Together we care

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Quality Account
2014/15

People Centred | Positive | Compassion | Excellence

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

If you require any further information about the 2014/15 Quality Account please contact: The Corporate Assurance Team on **01253 655520** or email Judith Oates at judith.oates@bfwhospitals.nhs.uk

Contents

Part 1: Statement on Quality from the Chief Executive

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

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

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

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

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

The Quality Account for the 2014/15 period highlights the work we have been doing over the past 12 months to ensure our patients receive the highest quality and safest care possible. It includes a detailed overview of the improvements we have made during 2014/15 and sets out our key priorities for the next year 2015/16.

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

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

In April 2014 the Trust received the results of its inspection by the Care Quality Commission which took place in January. The overall rating for Blackpool Victoria Hospital was 'requires improvement' while the overall ratings for both Clifton Hospital and Fleetwood Hospital were both 'good'. The overall rating for the Trust was 'requires improvement'.

Across the Trust, the inspection team found areas of good practice. These included:

- Care in the Trust was recognised as good by patients and staff were praised by many who had used hospital services.
- The Trust has a highly committed workforce, with a strong team culture.
- The Trust-wide chaplaincy and End of Life Care service was recognised as highly responsive and was valued by those who had used it.
- New facilities for children and within maternity services were recognised as good developments.

There were a number of areas where the report said the Trust must improve in areas such as record keeping, incident reporting and staffing levels and an action plan to tackle these areas has been a major focus this year.

Once again we received national recognition for our work to improve patient safety and quality. The Trust named as one of the CHKS 40 Top Hospitals for 2014. The award is presented to the 40 top-performing CHKS client trusts and the rankings are based on 22 key measures of quality, including clinical effectiveness, patient experience and quality of care.

The Trust was also recognised as one of the top healthcare organisations in the country to work for after being named in the HSJ's Best Places to Work list, which is compiled in partnership with NHS Employers and features the top 100 NHS workplaces across all acute, community, mental health and primary care sectors. We want to attract the most talented workforce, so we are committed to providing an environment that is welcoming and fosters innovation and creativity and this award is testament to that and is something that all staff should celebrate.

We have continued to make progress on reducing mortality rates and this is something the Trust is totally committed to achieving. During the past 12 months our Summary Hospital – Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) have reduced (SHMI 120 -116 and HSMR from 115-113). On all mortality metrics the Trust's relative risk has reduced year-on-year following a number of operational and clinical quality initiatives which have now resulted in substantial improvements in mortality figures. Our Better Care Now scheme has developed a number of clinical pathways that impact most on mortality and morbidity figures and are focusing particularly on the first 24-36 hours of patient care to standardise and improve the treatments they receive and this is providing excellent results.

The Trust has made an investment of £1m in clinical staff with 174 qualified nurses, midwives and health visitors commencing in post and 293 doctors and dental staff joining the organisation in temporary and permanent posts.

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

For example we are now offering more intravenous therapy treatments in the home or community setting which allow long-term recipients of intravenous drugs to be allowed home from a hospital ward to continue their treatment. The newly-established ascites service allows liver patients to have excess fluid drained during a day visit rather than being admitted to hospital for a three to four day period.

The service has given patients their lives back and is a testament to the innovation and dedication of our staff. The scheme was devised here and gives patients their independence to be able to visit the hospital for just an eight hour session rather than have to be admitted for about four days.

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

The Trust has also piloted a dedicated team working with 15 care homes across Blackpool. The team has worked with care home staff and other professionals to develop individual care plans for each resident which ensure they always receive appropriate treatment when needing medical intervention. The scheme has been so successful that it is now expanding to cover more care homes in the area.

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

We are now also seeing the benefits of our new entrance and car park at Blackpool Victoria Hospital which has helped provide a far better environment for our patients. The development was officially opened by Parliamentary Under Secretary of State for Health, Dr Dan Poulter MP, who praised the Trust for its investment which he said supported frontline staff and improved patient experience.

