality measures, via a number of programmes, in 2010/11.

A programme of work has been established that corresponds to each of the four areas we are targeting. Each individual scheme within the programme has contributed to one, or more, of the overall performance targets we have set i.e. improved hospital mortality rates, reducing avoidable harms, conformance to best practice and improving patient quality. Improvements have been delivered through staff engagement and the commitment of staff to make improvements. Quality improvements will continue to be monitored and reported to the Board of Directors as part of the Board Performance Business Monitoring Report and to Sub Committees of the Board through the reporting of specific programmes of work.

The following information provides an overview of the quality of care provided by the Trust based on performance in 2010/11 against the 2009/10 indicators for patient safety, clinical effectiveness and patient experience.

2.1.2 Patient Safety

Reduce The Trust's Hospital Mortality Rates

The Trust has worked with an independent benchmarking company over the last five years to track hospital mortality rates and take action where rates have been seen as high. Over the period we have implemented a range of actions to reduce our mortality rates and over the last 12 months have introduced a further set of actions. These include:

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

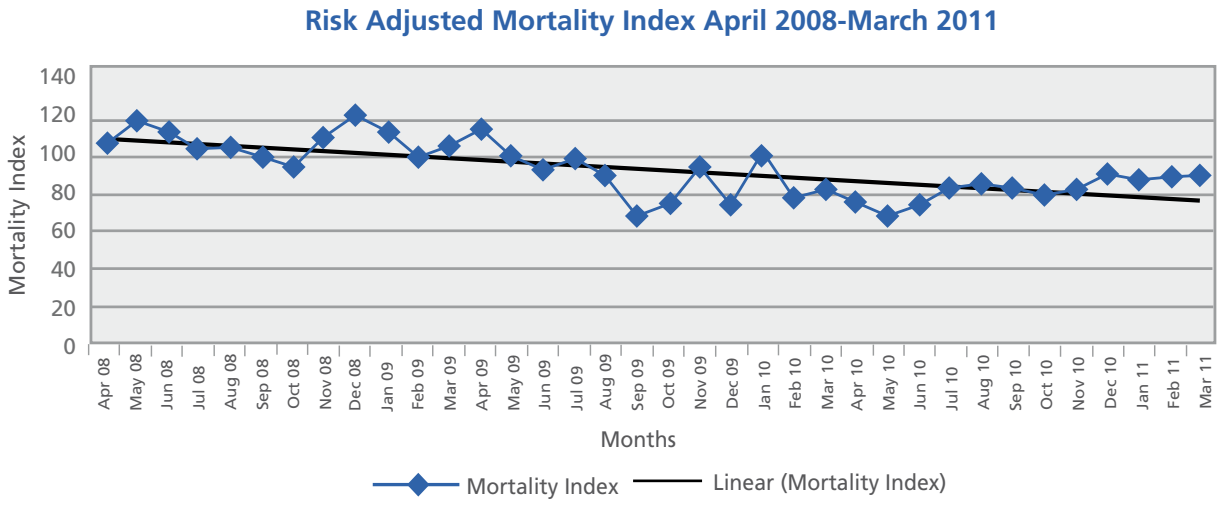
- The introduction of a mini 'Alert' course for all clinical staff as part of mandatory training. The aim of this is to improve the response to early warning scores and evidence of physiological deterioration.

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.

In the last few years the Trust has received negative publicity in the Dr Foster Good Hospitals Guide reports on mortality. The Trust is pleased to report that in this year's Good Hospitals Guide our published mortality rates were all within the expected range. The Trust has implemented a Mortality Board at which mortality in each specialty is reviewed and any unexpected findings are investigated. Graph 1 below shows our progress on improving our risk adjusted mortality which has fallen significantly. We have achieved a 15 point reduction in our Risk Adjusted Mortality Index (RAMI). A key objective for the Trust is to reduce the mortality index ratio by 73 by 2011/12. The Trust had a Risk Adjusted Mortality Index of 88 in 2010/11 and is on track to achieve its objective by 2011/12.

The improvement in our hospital mortality rates reflects a lot of hard work in many areas. The Trust has been 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. The Trust has won several awards for its patient safety work.

Graph 1



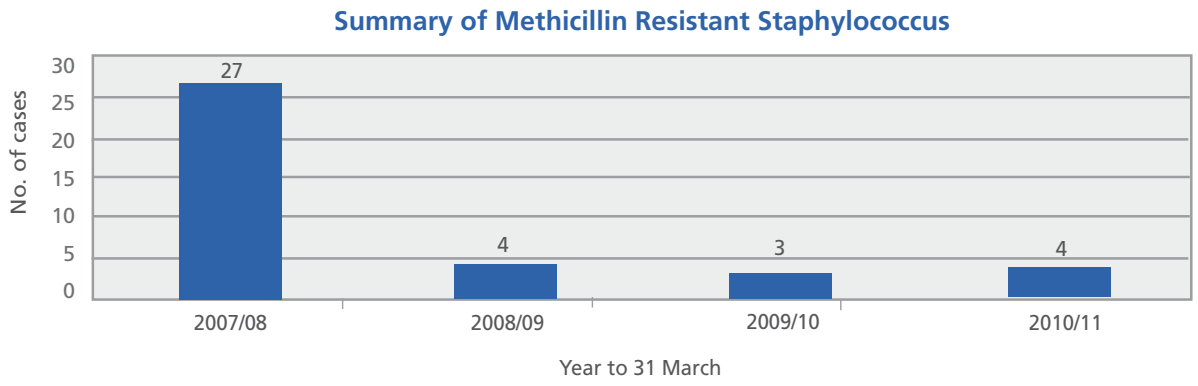
Reducing Infection Rates

Reduce Methicillin Resistant Staphylococcus Aureus (MRSA) Infection Rates

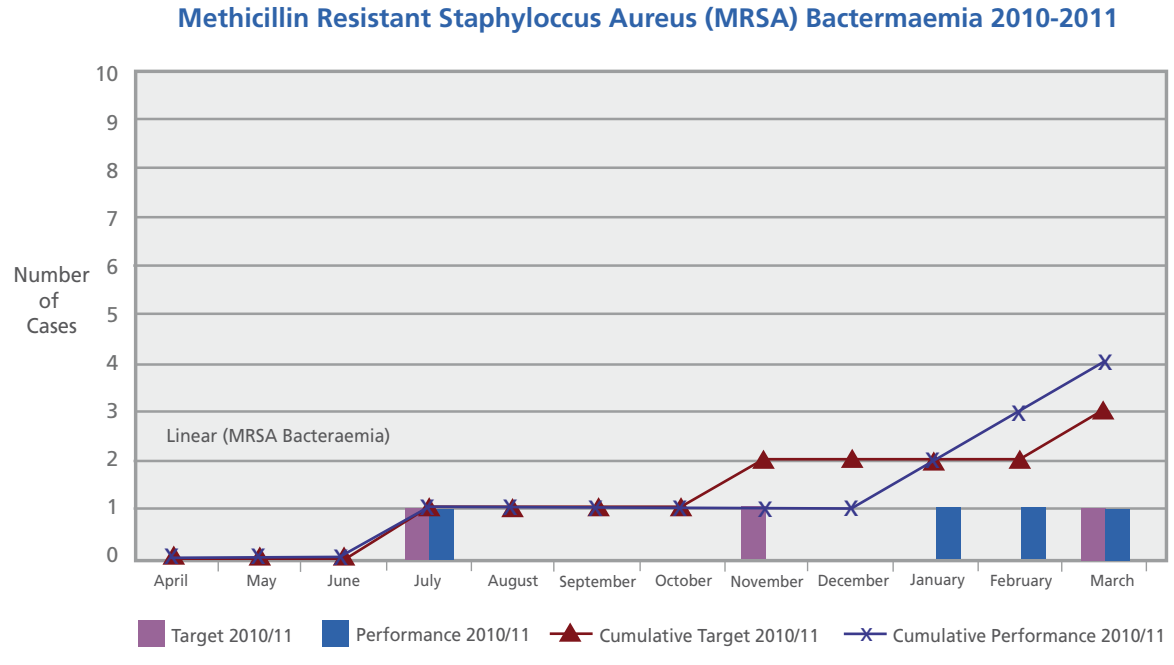
Following the significant reductions in Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia by 85% for the Acute Trust when compared to 2007/08, the Trust has continued to make tremendous progress in the last few years and embed Infection Prevention principles across the organisation, ensuring that the risk of acquiring an infection for patients is further reduced as shown in Graph 2.

The delivery of the MRSA Bacteraemia target remains a clinical risk, in relation to Monitor's Compliance Framework which identifies an MRSA trajectory of six cases for the reporting period. Striving for excellence, the Trust has a local MRSA target of three cases for the reporting period. The Trust has reported four cases for this year, which is over the local trajectory but remains within Monitor's Compliance Framework target, as detailed in Graph 3 below.

Graph 2



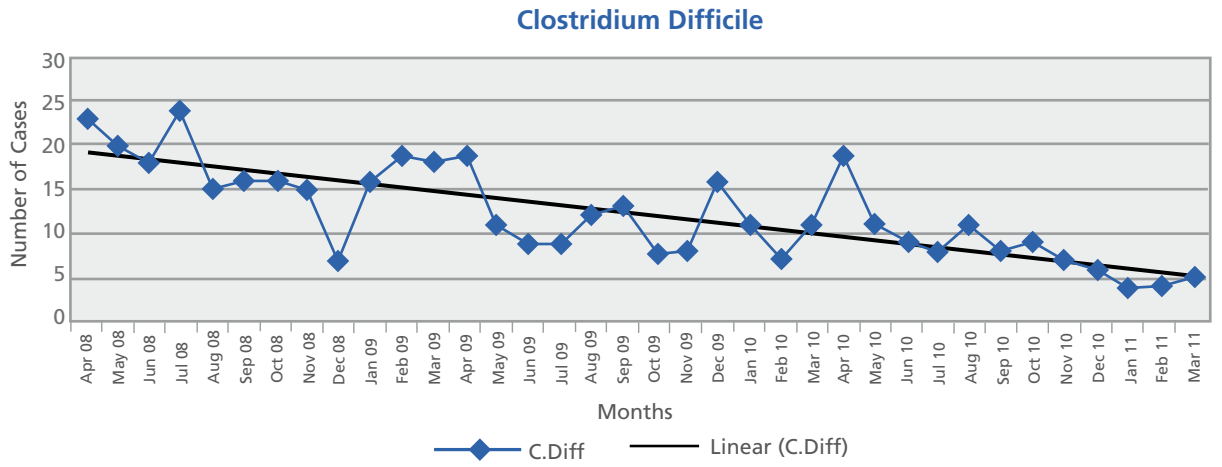
Graph 3



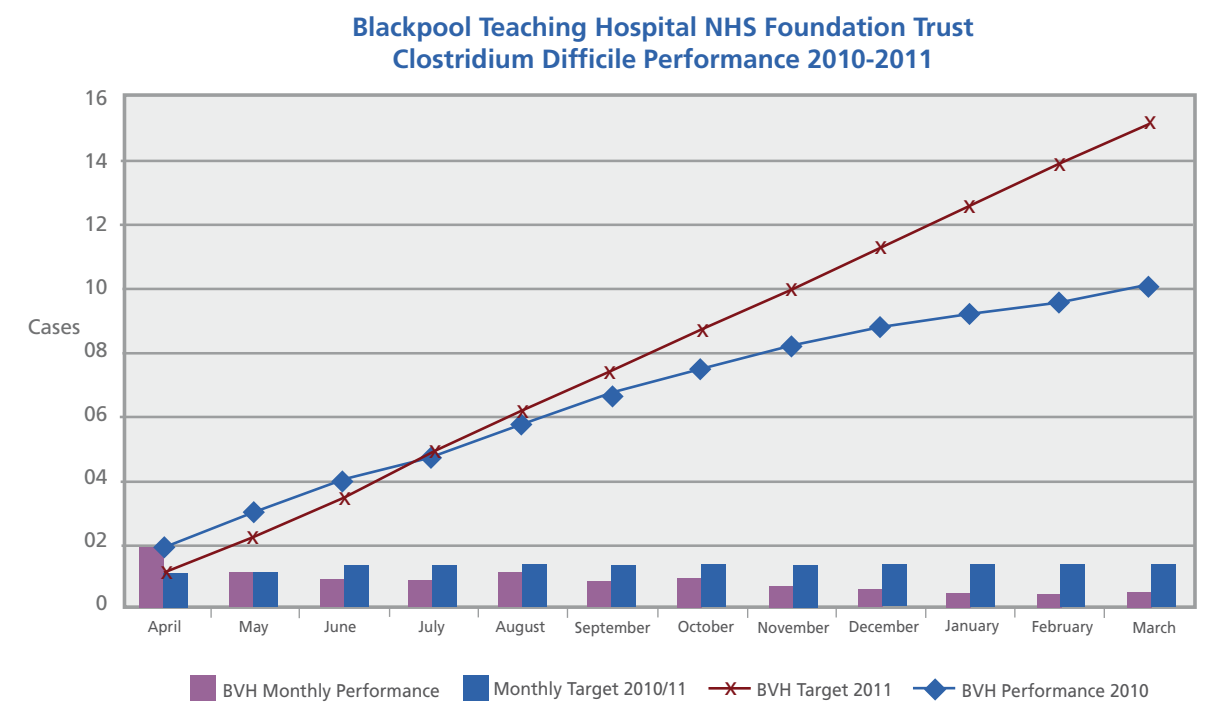
Reduce Clostridium Difficile Infection Rates

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. Following the significant reductions in Clostridium Difficile Infection (68.73% for the last four 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 101 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2010 and March 2011, in comparison to 134 for the period April 2009 to March 2010. This demonstrates a reduction of 24% which is above the 17.6% yearly reduction incorporated into the three year plan trajectories. The Trust was required to achieve a 53% reduction in Clostridium Difficile rates from the 2007 level, by March 2011 as shown in Graph 4a and 4b below.

Graph 4a

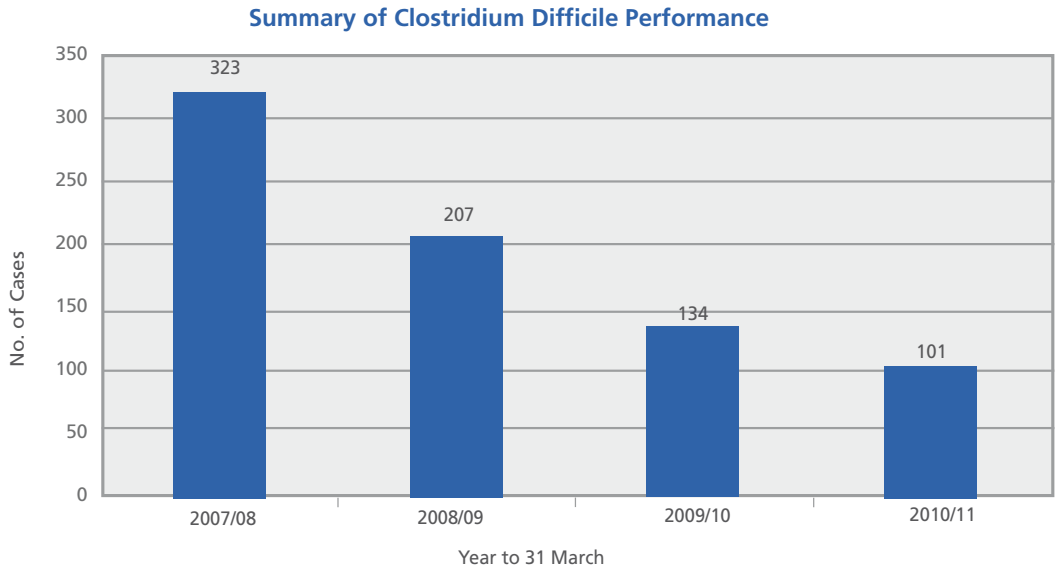


Graph 4b



Overall, the Trust has reduced the number of cases of Clostridium Difficile by 68.73% for the last four years for the Acute Trust when compared to 2007/2008 as shown in Graph 5. This is as a result of clinical engagement, new ways of working and the commitment of all staff to make improvements in this important area.

Graph 5



Global Trigger Tool To Be Used To Measure Adverse Events

Traditionally the Trust's efforts to detect and deal with adverse events have focused on reporting and tracking of errors. However, research published by the Institute for Healthcare Improvement has shown that only 10 to 20% of errors are reported and of those, 90 to 95% cause no harm to patients. The Trust has therefore decided to adopt the Institute for Healthcare Improvement Global Trigger Tool to measure adverse events. The Global Trigger Tool (GTT) is a method of measuring events of harm that may happen to a patient during their admission and stay in an acute hospital. It is an easy-to use method for accurately identifying events that cause harm to patients and measuring the rate at which they occur. It also provides information on whether changes being made in response to adverse incidents are improving safety.

The Global Trigger Tool team is a multidisciplinary team of five senior nurses and two consultants from across the divisions who have reviewed over 400 patient casenotes in order to establish the level of harm occurring to patients, identify the themes of harm, and recommend and institute improvement programmes. Our teamwork over the past 18 months has provided the Trust with its first opportunity to accurately identify and quantify the triggers to and causes of harm occurring to our patients. Therefore we can direct real improvements to be made in patient safety.

The methods employed are a retrospective review and scoring system of a randomly selected sample of patient casenotes to identify triggers to or actual harm occurring in either the active delivery of healthcare (commission) or in substandard care (omission). A quarterly report is produced and submitted to the Board for monitoring results.

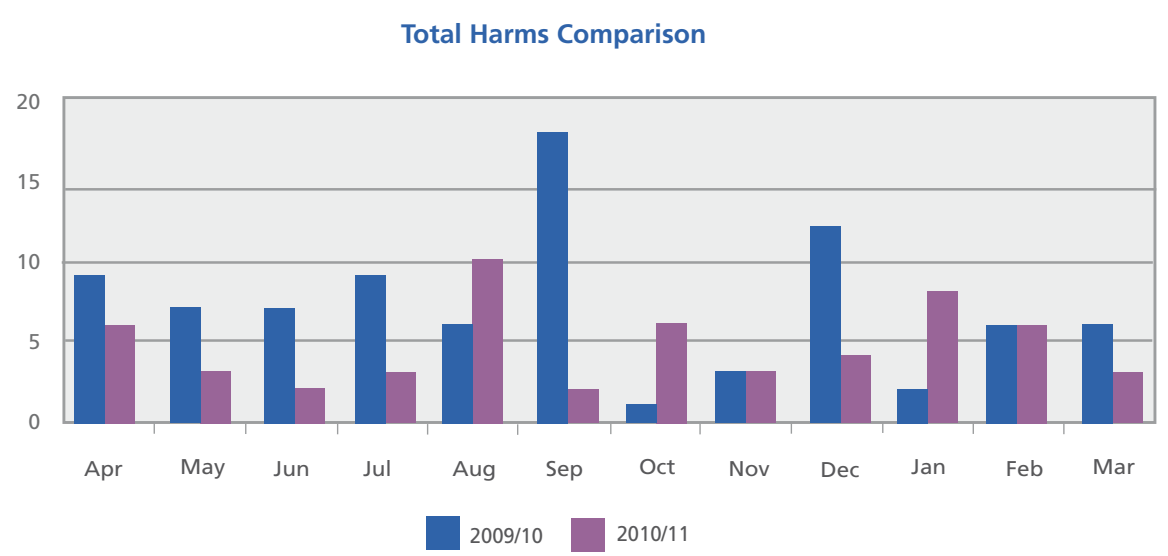
Our results in Graph 7 to date show a reduction in the number of harms occurring to patients which have been contributed to by the programmes we have proposed, together with greater awareness for patient safety that our teamwork has delivered. The following issues and interventions have been identified and addressed to improve the quality of care to our patients as a result of the findings of the team:

- Regular presentation of results, key findings and recommendations to the Board, as well as senior medical and nursing staff.
- Regular presentation of key cases and learning points at mortality grand rounds for education of all Trust staff.
- Identified a lack of senior medical review as a key factor with omissions in patient care.
- Identified potential millions of pounds in savings by the reduction in levels of patient harm leading to reduced length of stay.
- Recurring themes such as inadequate venous access, falls, pressure ulcers and medication errors are areas for attention.
- Safety issues regarding infections incorporated into the Trust wide "Surviving Sepsis" campaign.
- Focus on Trust wide documentation on Early Warning Score - a recurrent theme in omission of care.

- Requested a change in x-ray documentation - approved by the Ionising Radiation Medical Exposure Regulations (IRMER) Radiology group and now in use.
- Development of administration of medicines / medicines management programme which incorporated leadership and change processes - delivered to ward managers, foundation year doctors, student doctors and nurses.
- Blood transfusion policy revisited.
- Bedside-light maintenance commenced to facilitate bedside blood and drug checks.
- Initiation of "Recognise & Act - managing the deteriorating patient course" - successfully added to mandatory training for every Trust Registered Nurse and Midwife.
- Initiated Trust-wide pressure ulcer prevention project.
- Trust-wide Implementation of Situation Background Assessment Recommendations (SBAR) safety communication tool.

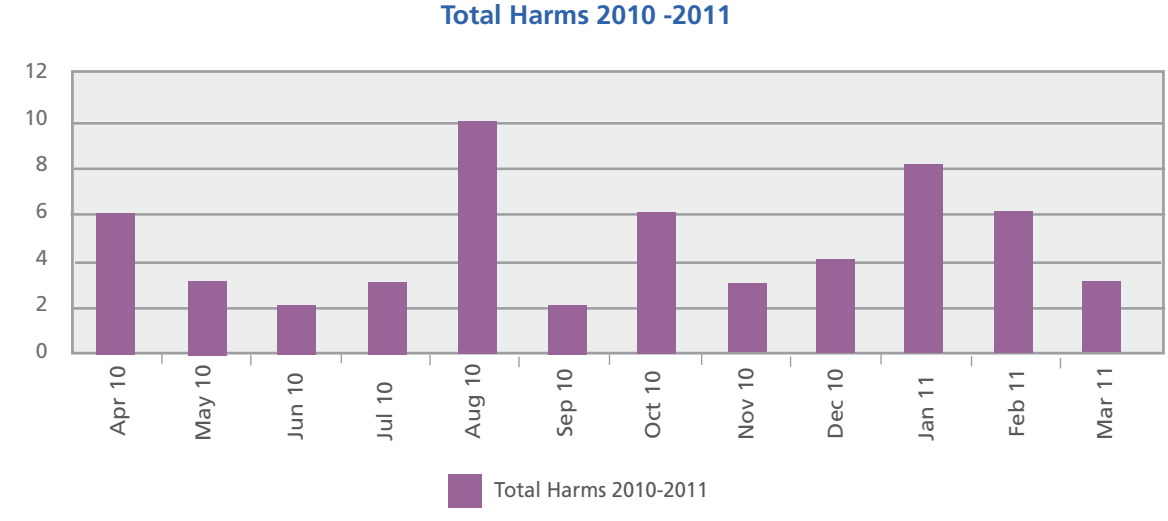
Graph 6 shows the total number of harms discovered per 20 sets of patient case notes reviewed each month.

Graph 6



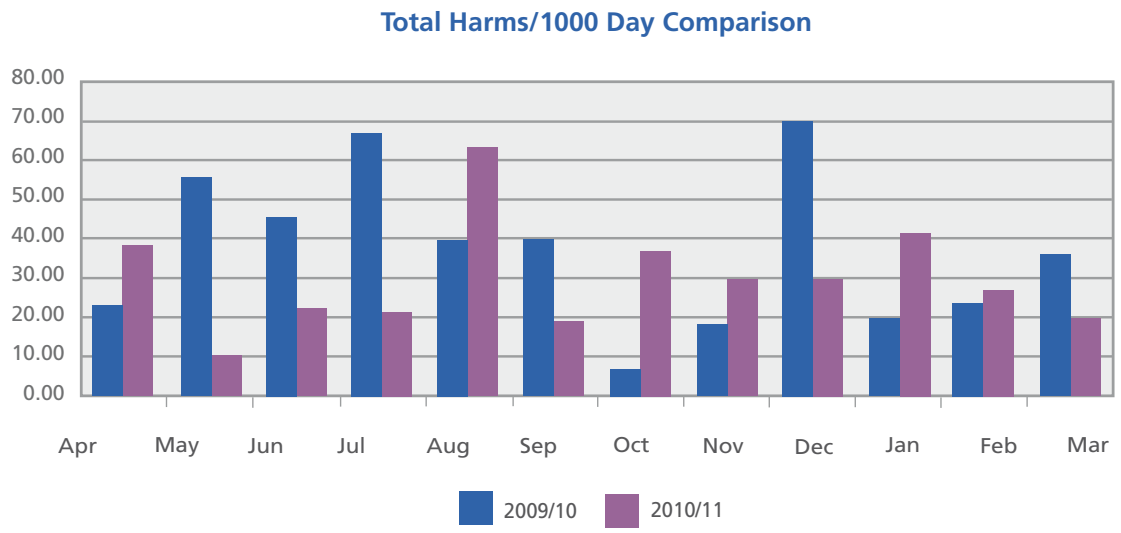
Graph 7 compares the total number of harms discovered per20 sets of patient case notes each month over the last year

Graph 7



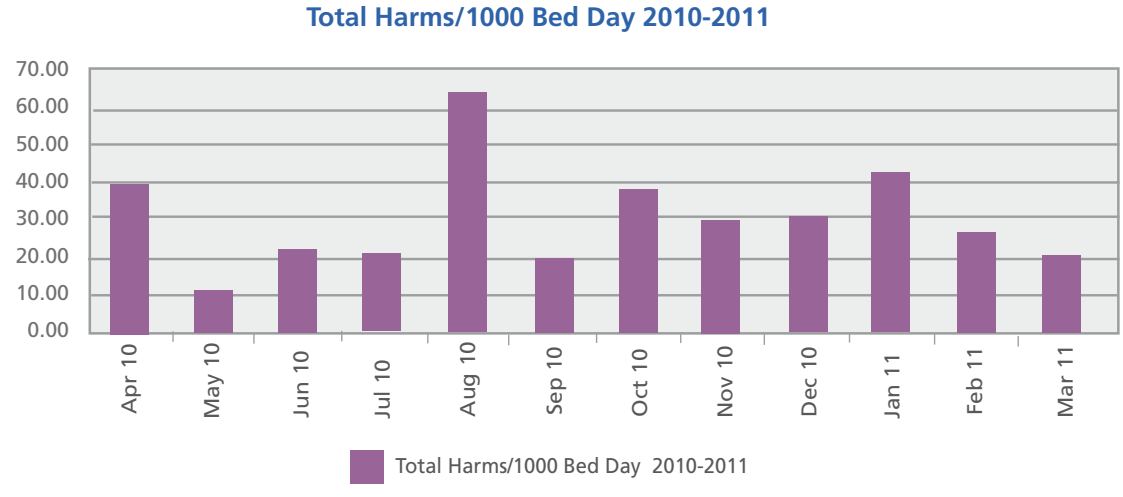
Graph 8 shows the number of harms discovered at the review scaled up to reflect the number of harms that could be expected per 1000 bed days. For example, in March 2011 the number of harms discovered in the patient case note review divided by the number of bed days that the reviewed cases stayed in hospital was around 0.02. This equates to around 20 harms per 1000 bed days.

Graph 8



Graph 9 shows the comparison between the harms per 1000 bed days over the last year.

Graph 9



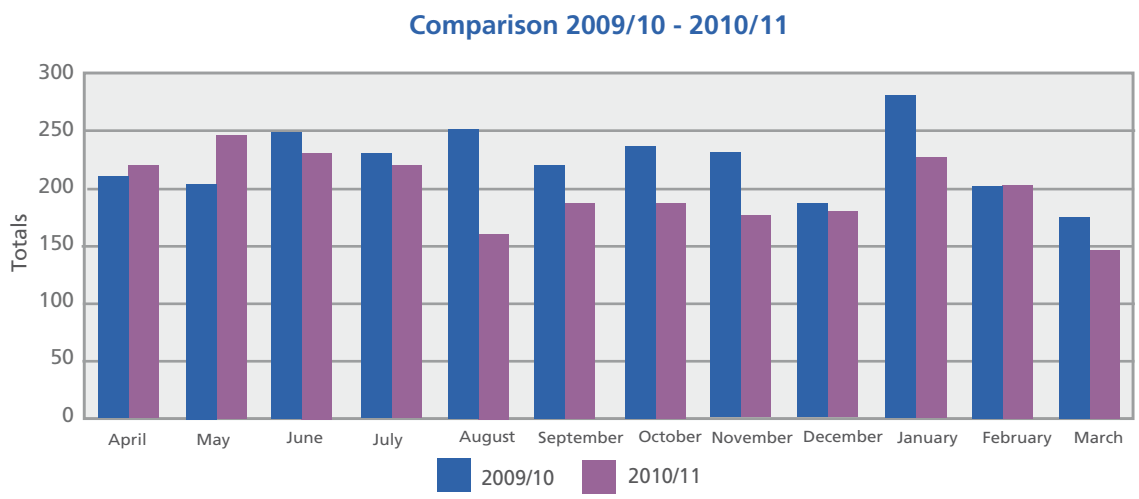
Reduction in Falls By 30%

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 10 on page 109. There have been a number of initiatives introduced during 2010/11 which have contributed to the downward trend in the number of falls each month.

- There has been intensive support and training given to pilot wards within the Medical, Surgical and Cardiac Divisions to improve the quality of falls risk assessment and the formulation of a care plan for patients at risk of falling. This has resulted in a significant improvement in the standard of care plans and an overall reduction in the number of falls.

- The Trust has introduced 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.
- "Hour rounds" have been introduced within some of the clinical areas to ensure that any patient who is at high risk of falling is visited at least once every hour. This has been proven to help reduce the risk of patients attempting to mobilise unaided as they know a member of staff will regularly attend to their needs.

Graph 10: Patient Slips, Trips and Falls



Reducing Medication Errors By 50% by 2011/12

The Pharmacy Department continues to actively engage all professionals in the safe management of medicines within the Trust. Safe medicines management ensures that the patients within our care receive their prescribed medication without exposure to risk or injury. Medicines are an integral part of modern disease management, whether they are used for prevention, treatment or alleviation of symptoms. The volume of medicines prescribed and their cost is increasing each year. It is estimated that over 700 million prescription items are dispensed in England each year at a total cost approaching £8 billion.

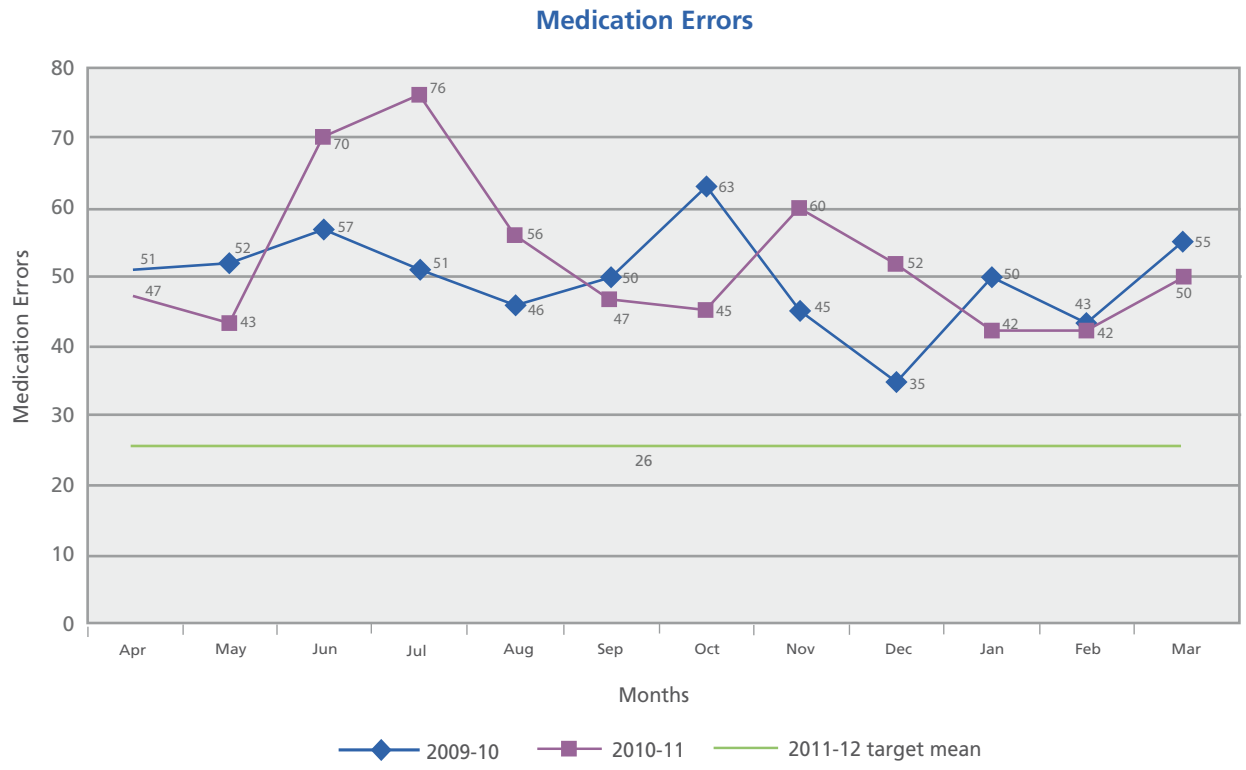
Nationally incidents involving medicines are the third largest group (9%) of all incidents reported to the National Reporting and Learning Service (NRLS) after patient accidents (35%) and treatment /procedure (9%) from a total of 811,746 incidents of all types reported during 2007 as highlighted in the publication" "Safety in Doses: Improving the use of medicines in the NHS" (published 2009).

Medication incident reports are those which actually caused harm or had the potential to cause harm involving an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicines advice. The most frequently reported types of medication incidents involve:

- wrong dose
- omitted or delayed medicines
- wrong medicine

The number of reported medication errors are detailed in Graph 11. The graph demonstrates the increasing awareness of safe medicines management within the Trust and the commitment of the staff to ensure that patients receive prescribed medicines safely.

Graph 11 - Medication Errors



The Medicines Management Team continue to work collaboratively, combining the knowledge and experiences of the Lead Pharmacist for Risk Management and the Medicines Management Specialist Nurse for Pharmacy to ensure that National Patient Safety Agency (NPSA) recommendations in relation to medicines are implemented and sustained within practice in all areas.

The number of NPSA alerts continues to increase and the Medicines Management Team has ensured that all alerts and associated deadlines for changes in practice have been met. This ensures that the Trust can declare compliance with the NPSA alerts, and demonstrate robust and comprehensive audit procedures undertaken by the Medicines Management Team that monitor sustained compliance and safety within all aspects of Medicines Management.

2.1.3 Clinical Effectiveness

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. Examples of the interventions can be found in the following information and tables below:

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

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

Applying all the interventions will support our goals of reducing hospital mortality, reducing preventable harms and improving patient outcomes, thereby improving the quality of their experience. Approximately 2,700 patients a year will benefit from this programme.