In 2013 we launched our five strategic aims for 2020: 100% patients and carers included in decisions about their care, 100% compliance with agreed patient pathways, Zero inappropriate admissions, Zero patient harms and Zero delays. Whilst these targets are ambitious they will underpin everything we do. Our plans for 2015/16 aim to build on the progress we have made as well as new improvement targets in relation to patient care.

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

We aim to be responsive to patients needs and will continue to listen to patients, staff, stakeholders,

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

To the best of my knowledge the information in the Quality Account 1st April 2014 – 31st March 2015 is a balanced and accurate account of the quality services we provide.

SIGNED: 

DATE: 28th May 2015

Gary Doherty
CHIEF EXECUTIVE

Part 2: Our Quality Achievements

In this section the Trust's performance in 2014/15 is reviewed and compared to the priorities that were published in the Trust's Quality Account in 2013/14. Priorities for improving the quality of services in 2015/16 that were agreed by the Board in consultation with stakeholders are also set out in this section. Legislated statements of assurance from the Board of Directors see section 2.3.

2.1 How we performed on Quality in 2014/15 against Priorities in 2013/14 Quality Account

This section tells you about some of the quality initiatives we progressed during 2014/15 and how we performed against the quality improvement priorities and aims we set ourselves last year.

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

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

The following symbols will tell you how we are performing and whether we met our aims. When we set our aims these were either set in year or to cover a three-year period. This was part of our quality journey. We are therefore pleased to report the significant progress made against our aims. An overview of performance in relation to the priorities for quality improvement that were detailed in the 2013/14 Quality Account is provided in Table 1. A more detailed description of performance against these priorities for clinical effectiveness of care, quality of the patient experience and patient safety will be reported on in detail in Part 3, section 3.4.

Table 1: Performance Against Trust Priorities

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

Priority 1: Clinical Effectiveness of Care	**2012/13**	**2013/14**	**2014/15**	**Actual Target 2014/15**	**Expected Score 2014/15**
Reduce premature mortality from the major causes of death - Reduce 'preventable' mortality by reducing the Trust's Hospital Mortality Rates / Summary Hospital Mortality Indicators				111	113
- The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust (See section 2.3.7 Core Clinical Indicators for results)				109	116
- The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. (See section 2.3.7 Core Clinical Indicators for results)				1.14%	1.05%

North West Advancing Quality initiative that seeks compliance with best practice to improve patient experience in six clinical areas:	2012/13	2013/14	Result Achieved 2014/15	CQS Target 2013/14	Result Achieved 2013/14
Acute Myocardial Infarction	🟢	🟢	Data not available until Jun/Jul 2015	88.08%	89.89%
Hip and Knee Surgery	🟢	🟢		83.17%	91.11%
Coronary Artery Bypass Graft Surgery	🟢	🟢		92.9%	80.59%
Heart Failure	🟢	🔴		77.85%	80.20%
Community Acquired Pneumonia	🟢	🟢		64.58%	79.38%
Stroke	🟢	🟢		54.8%	46.00%
Priority 1: Clinical Effectiveness of Care (continued)	**2012/13**	**2013/14**	**2014/15**	**Actual Target 2014/15**	**Expected Score 2014/15**
Enhancing quality of life for people with dementia:					
Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission	🔴	🔴	🟢	Achieved in Q3 and 4	90%
Medical Care Indicators used to assess and measure standards of clinical care and patient experience	🟢	🔴	🟢	82%	95%
Nursing Care Indicators used to assess and measure standards of clinical care and patient experience	🟢	🟢	🟢	Acute 95%	95%
	N/A	🔴	🔴	ALTC 58%	95%
	🟢	🔴	🟠	Trust 87%	95%
Improving outcomes from planned procedures by Improving Patient Reported Outcomes Measure (PROMs) scores for the following elective procedures:		**Provisional data**			
i Groin hernia surgery	🔴	🔴	2014-15 data not available until Sept 2016	Data N/A	Data N/A
ii Varicose veins surgery	🟢	🟢		Data N/A	Data N/A
iii Hip replacement surgery	🔴	🟢		Data N/A	Data N/A
iv Knee replacement surgery	🟢	🔴		Data N/A	Data N/A
Reduce emergency readmissions to hospital (for the same condition) within 28 days of discharge (See section 2.3.7 Core Clinical Indicators for results)	16+	12.04	12.04*	12.04*	*methodology under re evaluation
	< 16	10.73	10.73*	10.73*	*methodology under re evaluation
Priority 2: Quality of the Patient Experience	**2012/13**	**2013/14**	**2014/15**	**2014/15**	**2014/15**
Improve hospitals' responsiveness to inpatients' personal needs by improving the CQC National Inpatient Survey results in the following five areas:				**National Picker average**	**BTHFT actual**
Were you involved as much as you wanted to be in decisions about your care and treatment?	🟠	🟠	🟢	89%	86%
Did you find someone on the hospital staff to talk to about your worries and fears?	🟢	🟢	🟢	75%	76%
Were you given enough privacy when discussing your condition or treatment?	🟢	🟢	🟢	92%	92%
Did a member of staff tell you about medication side effects to watch for when you went home?	🟠	🟠	🟠	59%	56%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	🟢	🟠	🟢	71%	71%