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

Table 2 - CQUIN and the respective Targets For The Trust

Scheme	Threshold	Collection Period
Acute Myocardial Infarction (AMI)	95%	Discharges which occur between 1st April 2010 and 31st March 2011.
Coronary Artery Bypass Graft (CABG)	95%	
Community Acquired Pneumonia	78.41%	
Hip and Knee Surgery	95%	
Heart Failure	65.34%	
Stroke (New target introduced October 2010)	Cumulative Composite Quality Score >=90% Appropriate Care score >=50%	Discharges which occur between the 1st October 2010 to 31st March 2011.

Comparison of Data

For each of the key areas a series of appropriate patient care measures has been determined, known as the Composite Quality Score (CQS). Data are collected to demonstrate if these measures are being met and a Composite Quality Score for each key area is derived for every Trust in the programme. Performance thresholds have been agreed using this data which, whilst stretching, 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 Commissioning for Quality and Innovation (CQUIN) payment for each organisation and the data collection periods for each scheme are slightly different, and therefore each CQUIN and the respective targets for the Trust are detailed in table 2 above:

In addition, to qualify for the Commissioning for Quality and Innovation awards, Trusts must achieve a minimum cumulative clinical coding and Quality Measures Reporter (QMR) data completeness score of 80%.

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

Acute Myocardial Infarction (Heart Attack)

Review

The Trust has always performed well against the advancing quality measure for Acute Myocardial Infarction.

A number of measures have been introduced to ensure compliance with all performance measures. The introduction of management prompt cards held within the patients' case notes have been developed. This allows accurate information to be detailed and captured in one place to assist with data entry. These cards provide advice to clinicians regarding the management plan required to ensure that care in accordance with best practice is provided.

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 treatment plan (see table 3 below).

Table 3

Acute Myocardial Infarction (Heart Attack)	Trust Performance	
Measure	**Year 1**	**Year 2**
Aspirin at arrival	100.00%	100.00%
Aspirin prescribed at discharge	99.40%	100.00%
ACEI or ARB for LVSD	100.00%	100.00%
Adult smoking cessation advice/counselling	92.86%	96.00%
Beta Blocker prescribed at discharge	98.03%	100.00%
Beta Blocker at arrival	99.07%	
Fibrinolytic therapy received within 30 minutes of hospital arrival	100.00%	
Primary Coronary Intervention (PCI) received within 90 minutes of hospital arrival	100.00%	100.00%
Survival Index	96.76%	99.00%
Acute Myocardial Infarction (AMI) Composite Quality Score (CQS)	**98.55%**	**99.62%**
Top 25% CQS Threshold	**97.02%**	**99.04%**
Top 50% CQS Threshold	**94.40%**	**98.00%**
Attainment Threshold		**87.35%**
Year 1 – Trusts had to achieve over the Top 25% or Top 50% to receive the incentive.		
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% or Top 50% incentive.		

Hip and Knee Replacement Surgery

Review

Both antibiotic and Venous Thrombo-Embolism prophylaxis is the subject of a set of departmental protocols. Compliance with the Venous Thrombo Embolism prophylaxis protocol is 99% or better. With regard to antibiotic prophylaxis we have developed a protocol, involving both flucloxacillin and gentamicin as a first line for patients without penicillin/ cephalosporin allergy, and compliance in this area is 100%. Table 4 below details the performance in this Advancing Quality performance measure.

Table 4

Hip and Knee Replacement Surgery	**Trust Performance**	
Measure	**Year 1**	**Year 2**
Prophylactic antibiotic received within 1 hour prior to surgical incision	99.53%	88.14%
Prophylactic antibiotic selection for surgical patients	98.88%	97.36%
Prophylactic antibiotic discontinued within 24 hours after surgery end time	95.33%	98.31%
Recommended venous thrombo-embolism prophylaxis ordered	100.00%	99.66%
Received appropriate Venous Thrombo Embolism (VTE) prophylaxis within 24 hrs prior to surgery to 24 hrs after surgery	99.84%	99.66%
Readmission (28 Day) avoidance index	90.31%	94.02%
Hip and Knee Composite Quality Score (CQS)	**94.52%**	**96.19%**
Top 25% CQS Threshold	**94.52%**	**96.89%**
Top 50% CQS Threshold	**92.04%**	**94.27%**
Attainment Threshold		**75.67%**
Year 1 – Trusts had to achieve over the Top 25% or Top 50% to receive the incentive.		
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% or Top 50% incentive.		

Coronary Artery Bypass Graft Surgery (CABG)

Review

There are four Trusts doing Coronary Artery Bypass Graft within the North West who have all scored highly for Year 1 and Year 2. It is very competitive due to the low number of Trusts.

A number of actions have been introduced to further improve performance against the measures. The introduction of management prompt cards held within the patients' case notes have been developed. This allows accurate information to be detailed and captured in one place to assist with data entry.

These cards provide advice to clinicians as to the management plan required to ensure best practice takes place.

The introduction of new prescription sheets within the Cardiac Intensive Care unit with the facility to prescribe antibiotics for a 48 hour period have been introduced. This ensures clinicians review each patient and only continue with antibiotics based on clinical need when they are re-prescribed.

The data entry clerk reviews all patients prior to submitting information to ensure the data is complete (see Table 5 below).

Table 5

Coronary Artery Bypass Graft	Trust Performance	
Measure	**Year 1**	**Year 2**
Aspirin prescribed at discharge	99.53%	98.54%
Prophylactic antibiotic received within 1 hr prior to surgical incision	94.71%	87.89%
Prophylactic antibiotic selection for surgical patients	98.14%	94.88%
Prophylactic antibiotics discontinued within 24 (48) hrs after surgery end time	82.15%	89.82%
Coronary Artery Bypass Graft Composite Quality Score (CQS)	**93.77%**	**92.73%**
Top 25% CQS Threshold	**98.71%**	**97.75%**
Top 50% CQS Threshold	**95.01%**	**97.73%**
Attainment Threshold		**95.00%**
Year 1 – Trusts had to achieve over the Top 25% or Top 50% to receive the incentive.		
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% or Top 50% incentive.		

Heart Failure

Review

The Trust has shown an improvement in performance in relation to the management of patients with heart failure.

The introduction of management prompt cards has facilitated correct pathway management. These cards provide advice to clinicians regarding the management plan required to ensure that care in accordance with best practice is provided.

Heart Failure Specialist Nurses now attend the Clinical Decision 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 assist with effective diagnosis and treatment. Near the end of their hospital stay, patients are seen by the Cardiac Rehabilitation Team who ensure appropriate discharge advice has been given, see Table 6.

Table 6		
Heart Failure	**Trust Performance**	
Measure	**Year 1**	**Year 2**
Discharge instructions	7.33%	18.42%
Evaluation of LVS function	70.20%	84.62%
ACEI or ARB for LVSD	76.06%	81.37%
Adult smoking cessation advice / counselling	27.78%	53.85%
Heart Failure Composite Quality Score (CQS)	**42.40%**	**59.10%**
Top 25% CQS Threshold	**74.65%**	**77.60%**
Top 50% CQS Threshold	**59.60%**	**72.19%**
Attainment Threshold		**65.34%**
Year 1 – Trusts had to achieve over the Top 25% or Top 50% to receive the incentive.		
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% or Top 50% incentive.		

Pneumonia

Review

Performance of Blackpool Teaching Hospitals NHS Foundation Trust based on Premier data for Year 2 shows the Composite Process Score (CPS) to be 76.28%. This compares to performance of the Top 25% of Trusts participating in Advancing Quality Pneumonia, which is 84.03% and 82.24% for top 50%.Table 7 below summarises the achievement scores for the five key measures:

Table 7		
Pneumonia	**Trust Performance**	
Measure	**Year 1**	**Year 2**
Oxygenation assessment	96.89%	100.00%
Blood Cultures performed in A&E prior to initial antibiotics received in hospital	17.09%	41.60%
Adult smoking cessation advice / counselling	10.20%	39.62%
Initial antibiotic received within 6 hours of hospital arrival	54.21%	64.94%
Initial antibiotic selection for CAP in immunocompetent patients	67.13%	97.32%
Pneumonia Composite Quality Score (CQS)	**62.08%**	**76.28%**
Top 25% CQS Threshold	**82.11%**	**84.03%**
Top 50% CQS Threshold	**74.77%**	**82.24%**
Attainment Threshold		**78.41%**
Year 1 – Trusts had to achieve over the Top 25% or Top 50% to receive the incentive.		
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% or Top 50% incentive.		

As is clear from the figures, the Trust has made significant progress compared to year one and narrowly missed the attainment threshold by 1.13% The Trust is achieving top 25% performance in oxygenation assessments and appropriate initial antibiotic selection. To achieve top 25% in blood cultures performed prior to initial antibiotics, the Trust must achieve a performance above 80.49%. A performance above 64.29% is required for smoking cessation, and 75.52% for initial antibiotic administration within six hours.

The incentive scheme for Advancing Quality in year three will be based on a percentage of total contract value, as advised by NHS North West. The awards form part of the regional Commissioning for Quality and Innovation (CQUIN) and as such reflect CQUIN principles. Each Trust will have an individual CQUIN level of attainment based on their year one position and a range of expected improvement. The CQUIN threshold for Blackpool Teaching Hospitals NHS Foundation Trust is 78.41%.

At regular multidisciplinary meetings involving clinicians, nurses and managers from Accident and Emergency, the Clinical Decision Unit and the Medical specialties, recent clinical cases are reviewed in order that areas for improvement can be identified. The Trust is confident that the introduction of a pneumonia pathway into the electronic patient record will further improve our performance parameters.

Implementing 100,000 Lives and Saving Lives Programme

These programmes have been adopted by the Trust, following their launch by the Institute for Healthcare Improvement and the Department of Health. As with the Advancing Quality Programme these schemes use evidence-based interventions with the aim of reducing patient harm across the Trust. The outcomes from implementing these measures will be:

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

All patients who are treated at the Trust will benefit from these changes. We have established robust mechanisms to audit both compliance with the recommended provision of care and the impact on patient outcomes, in particular mortality rates and preventable harms. The Trust will also be continuing the implementation of best practice as described within the 'Map of Medicine' and National Institute for Health and Clinical Excellence (NICE) guidelines.

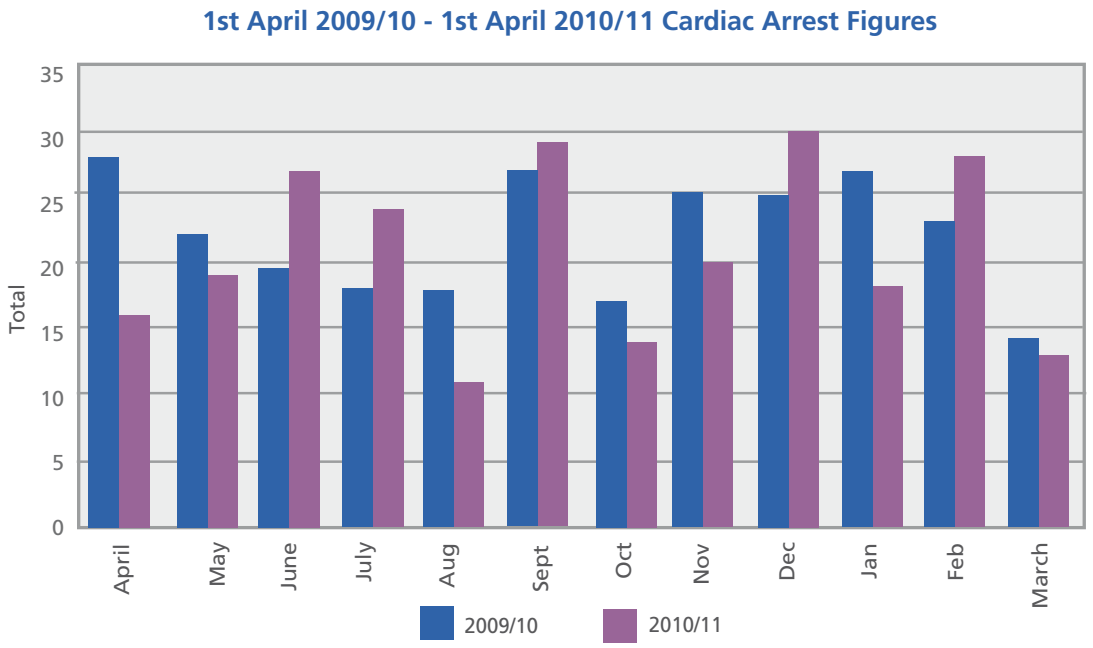
The first two outcomes have been reported on in this year. The Trust anticipates having further data available and all outcomes will be reported in the following financial year.

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

Data relating to in-hospital cardiac arrest calls is provided to the Care of the Acutely Ill Group/Resuscitation Committee each month, together with a detailed presentation of improvement activities twice a year. Action plans for reducing in-hospital cardiac arrests and embedding "Do Not Attempt Resuscitation (DNAR)" principles are also discussed at each meeting.

The number of in-hospital cardiac arrests for the period 1st April 2010 to 31st March 2011 was 249. This is represented In Graph 12.

Graph 12



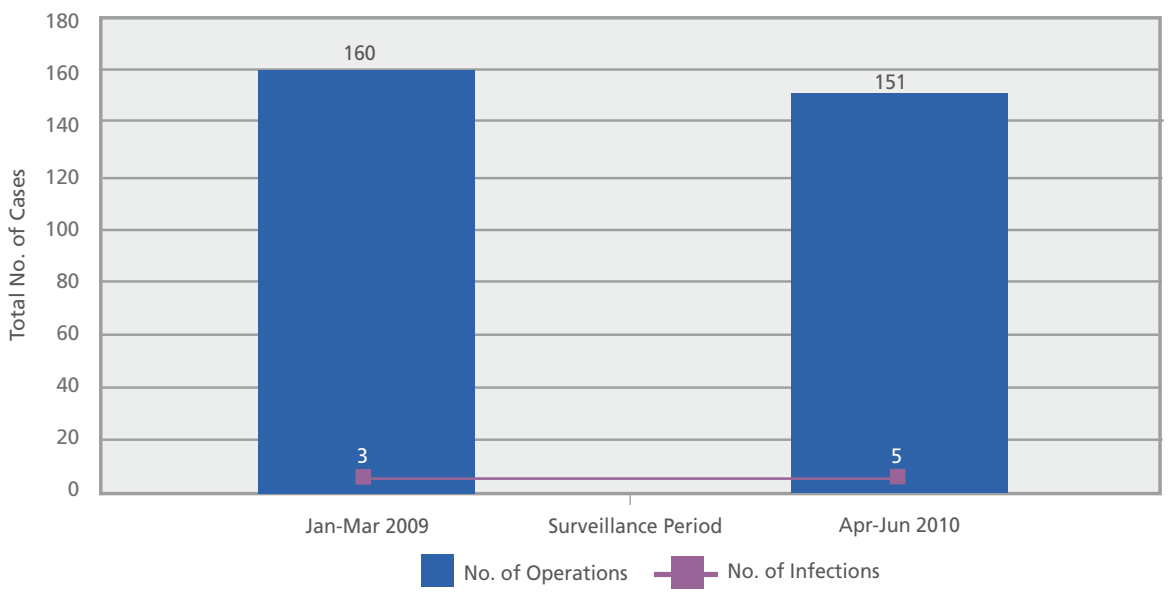
The following information provides an overview of some of the initiatives that the Trust has undertaken to reduce the number of in-hospital cardiac arrests:

- Increase in Advanced Life Support education.
- Increase in Immediate Life Support education.
- Increase in Early Warning Score and Do Not Attempt Resuscitation (DNAR) education.
- Establishment of DNAR focus groups.
- Implementation of a Critical Care Outreach Service.

Reducing the Incidence of Surgical Site Infections

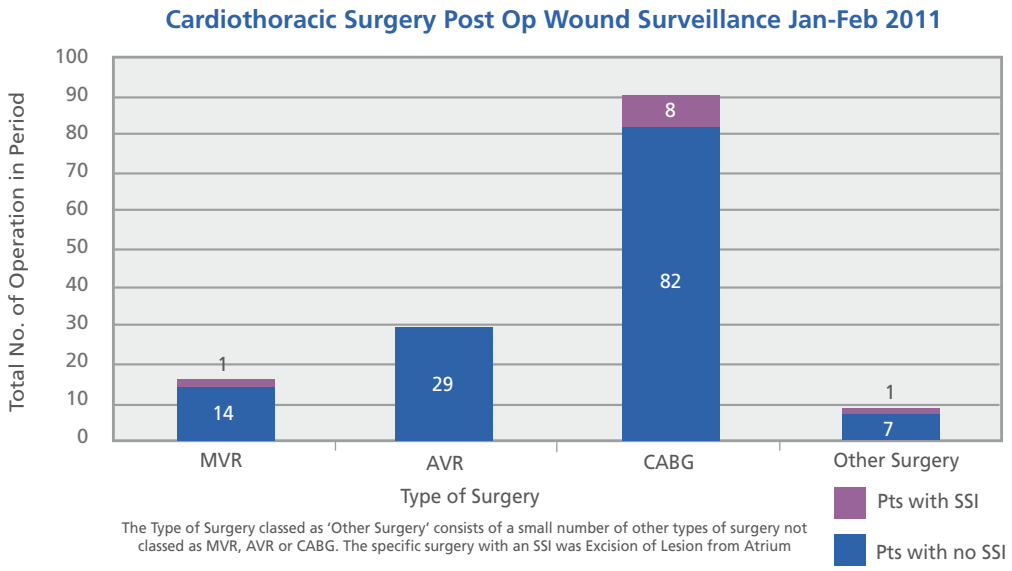
Monitoring of the incidence of surgical site infections is undertaken through a rolling schedule of audit and surveillance across all surgical specialties, with the review of all orthopaedic surgical infections being mandatory. All issues highlighted as a result of this surveillance will be used to improve practice across the Trust. Graph 13 below demonstrates the small number of infections that have been identified following surveillance of patients undergoing hip surgery.

Graph 13



Graph 14 details the numbers of various different types of Cardiac Surgery operations performed together with the number of post operative wound infections during January – February 2011. The Trust has identified that there are improvements to be made for those patients who have a Coronary Artery Bypass Graft (CABG).

Graph 14



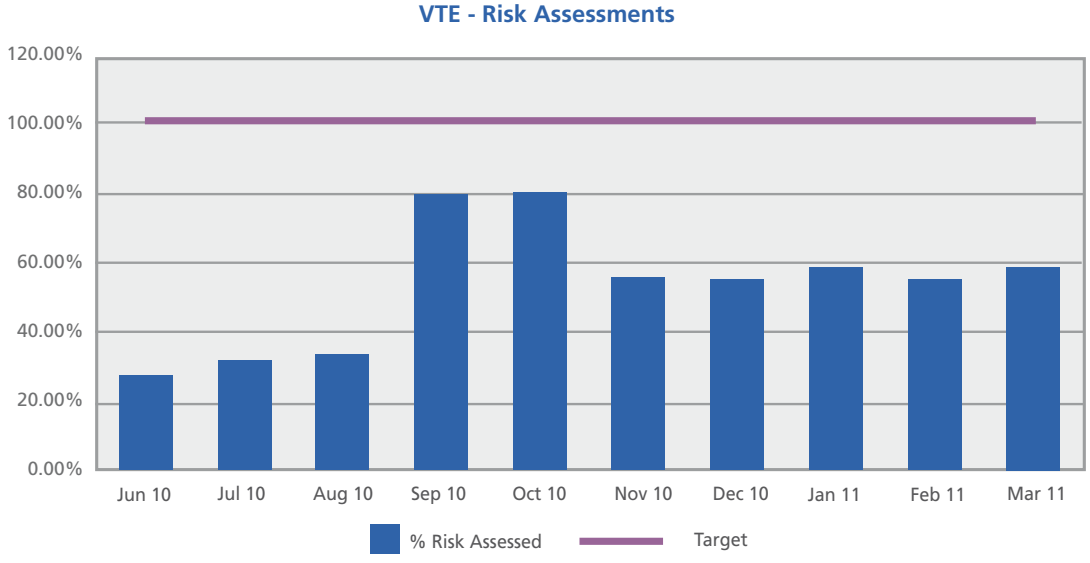
The Type of Surgery classed as 'Other Surgery' consists of a small number of other types of surgery not classed as MVR, AVR or CABG. The specific surgery with an SSI was Excision of Lesion from Atrium

Embed Implementation Of Venous Thrombo Embolism Guideline

The Trust's aim is to implement current best practice guidelines and 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. Graph 15 shows the number of risk assessments undertaken for adult patients on admission from June 2010 to March 2011.

The Trust has established a small project group to produce and implement a standard Risk Assessment Tool which can be used to assess patients' risk of Venous Thrombo Embolism. The use of three Risk Assessment forms has been agreed for use in the medical specialties, surgical specialties and obstetrics. Full training on the completion of the risk assessment has been provided, and this now forms part of the clerking process for patients within these specialties. To ensure that the Trust increases the number of patients who receive this risk assessment and appropriate treatment, a Thrombosis Committee has been established which monitors performance of individual clinical areas regarding VTE assessments.

Graph 15



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 was to reduce harms 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 hope to improve referral times to palliative care services and the way that our staff interact with relatives at this difficult time.

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

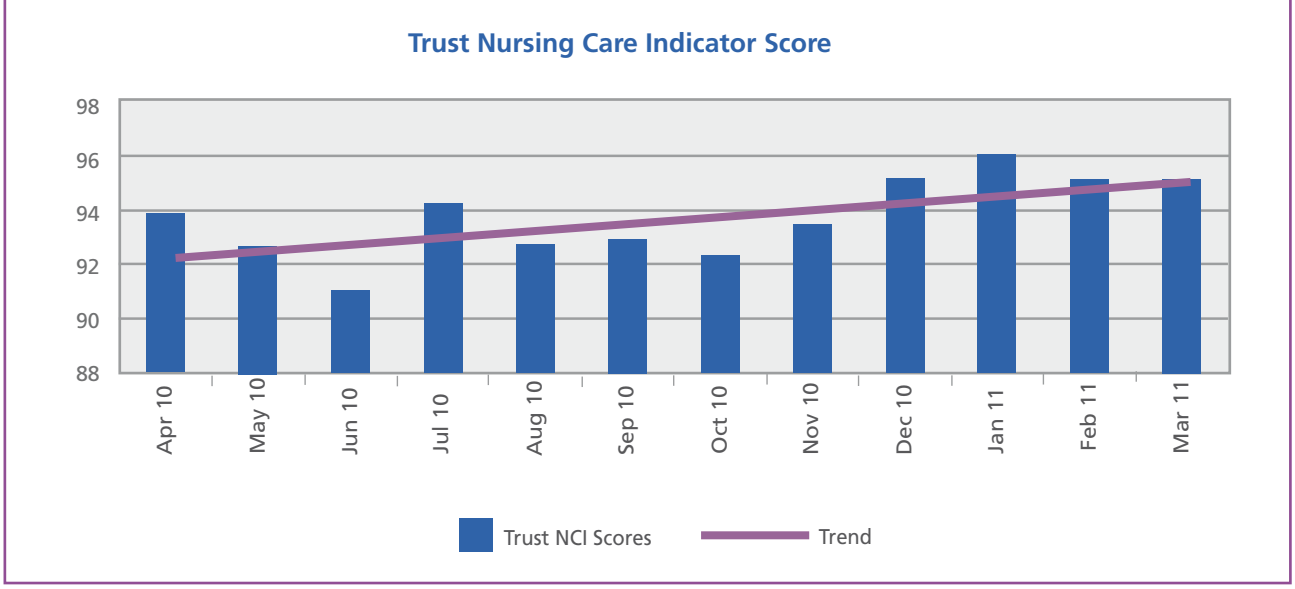
In the development of the Nursing Care Indicators, key themes for measurement were identified from complaints, the patients' survey, the Trust documentation audit, the benchmarks held within the essence of care benchmarking tool, and assessments against Trust nursing practice standards. Measurement of the Nursing Care Indicators is an evolving process and in June 2010, two new indicators were developed and added to the framework. During 2011 the Trust intends to expand them further into Neonatal and Day Case areas. The Nursing Care Indictors are subject to internal review and the Trust is in the process of adding to the suite of indicators in line with changing standards and requirements.

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 (added June 2010)
- Continence Care (added June 2010)

Graph 16 shows the overall Trust performance, expressed as an average percentage of all ten nursing care indicators, for 2010/11.

Graph 16



2.1.4 Patient Experience

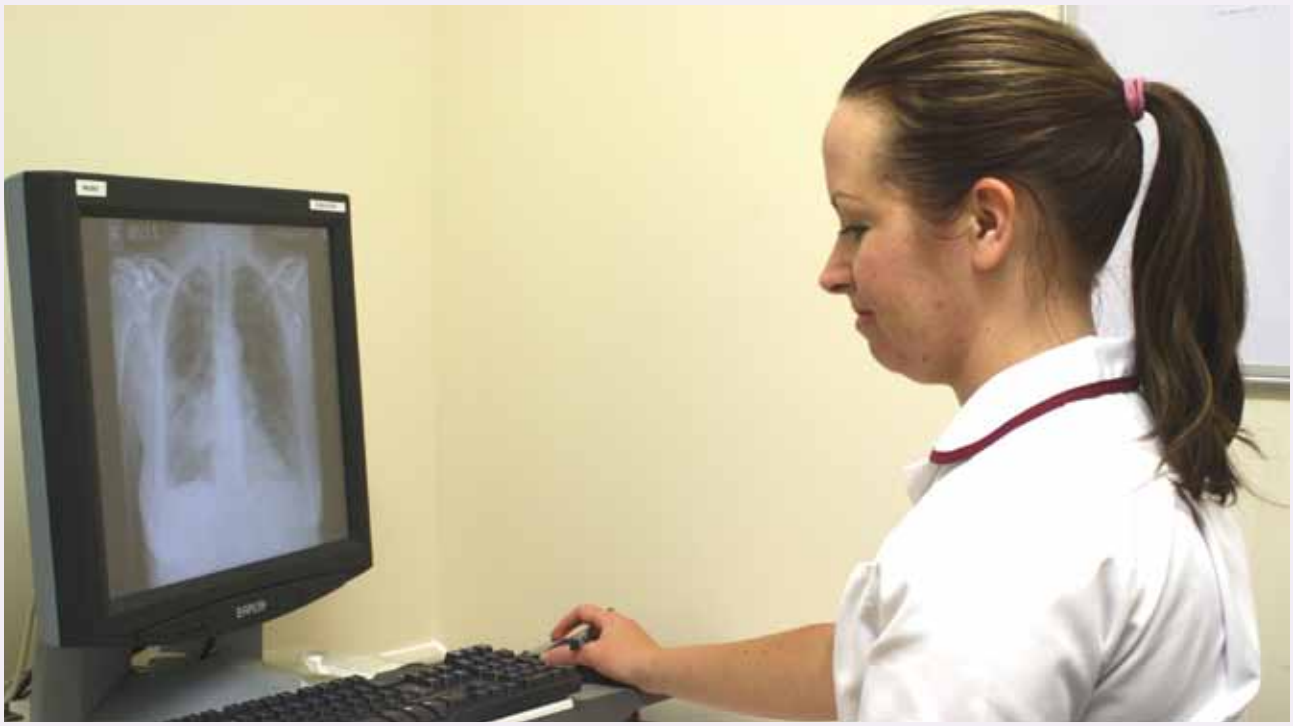
Improve the National In-Patient Survey Results

The National Inpatient Survey is undertaken on an annual basis by the Picker Institute, an independent organisation. Table 8 shows a comparison of data for three indicators from 2008 to 2010. These three indicators were chosen to be monitored since they relate to key issues that are of great importance to the Board and/or have been identified by our patients as of most importance to them.

Table 8

National Inpatient Experience Survey

Indicator	2008 Result	2009 Result	2010 Result
In your opinion, how clean was the hospital room or ward that you were in?	Very clean - 70% of patients stated that the hospital or room was very clean (national average was 60%)	Very clean - 72% of patients stated that the hospital or room was very clean (national average was 65%)	Very clean – 69% of patients stated that the hospital or room was very clean (national average was 67%)
Were you given enough privacy when being examined or treated?	Yes always - 89% of patients stated that they were always given enough privacy when being examined (National average was 89%)	Yes always - 91% of patients stated that they were always given enough privacy when being examined (National average was 89%)	Yes always – 89% of patients stated that they were always given enough privacy when being examined (National average was 89%)
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	Yes always - 81% of patients felt they were treated with respect and dignity whilst they were in hospital. (National average 80%)	Yes always - 81% of patients felt they were treated with respect and dignity whilst they were in hospital. (National average 80%)	Yes always – 81% of patients felt they were treated with respect and dignity whilst they were in hospital (National average 81%)



Improve National Out-Patient Survey Results In The Following Four Key Areas

The Trust was not required to complete the National Outpatient Survey for 2010/2011 and the next National Outpatient Survey will be undertaken in 2013. However, in relation to the four areas for improvement that were identified in the 2009/2010 National Outpatient Survey Results, improvements have been undertaken as described in Table 9.

Table 9

National Out-Patient Survey

Indicator	2009 Result	Progress
No copies of GP letters provided to patients	21% National Average 27%	The Divisions ensured that a typist was available in the clinic to type the letter as it was dictated by the doctor. This meant that the patient could collect the letter at the time of leaving the outpatient department.
Poor information provided to patients in relation to their clinical condition	38% National Average 45%	Over 300 information leaflets for diagnosed conditions and operations , including the relevant risks and benefits, have been created. A Nurse Practitioner triage service is in place in the outpatients department to offer specialist advice, information and care to all surgical patients. Supernumerary team leaders are in post to ensure that patients who require further advice are seen before leaving the clinic The following actions are ongoing: Introduction of patients' diaries to log events when visiting the outpatient department. This will help to identify trends in specific clinics and with different consultants / teams. A "discharge from clinic" booklet is being written to provide patients with appropriate information and points of contact for the future if required. A pre-written consent form is being developed for all surgical specialties, providing details of risks and benefits of surgery. There are plans to ensure that the outpatient 'check out desk' ensures that all patients leaving the department are happy with their consultation. This is planned to be reviewed in April 2011.
Poor communication – staff not introducing themselves / Lack of information regarding waiting times and delays in clinic	66% National Average 71%	Employment of a dedicated Professional Development Nurse to enhance training, including customer care training. Team leaders to announce and display waiting times in the outpatient department on a 30 minute basis – this project also included several sub-actions to ensure that clinics ran to time (reducing follow ups, reducing interruptions, monitoring start times etc). All staff will be expected to introduce themselves. This is being audited on a daily basis by the team leaders. A Nurse Practitioner service is now in place to offer advice and care to all surgical patients. A dedicated treatment room with dedicated nurses to explain treatments in more detail was implemented and has been extremely successful within Orthopaedics; other specialties have not been as successful due to the geographical spread of the clinics.
Lack of time to discuss health issues	71% National Average 76%	It is felt that all of the actions highlighted above will assist in addressing the issues raised in the survey, and in ensuring that clinic staff have time to discuss issues relating to the patients' experience and any health concerns that they may have.

Liverpool End of Life Care

Seeking Patients and Carers Views to Improve End of Life Care

The Trust continues to recognise the importance of providing high quality care to all patients at the end of their lives. We have been working hard to improve the care we provide during this often very difficult period for patients and their carers, families and friends. Key to improving quality in end of life care is our strong working relationship with our local Primary Care Trusts and Trinity Palliative Care Services to ensure continuity and co-ordination of care for patients and their families.

The Bereavement and Carer Group within the Trust has designed a questionnaire to be distributed to all bereaved families after death to allow us to obtain feedback about the quality of our services and areas for further improvement. Although this is in an early stage, feedback on the care provided to patients and their families has been generally positive. Where this is not the case, the Bereavement Coordinator has contacted the family (where identified) to discuss their comments so that we can make improvements in our care.

Further quality improvements include:

- Development of a Rapid Discharge Pathway at end of life. Many patients spend the last days of their life in hospital even when hospital based care is no longer appropriate nor wished for by the patient and their family. Over the past year 23 patients who were felt to be within their last few days of life were safely discharged home at their request within 4 hours of their admission, with their care taken over by community teams. A further 68 patients were discharged either home or to a nursing home, depending on their preference, within 24 hours.

- The Liverpool Care Pathway for the Dying Patient continues to be used across our hospitals. It is nationally recognised as the most appropriate pathway available to support clinical staff when caring for patients who have reached the final stage of their lives, to follow evidence based good practice in the care of patients and to ensure the same high quality care is provided to all. With ongoing training and support provided by our Trust End of Life Care Facilitator and Trinity Palliative Care Specialist Nurses, we have seen the proportion of pathways used increase from 12% to 30% over the last 18 months.

- Training is crucial to ensure ongoing improvement and increase staff confidence and competence in End of Life Care. In September 2010, a 6 month training pilot started on 2 medical wards within the Trust and includes the following 4 key areas to support End of Life Care: symptom control, communication skills, advanced care planning and holistic assessment. Although the pilot is still in progress, feedback from ward staff is extremely positive and it is hoped that this model will be extended to other areas within the Trust. In partnership with Trinity Palliative Care Services, 48 undergraduates from the University Of Liverpool Medical School underwent a 4 week training module in palliative care. Other groups trained include pharmacists, occupational therapists, junior doctors, nurses and general practice trainees.

- The Trust's Bereavement and Carers Group continues to monitor and develop bereavement care. As part of this group the Bereavement Care Development Officer has been working on four main work-streams:

  1. The development of a 'care after death pathway' to document all care of the deceased person.

  2. The dignified introduction of body bags with training for staff in their use.

  3. The introduction of the new bereavement care questionnaire given to the bereaved via the General Office. This questionnaire is starting to give valuable and up to date information on the experiences of the bereaved.

  4. The development of bereavement standards for wards to commit to, ensuring effective and dignified care for the deceased, their families and next of kin.

Additionally the Trust continues to provide memorial services for the bereaved and has also built modern viewing facilities in the new mortuary.

- The Trust End of Life Care Board continues to monitor the progress of End of Life Care within the Trust and across our healthcare economy. End of Life Care has been identified as one of the high priorities for the Fylde Coast and it has been agreed that there is a need to merge all the various End of Life groups that exist within our partner organisations into one End of Life Board.

We see improvements in End of Life Care as an essential and ongoing programme of work. Over the next year we plan to focus on Advance Care planning, continuing to work closely with our colleagues in primary care, Trinity Palliative Care Services and with patients and carers to develop care pathways that ensure seamless patient centred care at end of life.

Patient Environment Action Team (PEAT) Survey

To Improve PEAT Survey Results/Standards

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

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

- Cleanliness
- Specific bathrooms/toilet cleanliness
- Catering Services
- Environment
- Infection Prevention
- Privacy & 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 2011, PEAT audits were extremely encouraging across all hospital sites resulting in Good or Excellent standards achieved. The results in Table 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.

Table 10

Site	Overall Rating 2009/2010	Overall Rating 2010/2011
Victoria Hospital	Good	Good
Clifton Hospital	Excellent	Excellent
Bispham Nurse Led Unit	Excellent	Excellent
Wesham Rehabilitation Unit	Excellent	N/A
Rossall Rehabilitation Unit	Excellent	Excellent

Ensure Single Sex Accommodation To Provide Privacy And Dignity For Patients

Blackpool Teaching Hospitals NHS Foundation Trust is pleased to confirm that it is compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will not share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in emergency or critical care areas), or when patients actively choose to share.