Improve staff survey results in the following area:				National average	BTHFT actual
Percentage of staff who would recommend their friends or family needing care	Not reported in 2012/13	Not reported in 2013/14		To be the Best 20% of Trusts	73%
Report on Friend and Family Test and achieve above national target	Not reported in 2012/13	Not reported in 2013/14		To be above national average	79%
Improving the experience of care for people at the end of their lives:	**2012/13**	**2013/14**	**2014/15**	**2014/15**	**2014/15**
Seeking patients and carers views to improve End of Life Care				Not Nationally Measured	Patient questionnaire in place
Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place across all services.				Not nationally Measured	Identification of preferences for future care monitored
Patient Led Assessment of the Care Environment (PLACE) Survey				**Actual 2014/15**	**Expected Score 2014/15**
To improve PLACE survey results/standards			Results not available until September 2015		
Priority 3: Patient Safety	**2012/13**	**2013/14**	**2014/15**	**Actual 2014/15**	**Expected Score 2014/15**
Achieve 95% Harm Free care to our patients by 2016 through the following strands of work:					
Risk-assessment for Thrombo-Embolism (VTE) - Improve the percentage of admitted patients who were risk- assessed for VTE; and - Compare the national average for the above percentage - (See section 2.3.7 Core Clinical Indicators for results)				99.86%	99.5%
- Achieve a 10% reduction on the previous year in all VTE				13.85%	10%
Table 1: Performance Against Trust Priorities	**2012/13**	**2013/14**	**2014/15**	**Actual Performance 2014/15**	**Expected Score 2014/15**
Rates of Clostridium Difficile and MRSA - Reduce the incidence of Clostridium Difficile infection rates in the Trust in relation to lapses in care as reflected by national targets				24	28
- Reduce the incidence of MRSA infection rates in the Trust as reflected by national targets				3	0
Reported Patient Safety Incidents - To monitor the rate of patient safety incidents and reduce the percentage resulting in severe harm or death				27	30
Reduce the incidence of inpatient Falls by 30% resulting in moderate or major harm				35 (20.5% reduction)	31
Reduce the incidence of Medication Errors by 30% resulting in moderate or major harm				24	12

- Reduce the incidence of new hospital acquired pressure ulcers stage 2 by 30%, stage 3 by 40% and stage 4 by 100%; and				Stage 2-56 (24%increase)	50%
				Stage 3-3 (50% reduction)	100%
				Stage 4-0 (100% reduction)	100%
- reduce stage 2, 3 and 4 community acquired pressure ulcers by 10% (see page 60 for definitions)				Stage 2-58 (19.4% reduction)	30%
				Stage 3-10 (28.6% reduction)	30%
				Stage 4-81 (15.6% reduction)	50%
- Introduce the Think Glucose Programme	Not reported in 2012/13			Commenced	Commenced

2.2 Selected Priorities for Quality Improvement in 2015/16

This section tells you about how we prioritised our quality improvements for 2015/16. This section also includes a rationale for the selection of those priorities and how the views of patients, the wider public and staff were taken into account. Information on how progress to achieve the priorities will be monitored, measured and reported is also outlined in this section.