If our care should fall short of the required standards, we will report it. We will also establish an audit mechanism to make sure that we do not misclassify any of our reports. We will publish the results of these audits on our website www.bfwhospitals.nhs.uk.

2.1.5 Priorities for Improvement in 2011/12

The Trust has identified 3 key elements in the quality of care it delivers to its patients. These are:

- Clinical effectiveness
- Patient experience
- Patient safety

After consultation at Board level the Trust confirmed the top quality improvement priorities for 2011/12, which it believes will have maximum benefits for our patients. These are reflected in the Trust's Corporate Objectives and reinforced by the standards outlined in the NHS Outcomes Framework 2011/12 five domains of quality as identified in Table 11.

Table 11

Domains of Quality	Priorities for Improvement 2011/12			Indicators for Quality Improvement 2011/12
	National Level	Trust Level		
Domain 1	Preventing people from dying prematurely DH 2011)	To Provide Best In NHS Care For Our Patients	Clinical Effectiveness	North West Advancing Quality initiative that seeks compliance with best practice in six clinical areas: – Acute Myocardial Infarction – Hip and Knee Surgery – Cardio by-pass Surgery – Heart Failure – Pneumonia – Stroke **Improve referral to treatment times for patients who suffer a Trans Ischemic Attack (TIA)** Implementing 100,000 lives and Saving Lives Programme: – Reducing Cardiac Arrest calls – Reducing the incidence of Surgical Site Infections – Further embed and improve the implementation of Venous Thrombo Embolism (VTE) guideline within the Trust Nursing Care Indicators used to assess and measure standards of clinical care and patient experience. **Implement Nursing and Midwifery high impact actions to improve the quality and cost effectiveness of care.**
Domain 2	Enhancing quality of life for people with long-term conditions (DH 2011			
Domain 3	Helping people to recover from episodes of ill health or following injury (DH 2011			

Table 11				
Domains of Quality	**Priorities for Improvement 2011/12**			**Indicators for Quality Improvement 2011/12**
	National Level	**Trust Level**		
Domain 4	Ensuring that people have a positive experience of care (DH 2011)	To Provide Best In NHS Care For Our Patients To Deliver Best Environment For Patients, Staff And The Wider Community	Patient Experience	Improve National Inpatient Survey results in the following six areas; – In your opinion, how clean was the hospital room or ward that you were in? – Were you given enough privacy when being examined or treated? – Overall, did you feel you were treated with respect and dignity while you were in the hospital? – **Were you bothered by noise at night from other patients** – **Were you bothered by noise at night from hospital staff** – **How would you rate the hospital food** Improve National Outpatient Survey results in the following four key areas: – No copies of GP letters to patients – Poor information – Poor communication – Staff not introducing themselves / Lack of information regarding waiting times and delays in clinic – Lack of time to discuss health issues Patient Environment Action Team (PEAT) Survey – To improve PEAT survey results/standards Liverpool End of Life Care Pathway – 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 and so reduce in-hospital deaths** Ensure single sex accommodation is available for patients to ensure privacy and dignity whilst in hospital
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm (DH 2011)	To reduce Avoidable Harms To Our Patients	Patient Safety	Reduce the Trust's hospital mortality rate Reduce MRSA and Clostridium Difficile infection rates as reflected by national targets Reduce patient harms through the following strands of work: – Global Trigger Tool to be used to measure adverse events – Reduction of Falls by 30% – Reducing Medication errors by 50% by 2011/12

NHS North Lancashire Teaching Hospitals: Community Healthcare Quality Improvement Priorities 2011/12		
Quality Improvement Area	**Quality Improvement Target Set by Provider**	**Quality Improvement Measure and Reporting Arrangements**
Patient Safety	Reduction in grade 3 & 4* pressure ulcers **MRSA and Clostridium Difficile (all services)	Patient incident reports submitted by staff will be analysed and reported quarterly to the Provider Services Risk Committee. A reduction trend over the year is anticipated, based on increased staff awareness and training All confirmed cases of MRSA and Clostridium Difficile are reported and investigated. A very low number of cases each year is identified as having been acquired through contact with the Provider Services. This position must be monitored and maintained and will be reported to the Hygiene Code Implementation and Decontamination Group.
Clinical Effectiveness	Meet the national target - Access to genito-urinary medicine (GUM) clinics within 48 hours (sexual health service)	• Percentage: first attendances at a GUM service who were offered an appointment to be seen within 48 hours of contacting a service • Percentage: first attendances who were seen within 48 hours of contacting a GUM service Monitoring of data at Contract Performance and Review meeting.
Patient Experience	Choice of where to die (palliative care service)	The service will record numbers of patients on their caseload who die and the proportion of these whose treatment has been managed appropriately to allow them to die in their preferred place of care. Establish the baseline in 2011/12, with monthly reporting. Monitoring of data at the Contract Performance and Review meeting

NHS Blackpool: Community Healthcare Quality Improvement Priorities 2011/12		
Quality Improvement Area	**Quality Improvement Target Set by Provider**	**Quality Improvement Measure and Reporting Arrangements**
Patient Safety	Reduction in grade 3 & 4 pressure ulcers	Increase in the number of patients with a Waterlow score of 15 or with a Malnutrition Universal Screening Tool (MUST Tool) completed. Increase in the number of patients with a grade 2 pressure ulcer with a Malnutrition Universal Screening Tool (MUST Tool) completed 80% of community nursing staff to complete pressure ulcer training. Training to incorporate preventing, avoiding and treating pressure ulcers and include National Institute for Health and Clinical Excellence (NICE) guidance. Reduction in the number of hospital admissions and hospital attendances for patients requiring tissue viability care
	Methicillin-resistant Staphylococcus aureus (MRSA) & Clostridium Difficile	All confirmed cases Methicillin-Resistant Staphylococcus Aureus (MRSA) & Clostridium Difficile are reported and investigated. A very low number of cases each year is identified as having been acquired through contact with the Blackpool Community Health Services. This position must be monitored and maintained and will be reported to the Infection Prevention Committee. Trajectory for 2011 / 2012 is less than 5 MRSA reported incidents.
Clinical Effectiveness	48 hour target to access sexual health	All first attendances at the Genito-urinary medicine service to be seen within 48 hours of contacting the service
	Productive Community Services Implementation	Services to complete at least 1 Productive Community Services module and evidence that they are working towards another during 2011/12
Patient Experience	Choice of where to die Preferred place of death	The service will record numbers of patients on their caseload who die and the proportion of these who have been facilitated to die in their preferred place of care.
Patient Safety, Clinical Effectiveness and Patient Experience	Reducing Urinary Tract Infections	Increasing the number of staff trained to carry out male and female catheterisation Develop a catheter leaflet in line with National Institute for Health and Clinical Excellence (NICE) guidance (2006) for patients and carers

Additional indicators for quality improvement in 2010/11 have been identified as detailed above in Table 11 in bold italics and added for the following reasons:

Additional indicators have been identified to meet national healthcare directives and current local quality improvement priorities for 2011/12, with the expectation of reporting on these in the next annual Quality Report. The additional quality improvement priorities for 2011/12 have been identified as detailed below:

- To implement an additional Advancing Quality Target related to the provision of stroke care, and aim to perform in the top 25% of participating Trusts
- Improve the time from referral to treatment for patients suffering from a Trans Ischemic Attack (TIA)
- Further embed the implementation of the Venous Thrombo Embolism (VTE) guideline and improve compliance with the associated standards
- To improve the Trust's results in the National Inpatient Survey in three further areas:
  - Were you bothered by noise at night from other patients?
  - Were you bothered by noise at night from hospital staff?
  - How would you rate the hospital food?
- To improve the Liverpool End of Life Care Pathway by ensuring that patients who are known to be at the end of their lives are able to spend their last days in their preferred place and so reduce hospital deaths
- To implement the Nursing and Midwifery High Impact Actions to improve the quality and cost effectiveness of patient care.

It is anticipated that the Trust will provide community health services after 1 August 2011. Therefore, the community health service priorities for improvement for 2011/12 have also been included in the Quality Report. These priorities for improvement for 2011/12 will be reported on in the 2011/12 Quality Report.

Monitoring, Measuring And Reporting Progress To Achieve The Priorities for Improvement

The indicators for quality improvement for 2011/12 will continue to be monitored and measured and progress reported to the Board of Directors as part of the monthly Board Performance Business Monitoring Report. For indicators that are calculated less frequently, these will be monitored by the Board 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 quality boards and the integrated quality monitoring reports. The quality improvement priorities will also be monitored through the high level Risk Register and Divisional Risk Register process and by the Sub-Committees of the Board.

Reporting Progress

The Trust will report ongoing progress regarding implementation of the quality improvements for 2011/12 to our staff, patients and the public via our new performance section of our website. You can visit our new website and find up-to-date information about how your local hospital is performing in key areas:

- Safety
- Quality
- Delivery
- Environment
- Cost
- People

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 such as infections, death rates, patient falls and medication errors, the website also includes data on our waiting times, length of stay, complaints, cleanliness, hospital food, and the opinions of our patients, carers and staff about our hospitals.

We are keen to build on the amount of data we publish but we need to ensure 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 the feedback form which is available on the website: http://www.bfwh.nhs.uk/about/performance/

Explanation For The Priority Selection Of Priorities

It has been agreed not to remove any indicators for quality improvement identified in 2010/11 because these continue to be considered as priorities by the Board of Directors.

Additional Indicators

Additional indicators for quality improvement in 2011/12 have been identified as detailed in Table 16 in bold italics and added for the following reasons:

a) Stroke

Improved quality of care for the treatment of those patients who have suffered a stroke was identified as a key objective by the Trust during 2010/11. In particular, we were keen to ensure that patients who had suffered a stroke spent as much of their stay in hospital as possible on a dedicated stroke unit. Our target for this is 90% of the patient's total length of stay which was not achieved in 2010/11.

b) Trans Ischaemic Attack (TIA)

Improved quality of care for the treatment of those patients who have suffered a trans-ischaemic attack, or mini-stroke was identified as a key objective by the Trust during 2010/11. In particular, we were keen to ensure that GPs could refer patients to a dedicated TIA service within 24-hours of assessing the patient, and that patients with a suspected TIA received a brain scan within 24-hours of the onset of symptoms.

An internal review of the provision of TIA services was undertaken, which identified that the referral process and criteria for referral required further review to ensure that GP referrals were timely and that only those patients who were truly high risk were referred.

c) Nursing Midwifery High Impact Actions

Further stretched nursing care targets will be achieved for the coming year through the implementation of the Nursing and Midwifery High Impact Actions. This initiative aims to involve and encourage all nurses and midwives in England to work together to implement the high impact actions across the country to improve quality of patient care and reduce costs.

d) Improve National In-Patient Survey Results In Three Further Areas

The three additional questions relating to noise at night and hospital food were chosen following consultation with the public. The Trust wishes to ensure that these areas improve year on year.

e) Reduce Hospital Deaths Of People Known To Be At The End Of Life

This priority has been chosen following consultation with patients and carers. The Trust aims to develop a Rapid Discharge Pathway for patients at the end of their life who do not wish to die in hospital. The reason behind this is because many patients spend the last days of their life in hospital unnecessarily even when hospital based care is no longer appropriate nor wished for by the patient and their family.

Engagement With Patients, Public and Staff

The Trust has taken the views of patients, public and staff into account through feedback from the Trust's website, local and national patient surveys, information gathered from formal complaints, and comments received through the Patient Advice and Liaison Service (PALS).

Listening to what our staff, 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, patients, their families and carers have the best possible experience when using our services.

2.2 Statements Of Assurance From The Board

2.2.1 Information On The Review of Services

During 2010/11 the Blackpool Teaching Hospitals NHS Foundation Trust provided and/or subcontracted 49 (Service Lines) NHS Services. The Blackpool Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 49 of these NHS services

The income generated by the NHS services reviewed in 2010/11 represents 91% per cent of the total income generated from the provision of NHS services by the Blackpool Teaching Hospitals NHS Foundation Trust for 2010/11.

The quality aspirations and objectives outlined for 2010/11 reached into all care services provided by the Trust and therefore will have had impact on the quality of all services. Various activities enable assurance that quality improvement is being achieved including:

- Divisional monthly performance reports
- Quality Boards based in our wards and departments
- Clinical audit activities and reports
- External independent audits, such as the Pathology Accreditation and the NHS Litigation Authority Risk Management Standards Assessment

The patient safety walkabout visits undertaken by the Executive Directors on a weekly 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.

2.2.2 Information On Participation in Clinical Audits And National Confidential Enquiries

During 2010/11, 35 national clinical audits and 5 national confidential enquiries covered NHS services that Blackpool Teaching Hospitals NHS Foundation Trust provides.

During 2010/11 Blackpool, Teaching Hospitals NHS Foundation Trust participated in 94% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2010/11 are detailed in Column A of Tables 12 and 13.

The national clinical audit and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participated in during 2010/11 are detailed in Column B of tables 12 and 13.

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2010/11 are listed 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 12 and 13.

Table 12

List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2010/11

Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
1	NNAP: neonatal care	Yes	Yes	214	93%
2	ICNARC CMPD: adult critical care units	Yes	Yes	935	100%
3	Centre for Maternal and Child Enquiries (CMACE): Perinatal mortality	Yes	Yes	25	100%
4	NJR: hip and knee replacements	Yes	Yes	534	100%
5	DAHNO: head and neck cancer	Yes	Yes	25	100%
6	MINAP (inc ambulance care): AMI & other ACS	Yes	Yes	911	100%
7	Heart Failure Audit	Yes	Yes	321	100%
8	NHFD: hip fracture	Yes	Yes	427	100%
9	TARN: severe trauma	Yes	Yes	268	100%
10	National Sentinel Stroke Audit (n=40-60)	Yes	Yes	318	100%
11	National Audit of Dementia: dementia care (n=40)	Yes	Yes	40	100%
12	National Falls and Bone Health Audit (n=60)	Yes	Yes	60	100%
13	BTS: National Bronchectasis Audit	Yes	Yes	6	100%
14	National Audit of Familial Hypercholesterolaemia	Yes	Yes	No cases	No cases
15	RCP: National Care of the Dying Audit	Yes	Yes	Audit commenced January 2011 and not due for completion until July 2012, therefore data not available at present	
16	BAEM: National Renal Colic Audit	Yes	Yes	50	100%
17	Urinary Incontinence	Yes	Yes	78	98%
18	NBS: National Comparative re-audit of Platelet Transfusion	Yes	Yes	40	100%
19	NBS: National Comparative Audit of Bedside Transfusion Practice	Yes	Yes	70	100%
20	BTS: National Asthma Audit	Yes	Yes	18	100%
21	CCAD: Adult cardiac interventions	Yes	Yes	Contacted Division unable to provide details	

22	CCAD :Heart rhythm management (pacing and implantable cardiac defibrillators (ICDS)	Yes	Yes	Contacted Division unable to provide details	
23	CCAD: Congenital Heart Disease	Yes	Yes	Data collection In progress	
24	Adult cardiac surgery: CABG and valvular surgery	Yes	Yes	11,299	100%
25	NDA: National Diabetes Audit	Yes	Yes	89	100%
26	NBOCAP: bowel cancer	Yes	Yes	247	100%
27	NLCA: lung cancer	Yes	Yes	150	100%
28	RCP: Audit to assess and improve service for people with inflammatory bowel disease	Yes	Yes	18	45%
29	Paediatric intensive care network (PICANET)	Yes	Yes	Contacted Division unable to provide details	
30	National audit of patients undergoing emergency laparotomy	Yes	Yes	Awaiting National Report	
31	Where do Platelets go in the North West of England?	Yes	Yes	129	100%
32	Pharmaceutical Procurement Services	Yes	Yes	Process based audit not case submitted based	
33	Pulmonary Hypertension Audit	Yes	No	Not included in audit calendar as not identified as Trust priority	
34	National Insulin Pump Audit	Yes	No	Not participated in as data not collected in time by Division	
35	National Elective Surgery PROMs: four operations*	Yes	Yes	Contacted Division unable to provide details	

Table 13

List of National Confidential Enquires that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2010/11.

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	Parental Nutrition: A Mixed Bag (NCEPOD)	Yes	Yes	39	92%
2	Elective and Emergency Surgery in the Elderly – An Age Old Problem (NCEPOD)	Yes	Yes	10	33%
3	Resuscitation (NCEPOD)	Yes	Yes	2	100%
4	Peri-operative Care (NCEPOD)	Yes	Yes	6	100%
5	National Enquiry into Maternal and Child Health (CMACH);	Yes	Yes	25	100%

The reports of 3 national confidential enquiries were reviewed by the Provider in 2010/11 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of health care provided as shown in Table 14.

Table 14

National 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.
Parental Nutrition: A Mixed Bag (NCEPOD)	• Development of a Total Parental Nutrition Rapid Improvement Group
	• Review of guideline Administration of Parental Nutrition in Adult Patients CORP/GUID/029
	• Development of a referral proforma for patients requiring Total Parental Nutrition
	• Development of a clinical pathway for patients requiring Total Parental Nutrition
	• Development of multi-disciplinary ward rounds to review the care of patients receiving Total Parental Nutrition
	• Review of the procedure CORP/PROC/103 Identification and Treatment of Patients at Risk of Re-feeding Syndrome
	• Out of hours Total Parental Nutrition administration audit to be undertaken
	• Improved nursing care indicator assessment with regards completion of the Malnutrition Universal Screening Tool
Elective and Emergency Surgery in the Elderly – An Age Old Problem (NCEPOD)	• Presentation of report findings made to the following : • Grand Round • Clinical Policy Forum • Clinical Improvement Committee • Anaesthetic Meeting • Leads from each Division are currently carrying out a baseline assessment and formulating an action plan to improve healthcare provision.
Adding Insult to Injury – A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure) Audit completed in a previous year but reported in 2010/11	• A review of all fluid balance charts used throughout the Trust
	• Introduction of a new fluid balance chart throughout the Trust
	• Review of intravenous fluid administration equipment available throughout the Trust to ensure accurate timing and administration of fluid infusions
	• Education programme to recognise the acutely ill patient and recognising renal impairment
	• Development of a fluid balance monitoring procedure

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.

The reports of 81 Local and National Clinical Audits were reviewed by the provider in 2010/11 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as detailed in Table 15.

During 2010/11, 43% of clinical audits approved and registered with the Clinical Audit Department were fully completed, with action plans to address areas for improvements developed and fully implemented or currently being monitored by the relevant division and reporting committee. Of these, 19% are still in the data collection phase, 4% are awaiting the publication of a national report and 19% have completed the data collection and are currently undergoing review within the relevant division. The audits in the latter 3 categories will roll over to 2011/12 to ensure continuous monitoring and completion.

The reports of local clinical audits were reviewed by the provider in 2010/11 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as detailed in Table 15 below:

Table 15

Local Clinical Audits presented for assurance to the Board of Directors	Details of actions taken to improve the quality of local services and the outcomes of care.
Audit of record keeping of controlled drug administration in theatres	• Introduction of index type-system of signatures to meet controlled drug administration standards
Compliance with Trust Policy in written consent (Form 4) for Unconscious patients in critical care.	• Education programme for staff regarding the completion of the consent form 4
Hand Hygiene Compliance Audit	• Introduction of Hand Hygiene Champions • Collaborative working with the University of Central Lancashire to improve student nurse compliance with hand hygiene standards • Introduction of ward feedback sheets
Clinical Environment Audit	• Increased frequency of clinical environment audits • Improved cleaning schedules of equipment in clinical environments • Weekly checks and cleaning of microwaves
Trust Wide Wristband Audit	• Education programme regarding the following standards – Patients who have an allergy should wear a red wristband with a white insert and black writing; patients with no allergies should wear a white wristband with black writing; all writing should be legible; data to be included is first name, surname, date of birth, hospital number and NHS number. • The NHS number is now mandatory and should be included on all wristbands.
Trust Wide Record keeping audit	• Clinical Record Standards handout has been updated in line with version 4 of the health records.
Management of procedural documents	• Trust procedure amended and ratified. • New procedure cascaded and communicated throughout the Trust via e-mail.
Commode Audit	• Education programme for staff regarding Infection Prevention measures and standards • Revised process for use of Vernacare tape
Discharge of adult patients	• The Medicine, Surgical and Consultant Led Community Hospital patient transfer form has been amended to reflect required changes identified in the recommendations. • The Cardiac, A&E and Nurse Led Therapy patient transfer forms have been amended to reflect amendments identified in the recommendations. • Amendment and updating of the procedure "Safe Transfer of Patients" (ref: CORP/PROC/044)
Undertaking Clinical Audit	• Revised and improved procedure "Undertaking a Clinical Audit" (ref: CORP/PROC/561) • Clinical audit proposal form checklist has been devised for audit staff to use when checking accuracy of completion of proposal forms. • Divisional reports at the Clinical Improvement Committee meeting must now include an update on progress against action plans arising from the findings of clinical audits. • Monthly status reports provided to Executive Directors with regard to divisional performance in clinical audit
Management of ACS in elderly patients on Ward 25 and 26	• Syndrome in the elderly to aid timely diagnosis and initiation of treatment. • Collaborative working between Care of the Elderly and Cardiology clinicians to effectively manage patient care • Development of clear guidelines of management of patients on Warfarin presenting with Acute Coronary Syndrome • Guidance on secondary prevention medication for patients with Acute Coronary Syndrome • Education programme for junior doctors about atypical presentation of Acute Coronary Syndrome to aid timely diagnosis and initiation of treatment.

Table 15 cont.	
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.**
Surgical High Care Sepsis Audit	• Education programme for all clinical staff in the recognition of deteriorating patient/ Early Warning Score/Severe Sepsis Pathway.
Neonatal Transfer/Discharge Audit	• Neonatal Transfer/Discharge Policy amended to include transfers from the postnatal ward to the Neo Natal Unit of babies that have no respiratory distress symptoms
An audit to assess the outcomes of lesions treated with photodynamic therapy (PDT).	• Review of treating patients with morphoeic subtype of Basal Cell Carcinoma and recurrent Basal Cell Carcinoma
Audit of all Obstetric Admissions to Critical Care Services July 2009-July 2010	• Review of Consultant job plans to allow availability of access to Senior Medical Staff 24 hours a day. • Development of a guideline for transfer of obstetric patients to Intensive Therapy Unit/High Dependency Unit (ref: OBS/GYNAE/GUID/002) • Education programme for all clinical staff in the recognition of deteriorating obstetric patient/ Early Warning Score Pathway.
Management of Women with Medical Disorders in Pregnancy	• Communication with all community midwives and lead midwives to remind them of the referral process. • New staff to receive education via mandatory training days and at induction sessions with specialist midwife. • Referral criteria and pathway to be displayed in clinical areas.
Cardiac arrest record audit	• Education programme regarding the requirements of completion of the cardiac arrest record (ref: VS933)
Resuscitation- Monitoring and Compliance of Do Not Attempt Resuscitation	• Trust Red alert sent to all members of staff responsible for completing the "Do Not Attempt Resuscitation" documentation (ref: VS932) • Education programme for staff to raise awareness of importance of communication and documentation with nursing staff. • Do Not Attempt Resuscitation procedure updated.
Repair and maintenance of medical devices and equipment	• Quality control check system implemented • Education programme regarding process and quality control requirements
Post aseptic non touch technique project audit	• Education programme for junior/middle grade induction days • Staff witnessing poor practice should challenge the staff member and encourage best practice. • Ward/department managers to manage the performance of anyone who is continually displaying poor practice.
Reporting of thyroid FNA's over a one year period	• Surgical Division to explore the possibility of a pilot study into using Giemsa stain.
Post pain relief following total knee replacement	• Further education programmes for staff in the prescribing of analgesia post knee surgery undertaken. • Revision of the "Life Cycle Management" Policy (ref: CORP/POL//199)
Induction of labour with PGE2 gel following previous caesarean section	• Clinical advice regarding selection and counselling • Consultant involvement in decision making for Induction of Labour in a previous caesarean section. • Development of a guideline for Induction Of Labour in women who have had a previous Caesarean Section
Re-audit of Management of TVT/TOT	• Education of staff regarding documentation of demonstrable stress leakage or urine in the clinic. • Urodynamics is not recommended for women with pure stress incontinence. • Trial of physiotherapy should be offered as the first treatment to all women with stress/mixed incontinence. • Education of staff in provision and documentation of leaflet provided, prior to consenting for the operative procedure.

Table 15 cont.	
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.**
Documentation of controlled drugs administration in theatres	• Introduction of index type-system of signatures to cross check and ensure standards achieved
Diagnosis and management of early inflammatory arthritis	• Consideration by Division to develop a business case for an early arthritis clinic as part of service re-design.
Local Audit of incontinence in the Elderly	• Development of new documentation • Pilot of new documentation • Staff Education Programme
Management of women with substance abuse in pregnancy	• Review and improvement to ante-natal care provision • Specialist midwife clinic at BVH • Multidisciplinary working
Audit on Benign Hysterectomy Post Op Recovery	• Communication to all operators and anaesthetists to remind them of "fast track system" to pre-assessment, pre-operative/intra-operative management of post-op analgesia.
Usage of Total Parental Nutrition	• Link to Total Parental Nutrition Rapid Development Group regarding National Confidential Enquiries of Peri-Operative Deaths • Development of a Total Parental Nutrition proforma • Establishment of a multi disciplinary Nutrition Support Team • Review of guideline "Administration of Parental Nutrition in Adult Patients" (ref: CORP/GUID/029)
Post operative oxygen prescriptions administration	• Revised oxygen prescription chart
Health Promotion in Blackpool Victoria Hospital	• Added as an agenda item at Public Health Strategy Implementation Steering Group • Continue to deliver stop smoking in Secondary Care Programme • Develop proposal for care pathway and present to the Public Health Service Improvement Group. • Ensure resource tools are accessible for staff to use with patients • Develop obesity poster campaign to roll out 6 months following alcohol campaign
Arrangements for the control and supply of controlled drugs	• Improved control of refrigerator drug storage in pharmacy • Controlled storage of stationery • Review of Pharmacy staff training • Authorised signature lists to be regularly maintained.
To assess iron deficiency anaemia compliance against BSG Guidelines	• Development of an Iron deficiency investigation algorithm
Reducing harm from omitted and delayed medicines in hospital	• Policies and Procedures for the prescribing of medicines within the Trust to be revisited.
Fluid balance chart	• Development of a new fluid balance chart in Haematology.
Accuracy of renal tumour staging	• Discuss at Urology Multi-disciplinary team in order to identify any issues to address • Re-audit 2014
Management of National Confidential Enquiries of Peri-Operative Deaths Compliance with CORP/PROC/065	• Education of staff re undertaking a GAP analysis • Clinical Improvement Committee (CIC) Divisional representatives to include action plan progress updates in their CIC reports. • Lead Clinicians to be invited annually to the CIC to provide update presentation on progress • Evidence of progress on action plans to be forwarded to the Clinical Improvement Co-ordinator.

Table 15 cont.	
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.**
Management of NICE- Compliance with CORP/PROC/023	• Education of staff regarding undertaking a gap analysis • Clinical Improvement Committee (CIC) Divisional representatives to include action plan progress updates in their CIC reports. • Bi-Monthly framework reports to be tabled at the CIC identifying NICE progress and gaps. • Quarterly summaries to be presented to CIC • Meet with Divisional reps to ascertain compliance position for backlog guidance
Neonatal transfer/discharge audit	• Education of staff regarding standards and policy requirements. • Policy amended to include transfers from the postnatal ward to the Neonatal Unit of babies that have no respiratory distress symptoms.
Maternal transfer/discharge audit	• **Transfer**-Clinical Governance Midwife/Data Manager to remind all midwives to provide a blank set of baby notes when mother is transferred and record in birth notes. • Lead Consultant for Labour Ward to communicate with registrars re completion of a referral request form. • **Discharge** – Communication and education of all midwives by way of an e-mail to ensure that all information is contained on the checklist, ensure breast self awareness is explained, that the checklist is signed and dated in order to meet documentation standards. • Education of staff regarding completion of 'Euroking' discharge and that discharge information is documented in the birth record.
Paediatric Transfer/Discharge Audit	• **Transfer** – Education of all nursing and medical staff regarding the correct procedure for completion and filing of the medical and nursing transfer letter. • Education of all nursing and medical staff regarding completion of the Transfer checklist. • **Discharge – Standards met**
Discharge of adult patients	• Communication to all Divisions regarding the importance of reminding staff to complete all sections of the e-discharge form via the e-mail system. • Amendment of the Medicine, Surgical and Consultant Led Community Hospital transfer form • Amendment of the Cardiac, Accident and Emergency (A&E) and Nurse Led Therapy transfer forms • Amendment of the procedure document (CORP/PROC/044). • Revised procedural document cascaded across the Trust via the e-mail system.
Transfer of patients	• Amendment of the Cardiac, A&E, Medicine, Surgical and Consultant Led Community Hospital Transfer form • Amendment of the procedure document (CORP/PROC/044).
Re-audit of Foetal Blood Sampling	• Cord gases to be taken while awaiting placental separation and while taking Rhesus negative bloods. • Synchronise clock on machine and delivery suite and other areas. • Education programme at doctor's induction.
Safe and secure handling of medicines	• Procedure for record keeping requirements with minimum retention periods to be developed • Policy to be put in place for medication error potential analysis to be carried out for any new product. • Labelling on shelves to be re-viewed. • To make space to ensure there is a separate secure area for the storage of recalled products. • Process in place to review storage. • Purchase contract medicines.

Table 15 cont.	
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.**
Training and Competency Assessment of Medical Devices	• Quality control check System implemented • Education programme re process and quality control requirements • Report to be developed identifying the short falls of the existing equipment inventory. • Communication circulated to clarify equipment fault reporting procedure.
NPSA Rapid Response 4 fire hazard with paraffin based skin products on dressings and clothing	• Results to be presented to Medicines Management Committee. • Results disseminated to all Divisions. • Re-audit annually Jan/Feb 2012
Reducing the risk of hyponatraemia when administering intravenous infusions to children	• Re-audit annually Feb 2012 • Disseminate through Medicines Management Committee April 2011 • Disseminate through all divisions
Obesity in Pregnancy	• Improved advice to be provided to patients. • Refer patients to dietician
Compliance with MRSA/MSSA policy	• Initiate MSSA screening for patients allowing quick identification of carriers, targeted infection control protocols and appropriate targeted treatment of infected or carrier patients.
Quality of completion of routine physiological observation with track & trigger	• Education programme to focus on Track & Trigger.
Re-audit on the management of shoulder dystocia	• All clinical staff to attend drill workshops. • Awareness raised regarding documentation requirements for patients with shoulder dystocia.
The quality of data entry on the Varian chemotherapy, electronic prescribing system	• Investigate interface with the Trust Patient Administration System • Remind all staff about basic demographic data to be entered.
Does the c-spine "self traction" radiographic position compliment or better the swimmers position for diagnosis	• Training package to be developed and presented to staff.
Audit of the accuracy of double contrast barium enemas in detecting colorectal carcinomas	• Periodic re-audit to ensure levels of accuracy and specificity are maintained.
Audit of the accuracy of double contrast barium enemas in detecting colorectal carcinomas	• Periodic re-audit to ensure levels of accuracy and specificity are maintained.
An audit of patients discharged from A&E with missed fractures	• Continuous personal development and training programmes developed to ensure improvement of staff skills and performance.
Assessment of Insulin Sliding Scale Infusions	• Evaluation and review of current IV insulin infusion guidelines. Regular training for the medical and nursing staff on the use of intravenous insulin infusion.
Sentinel audit in prescribing for the elderly	• Education of staff and target areas highlighted for improving the quality of prescribing practice. • Re-visit the age related variation in prescribing in future audits.
An Audit of paper prescribed oral chemotherapy using the NPSA alert	• Remind prescribers to use electronic prescribing system.
Pharmaceutical Procurement Services	• Standards met - Review at least four times during the year and report back to departmental meeting.
Implementation of NICE guidance in urinary tract infection in children	• Development of a care pathway for children diagnosed with a urinary tract infection • Education programme for staff

Table 15 cont.	
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.**
The documentation of the outcome of the radiological images	• Education Programme for staff in the documentation of radiological imaging.
Ensuring the accuracy of all prescription charts	• Results disseminated to Divisional Clinical Directors, Associate Directors of Operations, Head Nurses and Matrons. • Medicines Management will monitor action plans through discussion at MMC meetings. • The policy to be reviewed and re-launched to all professionals to increase awareness. • Education and training related to good prescribing principles will be delivered to all prescribers. • A good prescribing practice will be delivered to all areas and professionals.
Fire Hazard with Paraffin based skin products of dressing and clothing audit	• Audit demonstrated compliance with the alert.
Audit Checklist for the Handling of clinical trials in the Pharmacy Department	• To produce clinical trial specific procedures to back up the good practice already undertaken with clinical trial duties. • To report progression of action plans, quarterly, to the Quality and Governance pharmacy department meetings. • To implement pharmacist clinical trial training and to complete the band 6 Pharmacists training by 1st October 2010, then band 7 & 8 Pharmacists training by end of November 2010.
Theatre Controlled Drugs Record Book Audit	• Education of staff regarding policy and procedures
Medicine Management and National Patient Safety Agency Alerts Annual Audit 2009	• High rate of compliance shown in this audit. • Re-audit annually to ensure sustained compliance. • Policies revised to reflect all National Patient Safety Alert recommendations. • Education and training related to good prescribing principles will be delivered to all prescribers.
Audit of blood collection process using blood track courier	• Trust wide procedure developed to manage blood collection incidents.
Reducing the risk of hyponatraemia when administering intravenous infusion to children	• Policy updated and awaiting ratification. • Training packages being reviewed.
Good antimicrobial prescribing on the general surgical & orthopaedic wards at BVH	• Junior doctor training on induction to re-iterate the standards of the microbial formulary. • Microbial formulary requirements to be included in the implementation of the electronic patient record • Reports identifying non-compliances to be brought to the attention of the Divisional Board.
Vital Signs	• Rapid Assessment PITSTOP introduced • Development of patient alerts within the electronic patient record to prompt repeat observations in those with abnormal initial readings.
Fever in Children Under 5	• Improve Documentation – education of staff and utilisation of the electronic patient record
Renal Colic National Audit	• Development of a Renal Colic Pathway • Incorporation of pathway into the electronic patient record
Head Injury – Compliance with NICE Guidance CG56	• Design of a protocol • Incorporation of protocol into the electronic patient record
Cardiac Chest Pain in A&E	• Design of an ACS protocol • Incorporation of protocol into the electronic patient record

Table 15 cont.	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Assessment of compliance with NICE CG50 in Acutely ill patients in hospital	• New POTTS chart introduced • Improved Observational Procedure • Graded clinical response strategy revised and improved – published with flowchart • Patient follow up from Intensive Therapy Unit improved • Revised and improved Intensive Therapy Unit patient discharge document introduced
The documentation of the outcome of the radiological images	• Education programme for staff to improve processes
Audit of patient case notes who have undergone Blood Stem Cell Transplantation	• Education programme for staff re documentation requirements • CNS to review patients prior to discharge • Continue to improve presence of key workers in out- patient clinics

2.2.3 Information On Participation in Clinical Research in 2010/11

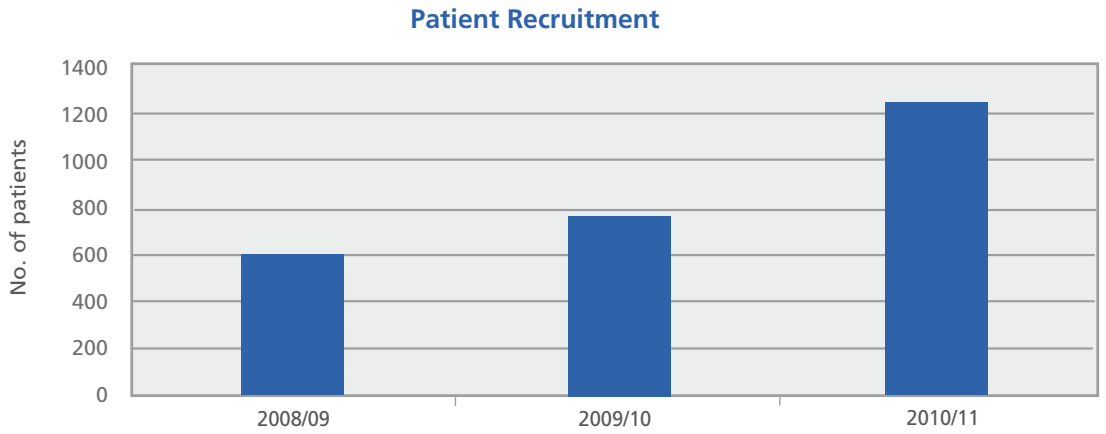
The number of patients receiving NHS services provided or sub-contracted by Blackpool Teaching Hospitals NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 1240, identified in Graph 17 below, of which the number of patients recruited to National Institute of Health Research (NIHR) Portfolio Studies is 1156*.