2.2.1 How we Prioritised our Quality Improvements in 2015/16

The Board of Directors has developed an organisational Strategic Framework which underpins the quality programme set out in this Quality Account for 2014/15. We believe the quality programme will enable us to maintain a focus on the quality and safety agenda, whilst delivering our Strategic Framework to improve the health and outcomes of our local population based on the values and principles set by the Board of Directors.

2.2.2 Rationale for the Selection of Priorities in 2015/16

The Trusts priorities for 2015/16 in relation to the key elements of the quality of care for clinical effectiveness, quality of the patient experience and patient safety, and the initiatives chosen to deliver these priorities were established as a result of consultation with patients, governors, managers and clinical staff. The Trust has shared its proposed priorities for 2015/16 with our Clinical Commissioning Groups, Blackpool Healthwatch, Lancashire Healthwatch, Blackpool Overview and Scrutiny Committee, Lancashire Overview and Scrutiny Committee and a sub group of the Council of Governors.

The Trust has taken the feedback received into account when developing its priorities for quality improvement for 2015/16 and after consultation at Board level, the following quality improvement priorities outlined in Table 2 were proposed and agreed by the Board of Directors which it believes will have maximum benefits for our patients.

These quality improvement priorities are also reinforced by the standards outlined in the *NHS Outcomes Framework 2015/16* which set out the high-level national outcomes that the NHS should be aiming to improve. The priorities focus on three key elements in the quality of care. These are:

1. Clinical Effectiveness of Care.
2. Quality of the Patient Experience.
3. Patient Safety.

The quality improvement priorities selected by the Board of Directors for implementation in 2015/16 have been aligned to the new Trust Strategy and Quality Goals and are detailed in Table 2.

Table 2: Priorities for Quality Improvement			
National Level NHS Outcomes Framework (DH 2015/16) Quality Domain(s)	**Trust Level**	**Key Elements in the Quality of Care**	**Description of Priority Indicators for Quality Improvement 2015/16**
Domain 1: Preventing people from dying prematurely. Domain 2: Enhancing quality of life for people with long-term conditions.	To provide and maintain high quality and safe services. To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Clinical Effectiveness of Care	Reduce premature mortality from the major causes of death - Reduce 'preventable' mortality by reducing the Trust's hospital mortality rates - The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.
Domain 1: Preventing people from dying prematurely.	To provide patient centred care across integrated pathways with primary/ community/ secondary and social care.	Clinical Effectiveness of Care	Our strategic aim is 100% compliance with agreed pathways by 2016 through the following strands of work: - Sepsis - Pneumonia - Stroke - Cardiac Chest Pain - Heart Failure - Acute Kidney Injury - Acute Abdominal Pain - COPD - Fractured Neck of Femur
Domain 2: Enhancing quality of life for people with long-term conditions.	To provide and maintain high quality and safe services. To deliver consistent best-practice NHS care which is evidence based.	Clinical Effectiveness of Care	Enhancing quality of life for people with dementia - Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission

Domain 3 Helping people to recover from episodes of ill health or following injury.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Clinical Effectiveness of Care	Medical Care Indicators and Nursing Care Indicators used to assess and measure standards of clinical care. Improving outcomes from planned procedures - Improve Patient Reported Outcomes Measure (PROMs) scores for the following elective procedures: i Groin hernia surgery ii Varicose veins surgery iii Hip replacement surgery iv Knee replacement surgery
			Emergency readmissions to hospitals within 28 days of discharge (Quality Accounts January 2014 DH) - The percentage of patients' of all ages and genders (aged 0 to15) and (16 or over) readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital; and - Compare the National Average for the above percentage

Table 2: Priorities for Quality Improvement

National Level NHS Outcomes Framework (DH 2015/16) Quality Domain(s)	Trust Level	Key Elements in the Quality of Care	Description of Priority Indicators for Quality Improvement 2015/16
Domain 4 Ensuring that people have a positive experience of care.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based.	Quality of The Patient Experience	Improve hospitals' responsiveness to inpatients' personal needs by improving the CQC National Inpatient Survey results in the following five questions: - Were you involved as much as you wanted to be in decisions about your care and treatment? - Did you find someone on the hospital staff to talk to about your worries and fears? - Were you given enough privacy when discussing your condition or treatment? - Did a member of staff tell you about medication side effects to watch for when you went home? - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
			Improve staff survey results in the following area: - Percentage of staff who would recommend the Trust to friends or family needing care.
			- Report on Friends and Family Test
Domain 4 Ensuring that people have a positive experience of care.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based.	Quality of The Patient Experience	Improving the experience of care for people at the end of their lives - Seeking patients and carers views to improve End of Life Care - Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place across all services.