* It should be noted that 2010/11 NIHR Portfolio Study data is not signed off nationally until 30th June 2011. We therefore estimate the total patient recruitment total to be higher than currently reported (as at 21st January 2011).

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

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

Graph 17 - Participation in Clinical Research



Blackpool Teaching Hospitals NHS Foundation Trust was involved in conducting 151 clinical research studies during 2010/11. There were 45 clinical staff participating in research approved by a research ethics committee at Blackpool Teaching Hospitals NHS Foundation Trust during 2010/11. These staff participated in research covering 15 medical specialties as outlined in Table 16 below:

Table 16- 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
Anaesthetics & Pain	0	13
Cancer	140	85
Cardio-Vascular	192	166
Critical Care	0	586
Dermatology	0	11
Diabetes	0	2
Gastro Intestinal	47	66
Medicines For Children	30	10
Musculo-Skeletal	9	20
Paediatrics	0	10
Public Health	0	4
Renal	114	90
Reproductive Health & Childbirth	73	30
Respiratory	3	11
Stroke	84	52
Total	**736**	**1156**

In addition, over the last three years, 48 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.

Blackpool Teaching Hospitals NHS Foundation Trust has participated in the NIHR North West Exemplar Programme during 2010/11. This is an initiative which aims to demonstrate that the NHS is a viable environment for conducting commercially-sponsored clinical trials, and that England can match the best in Europe in carrying out high quality studies quickly, efficiently, and in line with patient recruitment targets.

Blackpool Teaching Hospitals NHS Foundation Trust achieved the required Exemplar standards and is now rolling out these standards to all commercial studies. The programme highlighted Blackpool's achievements in:

- Senior level and board engagement in Research and Development.
- Streamlined governance processes.
- Good demonstrable results in relation to the timescale from Research and Development Form being completed and submitted to NHS permission in 43 days.
- Good communication and teamwork.
- First global patient recruited in 2 days from NHS permission.

Our engagement with clinical research also demonstrates Blackpool Teaching Hospitals NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques.

2.2.4 Information on the Use Of The Commissioning For Quality And Innovation Payment Framework

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

A proportion of the Blackpool Teaching Hospitals NHS Foundation Trust's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Blackpool Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at:
http:// www.monitornhsft.gov.uk/sites/all/modules/fckeditorplugins/ktbrowser/_openTKFilephp?id=3275

The payment mechanism in 2010/11 was that Contracted Commissioners paid 50% of the CQUIN value through block contracts followed by the remaining 50% upon the Trust successfully achieving the agreed goals. The total planned monetary value of CQUIN in 2010/11 is £3,161,291; however, it estimated that the Trust will achieve a total monetary value and a monetary total for the associated payment in 2010/11 is £2,718,710.

2.2.5 Information relating to 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 2010/11.

Special Reviews

Blackpool Teaching Hospitals NHS Foundation Trust has participated in special reviews or investigations by CQC relating to the following areas during 2010/11:

A CQC Review of support for Families with Disabled Children for Acute Services was submitted on the 14th February 2011. The aim of the review is to promote improvement in the delivery and commissioning of specialist health support for families with disabled children by:

- Producing robust and objective local area-based. assessments of support for families with disabled children, along with benchmarking information.
- Ensuring appropriate action takes place in the areas where performance is weakest.
- Publishing a national report setting out recommendations for service providers, commissioners, other partners in local services and central Government .

The assessment was structured using a framework based on the expectations set out in "Aiming High" and in consultation with a wide range of stakeholders, including parents and carers of disabled children and young people.

The section of data collection for the Acute Trust comprised of 3 sections:

- Section 1 General (Mandatory),
- Section 2 Delayed Discharge (Not mandatory),
- Section 3 Scenarios (Mandatory) comprising of different scenarios involving 3 hypothetical disabled children.

The data has been submitted, together with a portfolio of evidence, compiled as directed for scrutiny by the Care Quality Commission if a visit to the Trust is requested.

Blackpool Teaching Hospitals NHS Foundation Trust intends to take action to address the conclusions or requirements reported by the Care Quality Commission on receipt of the report findings.

The main output from the review will be the assessment of the quality of the local health support provided to families with disabled children for each local area in England, as defined by Primary Care Trust boundaries.

The Care Quality Commission will inform all participants of the results which will be fed back to local areas in early summer 2011. An action plan will be developed to address any areas identified for improvement which will be monitored by the Clinical Governance Committee.

2.2.6 Information on the Quality of Data

Good quality information and data is essential for:

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

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.

Over the last two years the following progress to improve data quality has been made:

- Ethnicity coding quality raised from 87.66% in January 2007 to 93.54% in January 2011.
- Inpatient NHS number coverage has been raised from 96.72% in Jan 2007 to 99% in January 2011.
- GP Code coverage maintained at over 99%.
- Gender assignment maintained at over 99.9%.

NHS Number And General Medical Practice Code Validity

Blackpool, Teaching Hospitals NHS Foundation Trust submitted records during 2010/11 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:

- 99.2% for Admitted Patient Care
- 99.4% for Outpatient care; and
- 94.6% for Accident and Emergency Care.

- which included the Patients valid General Practitioners Registration Code was:

- 99.9% for Admitted Patient Care
- 100% for Outpatient Care; and
- 99.7% for Accident and Emergency Care.

Information Governance Assessment Report 2010/11

Blackpool Teaching Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2010/11 was 80% and was graded (colour green) using the Information Governance Toolkit Grading Scheme.

In previous years grading was based on a Rating Score of Red/ Amber/Green. For 2010/11 there are now just two grades:

- **Satisfactory** (coloured green): Level 2 achieved in all requirements
- **Not Satisfactory** (coloured red): Level 2 not achieved in all requirements

The Trust has achieved a Level 2 Satisfactory rating (colour green) against the new grading criteria. This change links directly to the NHS Operating Framework (Informatics Planning 2010/11) which requires all organisations to achieve Level 2 in all requirements.

Blackpool Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality. There is an overarching Information Governance workplan which has been agreed by the Trust Board. This is alongside a formulated action plan for 2011/12.

The Information Governance Toolkit is available on the Connecting for Health website (www.igt.connectingforhealth.nhs.uk).

The Information 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.

Clinical Coding Error Rate

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

Although Payment by Result (PbR) data assurance audits undertaken by the Audit Commission did not focus on quality of coding during 2010/11 there has been an extensive internal audit programme within coding that has seen marked improvements in diagnosis and procedure coding at an individual coder level.

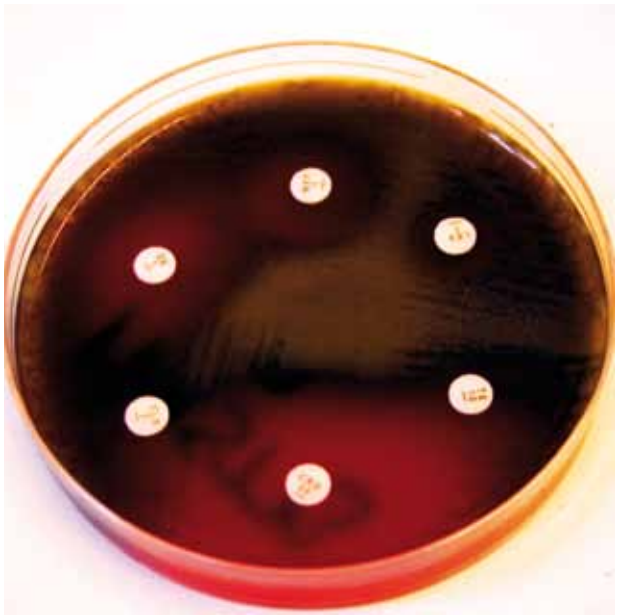
This has been essential in channelling training resource to appropriate areas to maximise the quality of coding within the Trust.

The Trust has commissioned an external company to provide a clinical coding audit for 2010/11 which was undertaken in May 2011. The results are detailed in Table 17a below:

Table 17a	
Data Published by the External Company	
Clinical Coding	**Percentages**
Primary Diagnoses Incorrect	9.0%
Secondary Diagnoses Incorrect	12.9%
Primary Procedures Incorrect	13%
Secondary Procedures Incorrect	8.3%

The results should not be extrapolated further than the actual sample audited. The following services were included in the sample as shown in Table 17b below:

Table 17b		
Data Sampled		
Area Audited	**Specialty/ Sub-chapter/ Healthcare Resource Group**	**Sample size**
Theme	General Medicine	100
Speciality	Speciality Clinical haematology	50
Sub-Chapter	Medical Oncology	50



Part 3 Other Information

3.1 Overview Of 2010/11 Performance

3.1.1 Overview Of The Quality Of Care Based On Performance In 2010/11 With An Explanation Of The Underlying Reason(s) For Selection

Table 1 in part 2 sets out the priorities for improvement which were identified in the 2009/10 report; none of these priorities have changed in 2010/11. However, we have identified two new priority indicators for monitoring in 2010/11 in relation to Stroke and Trans Ischemic Attacks.

Stroke

To improve the quality of care provided the Trust made a commitment to ensure that only stroke patients would be admitted to the stroke ward, with a bed set aside for emergency admissions or those patients requiring thrombolysis. In addition, core themes have been identified for improvement with patient pathways enhanced or redesigned.

The Trust has undertaken a 'stroke improvement project' which has demonstrated significant and marked improvements in service delivery and care of patients. The improvement project clearly identified an operating model of care for stroke services at the Trust and aligned this to the key performance indicators to evidence how well the Trust is performing. These processes range from initial recognition of a stroke to assessment, formal diagnosis leading to treatment, and rehabilitation. These actions have delivered improvements to the quality of care provided, with the percentage of patients receiving a CT scan within 24 hours of stroke onset improving from 1st June 2010 - 31st March 2011 below 70% to over 90%, and the percentage of patients being admitted directly to the stroke ward improving from 1st June 2010 - 31st March 2011 below 20% to over 90%. Further work during 2011/12 is required to ensure that improvements are embedded and the target met consistently.

Whilst we have greatly improved stroke services and continue to do so, in conjunction with the wider health and social care economy (NHS Blackpool, NHS North Lancashire, both Lancashire and Blackpool Local Authorities as well as third sector agencies) we have begun to review the entire stroke clinical pathway. This review covers the key interventions required before admission and following eventual discharge from hospital to ensure that there is a seamless delivery of services across organisational boundaries that has the best interests of patients at their heart. A series of events have commenced and will continue throughout 2011 to ensure that patients receive the best possible care on the Fylde Coast.

Trans Ischemic Attack

Pathways for the Trans Ischemic Attack (TIA) Service have been enhanced and redesigned. Local GPs are now able to contact a stroke specialist nurse via telephone to discuss and refer high risk TIA patients at anytime between the hours of 9am - 5pm, Monday to Friday, (alleviating the need for completion and faxing of a referral form), with patients being offered a same day appointment where possible. Redesign of pathways and improved communication between the TIA Service and Radiology has led to a significant improvement in the percentage of patients suffering from a TIA who receive a brain scan within 24 hours of the onset of symptoms, with performance in April 2011 being above the target for the first time.

Work will continue to ensure that changes to the pathway are embedded into practice and the improvement in performance are sustained.

3.1.2 Performance Against Key National Priorities

The Board of Directors monitors performance compliance against the relevant key national priorities and performance thresholds as set out in the Department of Health's Operating Framework 2010/11. For 2010/11 the key national priorities for the Department of Health's Operating Framework were:

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

Following discussions between the Care Quality Commission (CQC) and the Department of Health regarding the implications of the revisions to the NHS Operating Framework for 2010/11 for the 2009/10 periodic review of NHS organisations (the 'Annual Health Check'), it was agreed that the publication of 2009/10 performance against indicators that have been removed for 2010/11, was not required. The Trust however continued to monitor performance against all indicators. Table 18 shows the results from the benchmarking data published by the Care Quality Commission for the 2009/10 indicators together with the Trust's self assessment of performance in 2010/11 against the remaining indicators.

Table 18: Performance against Key National Priorities

Quality Standard	CQC Benchmarking Information 2009/10 (Z Scores*)	Trust Self Assessment 2009/10	Trust Self Assessment 2010/11
All Cancers: one month diagnosis to treatment:			
First Treatment (target >= 96%)	Much better than expected (2.26)	Achieved	Achieved Q1,100%; Q2, 100%; Q3, 99.6%; Q4; 99.8%
Subsequent treatment – Drugs (Target >=98%)	Data Failure	Achieved	Achieved 100% for all 4 quarters
Subsequent treatment – Surgery (Target >=94%)	As expected (1.49)	Achieved	Achieved 100% for all 4 quarters
All Cancers: two month GP urgent referral to treatment:			
62 day general (target >=85%)	As expected (0.73)	Achieved	Achieved Q1, 91.2%; Q2, 86%; Q3, 88.4%; Q4,89.4%
62 day screening (target >=90%)	Much worse than expected (-3.17)	Under-achieved	Achieved Q197%; Q2, 98%; Q3,90.9%; Q4, 94.6%
62 day upgrade (Target tbc)	As expected (0.43)		Achieved greater than 95% in all 4 quarters
All Cancers: two week wait	As expected (0.29)	Achieved	Achieved Q1, 95.4%; Q2, 95.1%; Q3, 95.4%; Q4, 95.8%
Breast Symptoms – 2wk wait	As expected (0.85)	Achieved	Achieved Q1, 93.7%; Q2, 95.7%; Q3, 94.9%; Q4, 96.2%

Table 18: Performance against Key National Priorities			
Quality Standard	**CQC Benchmarking Information 2009/10 (Z Scores*)**	**Trust Self Assessment 2009/10**	**Trust Self Assessment 2010/11**
Reperfusion (Thrombolysis waiting times).	N/A	N/A	Achieved
Delayed Transfers of Care (target <3.5%)	As expected (0.78)	1.42%	Achieved
Percentage of Operations Cancelled (target 0.8%)	As expected (1.42)	0.53%	Achieved 0.6%
Percentage of Operations not treated within 28 days (target 0%)	Better than expected (1.90)	0%	Achieved 0%
Patient experience	As expected (0.35)	Achieved	Achieved
Quality of Stroke Care	As expected (0.82)		Achieved
Ethnic coding data quality	As expected (1.05)	Achieved	Achieved
Maternity data quality	As expected (0.30)	Achieved	Achieved
Staff Satisfaction	Better than expected (1.97)	Achieved	Achieved
18 week Referral to Treatment (Admitted Pathway) (target >=90%)	Requirement to assess performance removed	95.48%	Achieved 94.08%
18 week Referral to Treatment (Non-Admitted Pathways [including Audiology]) (Target >=95%)		97.43%	Achieved 96.46%
Incidence of MRSA		8 (target <=12)	4 (target <=3)
Incidence of Clostridium Difficile		134 (target <=185)	101 (target <=152)
Total time in A&E (target 95% of patients to be admitted, transferred or discharged within 4hrs)		98.93%	Achieved 97.69%
Inpatients waiting longer than the 26 week standard (target 0)		0	No longer monitored
Outpatients waiting longer than the 13 week standard (target 0)		0	No longer monitored
Patient waiting longer than three months (13 weeks) for revascularisation (target 0)		0	0
Waiting times for Rapid Access Chest Pain Clinic		100%	100%
Access to healthcare for people with a learning disability		Achieved	Achieved
Participation in heart disease audits	Requirement to assess performance removed	Achieved	Achieved
Engagement in Clinical Audits		Achieved	Achieved
Smoking during pregnancy		26.05%	Under-achieved 26.99%
Breast-feeding initiation rates target		66.94%	Under-achieved 63.14%
Emergency Preparedness	Not applicable	**	**

* The closer a z score is to 0, the closer it is to the expected level of performance, or average. In this report, positive z scores represent performance that is above the expected level of performance and negative z scores represent performance that is below the expected level.