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Patient Safety	Achieve 95% Harm Free Care to our patients by 2016 through the following strands of work: Risk-assessment for Thrombo-Embolism (VTE) - Improve the percentage of admitted patients who were risk- assessed for VTE; and - Compare the national average for the above percentage - Achieve a 10% reduction on the previous year in all VTE
			Rates of Clostridium Difficile and MRSA - The rate of Clostridium Difficile infections per 100,000 bed days amongst patients aged two years and over apportioned to the Trust; and - Compare the national average for the above rate. - Reduce the incidence of MRSA infection rates in the Trust as reflected by national targets
			Reported patient safety incidents - To monitor the rate of patient safety incidents the Trust have reported per 100 admissions; and - The proportion of patient safety incidents the Trust has reported that resulted in severe harm or death - To reduce the number of avoidable patient harm through the implementation of the 'National Sign Up to Safety Campaign' which will: o Reduce the incidence of falls resulting in patient harm by 20% by March 2017. o Reduce the incidence of medication errors resulting in moderate or severe harm by 30% o Reduce avoidable harm caused by Trust attributable pressure by 30% from our April 2015 baseline
			Continue to introduce the plan Think Glucose Programme
The Priority Indicators for Quality Improvement will be measured through the objectives and Strategic Aims that are identified within the Organisational Strategic Framework. The Priority Indicators for Quality Improvement will be monitored by the Board at each of its meetings through the Chief Executive Assurance Report, and a number of committees within the Board Committee Structure. Further information can be found in section 2.2.5 and in the Glossary of Terms (available upon request).			

2.2.3 Rationale for the Selection of Priorities to be removed in 2015/16

This section should reflect a list of priorities that have been chosen to be removed by the Board of Directors from the quality improvements priorities for 2015/16. The rationale for the de-selection of priorities is that considerable progress and improvements have been delivered or put in place and other improvements have become a priority.

It has been agreed that no quality improvement priority used in 2014/15 will be removed as it is deemed necessary to continue to monitor all priorities which will be reported in the 2015/16 Quality Accounts.

2.2.4 Engagement with Patients, Public, Staff and Governors

The Trust's overarching aim is to ensure that patients, their families and carers receive an experience that not only meets but exceeds their expectations of services. To achieve this, the Trust listens and responds to the views of the local community, staff and governors, using their feedback constructively and innovatively to inform local service improvements.

The Trust collates information from local and national patient surveys, formal complaints, comments received through the Patient Relations Team and various local stakeholder meetings

and forums to benchmark services, measure performance, inform commissioners about service quality, improve public accountability, and provide evidence for regulators.

Asking people what it is like to use a service and where issues and problems may lie provides an opportunity to not only put things right but also to learn important lessons and develop new approaches in order to improve our services.

2.2.5 How we will Monitor, Measure and Report ongoing Progress to Achieve our Priorities for Quality Improvement 2015/16

We use a number of tools to measure our progress on improving quality and these tools inform the reports we present to the Board and its Sub-Committees. The priorities for quality improvement in 2015/16 will continue to be monitored and measured and progress reported to the Board of Directors at each of its meetings as part of the Board Integrated Performance Report and the Quality and Safety Assurance Report. For priorities that are calculated less frequently, these will be monitored by the Board of Directors by the submission of an individual report. The Trust has well-embedded delivery strategies already in place for all the quality priorities, and will track performance against improvement targets at all levels from ward level to Board level on a monthly basis using the ward quality boards and the integrated divisional quality monitoring reports. The priorities for quality improvement will also be monitored through the high level Risk Register and Divisional Risk Register process and by the Sub-Committees of the Board.