** The Pandemic Influenza Plan (Version 2) was reviewed in March 2011 and ratified by the Board. This document defines the key pandemic influenza management systems and responsibilities of staff. To strengthen the Pandemic Influenza Plan, debriefs were undertaken on the swine flu pandemic in February 2010 and the increase in H1N1 influenza patients being admitted to critical care in December 2010.

To support these arrangements the Trust has a Trust Wide Business Continuity Plan (Version 1) which was reviewed and ratified by the Board in October 2010. Beneath the Trust Business Continuity Plan are 33 Directorate Business Continuity Plans with operational information on alternative options to deliver their services. The Emergency Planning Officer has undertaken one-one training with the 77 on call or duty staff, this includes Duty Directors, Duty Managers, members of the Acute Response Team, Head Nurses, Senior Nurses covering bleep 002, On Call Consultant Haematologists and Loggists. However, this year it will be undertaken in a group format.

3.2 Additional Other Information

Improve Local Patient Experience Survey Results

Over the last few years the Trust has been committed to improving the experience of our patients. The Trust invested heavily in a "Being With Patients" programme to improve customer service to patients, with a message about caring for patients how they wish to be cared for, not how we want to provide care. This included training in effective communication methods and the physical approach to patient care. We have since incorporated these messages in other similar training. In 2010 we commissioned a company called Purple Monster to take the messages further across wider staff groups and to develop customer care champions across the organisation.

In 2011 we are continuing with further training by developing some in-house interactive sessions which combine messages from all previous programmes.

The success of these programmes is evidenced by our recent staff survey results and the retention for the second year running of Investors in People Gold status. Customer care qualities in our staff are also assessed during appraisals as part of 'Being the Blackpool Person'.

To improve National Cancer Patients' Experience Survey Programme 2010 Results

The 2010 National Cancer Patient Experience Survey was designed to provide information to drive local quality improvements in relation to cancer care. 158 acute hospital NHS Trusts participated in the survey, which included all adult patients with a primary diagnosis of cancer who had been admitted as an inpatient or as a day case between 1st January 2010 and 31st March 2010. 828 eligible patients from this Trust were sent the survey and 531 questionnaires were completed, representing a response rate of 67%, the same as the national response rate.

What patients' liked about our care (in top 20% of Trusts):

- The first appointment was within four weeks of referral
- Patients were given the name of a Cancer Clinical Nurse Specialist
- Patients felt that they were able to spend an appropriate length of time with a doctor

What they didn't like (in lowest 20% of Trusts):

The way in which they were informed they had cancer

- Staff didn't always listen effectively and were difficult to contact
- Staff didn't give a complete explanation of the purposes of test(s)
- Patients weren't always given a choice of treatment
- Lack of information regarding financial issues
- Staff talked about them as if they weren't there
- We didn't give the GP enough information
- We didn't always give the right amount of information to patients
- There were some concerns about the information and support given to patients undergoing radiotherapy and/or chemotherapy - issues regarding chemotherapy and radiotherapy are in the main, interrelated with the joint working arrangements with Lancashire Teaching Hospitals.

As the survey identified specific tumour group patients, the survey has been sent to the departments that provide specific services in each clinical area for them to develop their own action plans on issues relating to their specialty.

Customer care programme launched to improve performance and customer satisfaction

Over the last few years the Trust has continued its commitment to improving the patient experience, of our patients. We have trained staff in effective communication methods, and physical approach through a variety of programmes. We commissioned a company called Purple Monster to take the messages further between staff and to develop some customer care champions across the organisations in 2010. This training was effective and valued but at a cost. It has given us a good baseline on which to continue training in-house. We have also incorporated customer care training into the new Trust Induction programme for 2011 and beyond.

In 2011 we are developing this further with more training and action learning sets and this is driven by our recent staff survey results and the retention of Investors in People Gold status Customer care qualities in our staff are also assessed during appraisals as part of 'Being the Blackpool Person'. The Blackpool Person is in relation to our Organisational Development Programme focusing on engaging staff and harnessing their potential.

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 April 1st 2010 to March 31st 2011 we received 2,274 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 309. There were also 38 verbal complaints made. The overall numbers of formal complaints show a decrease of 78 compared to the previous year.

Date - Financial Year	Complaints
2010/2011	309
2009/2010	387
2008/2009	399

The main categories of complaints include:

- Clinical Care
- Communication
- Staff Attitude
- Waiting Times
- Essential Nursing

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 2010/11, 67 meetings were held in order to resolve a complaint in a more timely manner (14 after a final response and 53 before a final response).

Lessons learned from complaints 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.

Once local resolution has been exhausted the complainant has the right to contact the Health Service Ombudsman for a review of the complaint. During 2010/11, 21 complaints were considered by the Ombudsman. Of these, there are 14 cases where the Ombudsman has assessed the issues and decided not to investigate any further, 1 was not upheld, 2 were resolved by local resolution, and 1 has been closed pending local resolution. There are 3 cases still ongoing.

Patient Advice and Liaison Service (PALS)

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

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

Date - Financial Year	BVH Cases	BVH Issues
2010/2011	2609	2887
2009/2010	1990	2266
2008/2009	1453	1655

The number of cases handled by the PALS team this year has increased by 619 cases on the previous year. The main themes that have emerged from the cases recorded are:

- Administration (582 issues)
- Information (528 issues)
- Treatment Issues (519 issues)
- Waiting Times (506 issues)
- Communication (321 issues)

Lessons learned and service activity are reported to the Patient Experience Committee. Regular reports are produced throughout the year for the Learning from Incidents and Risks Committee (L.I.R.C), the Patient Environment Action Team (P.E.A.T), the Equality and Diversity (E&D) Committee. The Complaints, Litigation Incidents and PALS (C.L.I.P) Report contains the indicators that the service is required to achieve to meet the NHS Litigation Authority Risk Management Standards. In addition PALS activity and lessons learned also feature in the quarterly and annual Patient Experience Board reports.

Never Events

"Never Events" are defined as serious largely preventable patient safety incidents that should not occur if the prevailable preventable measures have been implemented by healthcare providers.

In 2010/11 the Trust has reported three "Never Events" relating to wrong site surgery. These incidents have been investigated by a multiagency team led by one of the Executive Directors and managed in accordance with the Trust's Serious Untoward Incident procedure.

Data Quality Reporting Information

- **Accident and Emergency**

There are a number of new Accident and Emergency indicators for 2011/12. The measurement of these indicators uses national Secondary Uses Service (SUS) information. There are known discrepancies within this data relating to the discharge time of patients and the transfer to the observation ward. An action plan is in place to ensure that discharge times are accurately recorded and forwarded to SUS to allow accurate measurement.

- **Trans Ischemic Attack Reporting**

The Trust has agreed with our host commissioner (purchaser) to provide accurate information on the referral to treatment times for patients who have had a Trans Ischemic Attack. A local database exists to capture this information and we are working with the department to ensure that this is fit for purpose and accurately reports this information.

- **18 Weeks Referral to Treatment Targets**

The Trust has delivered the 18 week referral to treatment performance target consistently since December 2007. The revision to the Operating Framework 2010/11 in June 2010, whilst removing the 18 week standard from performance monitoring, confirmed the patients' rights to treatment within 18 weeks under the NHS Constitution. The Trust therefore continued to monitor and redesign pathways to ensure the delivery of timely and efficient patient care. During 2010/11 Trust performance remained well above the standard, with 94.31% of patients for admitted care and 96.76% of patients for non admitted care being treated within 18 weeks of referral.

3.3 Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committees

The statements supplied by the above stakeholders in relation to their comments on the information contained within the Quality Report can be found on page 149. Additional stakeholder feedback from Public Governors has also been incorporated into Annex A. Following feedback, wherever possible, the Trust has attempted to address comments to improve the Quality Report whilst at the same time adhering to Monitor's annual reporting guidance for the Quality Report and additional reporting requirements set by Monitor.

3.4 Quality Report Production

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

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

3.5 How to Provide Feedback On The Quality Report

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

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

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

3.6 Quality Report Availability

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

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

Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committees

1.1 Statement from NHS Blackpool - 26/05/2011

NHS Blackpool Trust Board as lead commissioner for Blackpool Teaching Hospitals NHS Foundation Trust can confirm that a review of the Quality Report for 2010/12 has been undertaken as outlined below.

NHS Blackpool welcomes the opportunity to review the Quality Accounts for 2010-2011 from Blackpool Teaching Hospitals NHS Foundation Trust. The Quality Account reflects the complex work undertaken in running a busy hospital with the local health challenges it faces. Patients report through national Care Quality Commission (CQC) experience survey that the quality of services has improved in many areas. We are reassured that the trust is committed to building on these survey results, and is actively engaging with staff, patients and the public, in shaping services. Staff commitment to improving quality through ongoing audits and through teams such as Global Trigger Tool Team, and analysis of total harms identify lessons learned to improve safety of services.

Patient experience is also a strong indicator of service quality. The achievement of the national Commissioning for Quality and Innovation (CQUIN) goal related to the responsiveness to personal needs, showed that the patient experience was above average when compared to other hospitals in the region. The findings of a national out-patient CQC survey have enabled planning to improve several elements of out – patient care important to patients, such as GP letters to patients. Work on end of life care management undertaken by the trust in 2010- 11 has also demonstrated a commitment to promote consistent approaches to improve the experiences for patients, their families and carers.

We congratulate the Trust on the number of quality improvements in key areas, they are:

- For the third year running, Blackpool Teaching Hospitals Foundation Trust featured in the top 40 hospitals in the country, recognising their success as one of the best performing trusts, for waiting times, mortality, hospital readmissions, and reducing infection rates.

- For their recognition in commitment to patient safety. They have achieved two national awards in the Patient Safety Awards 2011 – Education and Training in Patient Safety and Patient Safety in Maternity Care categories.

- For stating compliance with eliminating mixed sex accommodation across the Trust.

- For achievement of CQUIN goals during the year that have been set within the contract by commissioners. Key achievements include; the implementation of antimicrobial guidelines, effective prescribing, the introduction of the Primary Care Formulary, implementation of Shared Care Prescribing, and Trauma And Research Network data completeness. Nursing Care Indicator monitoring has also showed widespread implementation across the Trust to promote consistent approaches to high quality nursing care.

- The Trust has also achieved a huge reduction in patient falls, medication errors, pressure ulcers and Clostridium Difficile (C.Diff) infections, which are all indicators of improving patient safety, patient experience and clinical effectiveness.

Good quality data is vital for informed commissioning decisions. Information governance standards have been satisfactorily implemented across the Trust and the quality of data is higher than expected in some areas. Data such as NHS number, GP practice code validity, and data related to Stroke, Transient Ischemic Attack (Mini Stroke), and data linkage to primary care, have been identified as priority areas for improvement in 2011-12. We look forward to seeing improvement in these data quality priority areas.

NHS Blackpool will continue to support the Trust to build on its successes to further improve its performance. Reducing MRSA infection is a challenging target for 2011-12 but the improvements in C.Diff reduction during 2010-11 demonstrates a strong commitment within the Trust to the reduction of hospital acquired infections.

We look forward to seeing improvements in 2011-12 on the implementation of the Venous Thromboembolism (VTE) national risk assessment tool for at least 90% of patients admitted to hospital. Similar improvements are also expected in programs related to Stroke and Heart Failure featured in the Advancing Quality Programme.

The regulatory body Monitor has set out the criteria for the quality report (also quality account). We are satisfied that on the whole this is a very good account of progress in a challenging year. We can confirm we have checked the accuracy of the information as far as we are able.

1.2 Statement from North Lancashire Teaching Primary Care Trust - 30/05/2011

As a significant commissioner of services from the Blackpool Teaching Hospitals Foundation Trust, NHS North Lancashire has been invited to review the Quality Account and provide a supporting statement for inclusion in the report.

NHS North Lancashire has taken reasonable steps to validate the information contained within the document. We confirm that the Blackpool Teaching Hospitals Foundation Trust's 2010/2011 Quality Report provides an accurate representation of the quality of services provided by the Trust.

This is the second year that the Quality Report has been produced and the report outlines the improvements achieved against last year's priorities. It provides a comprehensive account of improvements in quality across a broad range of clinical areas. The report highlights a number of important achievements in many areas of patient safety, patient experience and clinical effectiveness.

Our involvement in the development of the content and priorities of the report has been limited. We intend to build on this involvement to assist the Trust to include the new GP led commissioning arrangements within their 2011/2012 Quality Account.

1.3 Statement from Blackpool Local Involvement Network - 26/05/2011

Blackpool Local Involvement Network (LINk) welcomes the second publication of this report. We are pleased to read about actions put in to improve Patient Safety, Clinical Effectiveness and Patient Experience. The comprehensive information on the quality of health care provided is 'jargon-free'.

We are pleased to see a reduction in the number of Patient Slips, Trips and Falls. Whilst the number of medication errors has changed over the past 12 months, it is good to see that over the last few months, the numbers are decreasing.

Please see our comments:

- National In-Patient Experience Survey (Table 8) – although the results for 2010 are higher than the national average, no improvement has been made as the results are either less or equal in previous years.

- National Out-Patient Survey (Table 9) – It is unclear as to whether the Trust achieved or underachieved with the national average, and the progress given is not very clear on what has been achieved.

- Information On Participation In Clinical Audits And National Confidential Enquires (Table 12) – Data in Columns C & D were not included at the time we were asked to comment on the report.

- Performance against Key National Priorities (Table 18) – On the Trust Self Assessment 2010/11, it would be useful if results were known and included in the report before being sent out for comments.

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

Yours sincerely

Norma Rodgers
Chair of Blackpool LINk

1.4 Statement from Lancashire Local Involvement Network - 30/05/2011

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

1.5 Statement from Blackpool Health Overview and Scrutiny Committee - 26/05/2011

Due to the elections, the current Blackpool's Health Overview and Scrutiny Committee members has only recently been established and therefore the committee would not be providing a response in relation to the Quality Report. However, the committee will be happy to receive a copy of the Trust's published Quality Report.

1.6 Statement from Lancashire Health Overview and Scrutiny Committee - 30/05/2011

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

Table 19: Glossary of Abbreviations	
Abbreviation	**Meaning**
CHKS	Name of the Company which is used for benchmarking
RAMI	Risk Adjusted Mortality Index
HSMR	The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death for example, heart attacks, strokes or broken hips. For each group of patients we can work out how often, on average, across the whole country, patients survive their stay in hospital, and how often they die.
MRSA	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 get into the bloodstream, they can cause more serious infections, such as blood poisoning.
CDI	Clostridium Difficile Infection Clostridium Difficile (C. diff) is a bacterium that is present naturally in the gut of around two thirds of children and 3% of adults. C. diff does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. diff bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. At this point, a person is said to be 'infected' with C. diff.
CMACH	Confidential and Maternal and Child Health
NCEPOD	National Confidential Enquiries into Perinatal Outcomes of Death
NRLS	National Reporting and Learning Service
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
Medusa	Electronic version of the Injectable Medicines Guide
PCI	Primary Coronary Intervention
AMI	Acute Myocardial Infarction
VTE	Venous Thrombo Embolism
CABG	Coronary Artery Bypass Graft
CQS	Composite Quality Score
LVS	Left Ventricular Systolic Function Assessment
ACEI	Angiotension Converting Enzyme Inhibitors
ARB	Angiotension Receptor Blocker

Table 19: Glossary of Abbreviations	
Abbreviation	**Meaning**
LVSD	Left Ventricular Systolic Dysfunction
CAP	Community Acquired Pneumonia
AQ	Advancing Quality
CDU	Clinical Decisions Unit
NICE	National Institute for Health and Clinical Excellence
DNAR	Do Not Attempt Resuscitation
HCAI	Hospital Community Acquired Infection
NHSLA	NHS Litigation Authority
NIHR	National Institute for Health Research
CQUIN	Commissioning for Quality and Innovation
CQC	Care Quality Commission
LAC	Looked after Children
CNST	Clinical Negligence Scheme for Trusts
SUS	Secondary Uses System
HES	Hospital Episode Statistics
PbR	Payment by Results
HRG	Healthcare Resource Group
CC	Clinical Conditions
PCT	Primary Care Trust
SBAR	Situation Background Assessment Recommendations
IRMER	Ionising Radiation Medical Exposure Regulations 2000
GP	General Practitioners
PEAT	Patient Environment Action Team
LSCB	Local Safeguarding Children's Board
GHG	Green House Gas
ERIC	Estates Returns Information Collections
CRC	Carbon Reduction Commitment
CHP	Combined Heat and Power
DoH	Department of Health
NCI	Nursing Care Indicators

Table 19: Glossary of Abbreviations	
Abbreviation	**Meaning**
HRG	Developed by The Casemix Service, Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource. Healthcare Resource Groups offer organisations the ability to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time. Healthcare Resource Groups are currently used as a means of determining fair and equitable reimbursement for care services delivered by Health Care Providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the NHS. They improve the flow of finances within - and sometimes beyond - the NHS. HRG4 has been in use for Reference Costs since April 2007 (for financial year 2006/7 onwards) and for Payment by Results (PbR) since April 2009 (for financial year 2009 onwards). HRG4 was a major revision that introduced Healthcare Resource Groups to new clinical areas, to support the Department of Health's policy of Payment by Results. It includes a portfolio of new and updated HRG groupings that accurately record patient's treatment to reflect current practice and anticipated trends in healthcare.
CC	JD042: Minor Skin Disorders category 3 without CC "CC" means clinical conditions. Therefore in this context the patient had no other clinical conditions or co-morbidities.
TIA	Trans Ischemic Attack – A transient stroke that lasts only a few minutes. It occurs when blood to the brain is briefly interrupted

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