The Trust will also report ongoing progress regarding implementation of the quality improvements for 2015/16 to our staff, patients and the public via the performance section of our website. You can visit our website and find up-to-date information about how your local hospitals are performing in key areas: infections, death rates, patient falls and medication errors. Improving patient safety and delivering the highest quality care to our patients is our top priority. We believe that the public have a right to know about how their local hospitals are performing in these areas that are important to them. As well as information on key patient outcomes, the website also includes data on our waiting times, length of stay, complaints, patient harms, cleanliness, hospital food, and patients and staff opinion of our hospitals.

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

2.3 Statements of Assurance from the Board of Directors

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

2.3.1 Review of Services

During 2014/15 the Blackpool Teaching Hospitals NHS Foundation Trust provided and/or subcontracted 49 relevant health services.

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

The income generated by the relevant Health services reviewed in 2014/15 represents 90 per cent of the total income generated from the provision of relevant health services by the Blackpool Teaching Hospitals NHS Foundation Trust for 2014/15.

The quality aspirations and objectives outlined for 2014/15 reached into all care services provided by the Trust and therefore will have had impact on the quality of all services.

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

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

Formal patient safety walkabouts visits are undertaken by Executive Directors and Non-Executive Directors, these take place on a monthly basis and 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 is supported by a 'buddy ward' process with each Director buddying a number of wards the aim of which is to regularly visit and be visible to clinical areas to provide direct access and support clinical staff.

2.3.2 Participation in Clinical Audits and National Confidential Enquiries

During 2014/15, 31 national clinical audits and 3 national confidential enquiries covered relevant Health services that Blackpool Teaching Hospitals NHS Foundation Trust provides.

During that period Blackpool Teaching Hospitals NHS Foundation Trust participated in 97% 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 2014/15 are as follows in column A of Tables 3 and 4.
The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participated in during 2014/15 are as follows in Column B of Table 3 and 4.

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2014/15 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry identified in Column C and D of Tables 3 and 4.

Table 3					
List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2014/15					
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.	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	1487	91%
2.	Bowel cancer (NBOCAP)	✓	✓	218	100%
3.	Cardiac Rhythm Management (CRM)	✓	✓	1235	100%
4.	Case Mix Programme (CMP)	✓	✓	1059	100%
5.	Coronary Angioplasty/National Audit of PCI	✓	✓	1551	100%
6.	Diabetes (Adult)	✓	x	0	0
7.	Epilepsy 12 audit (Childhood Epilepsy)	✓	✓	39	100%
8.	Falls and Fragility Fractures Audit Programme (FFFAP)	✓	✓	367	100%
9.	Fitting child (care in emergency departments)	✓	✓	17	100%
10.	Head and neck oncology (DAHNO)	✓	✓	73	100%
11.	Inflammatory Bowel Disease (IBD) programme	✓	x	No data inputted	
12.	Lung cancer (NLCA)	✓	✓	293	100%
13.	Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	300	100%
14.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	✓	✓	43	100%
15.	Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	14	100%
16.	Mental health (care in emergency departments)	✓	✓	Data collection in progress	
17.	National Adult Cardiac Surgery Audit	✓	✓	965	100%
18.	National Audit of Intermediate Care	✓	✓	Data collection in progress	
19.	National Cardiac Arrest Audit (NCAA)	✓	✓	236	100%
20.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓	✓	73	100%
21.	National Comparative Audit of Blood Transfusion programme	✓	✓	310	100%
22.	National Emergency Laparotomy Audit (NELA)	✓	✓	243	96%
23.	National Heart Failure Audit	✓	✓	327	100%
24.	National Joint Registry (NJR)	✓	✓	All patients	100%
25.	National Vascular Registry	✓	x		

26.	Neonatal Intensive and Special Care (NNAP)	✓	✓	All patients	100%
27.	Oesophago-gastric cancer (NAOGC)	✓	✓	35	100%
28.	Older people (care in emergency departments)	✓	✓	100	100%
29.	Pleural Procedure	✓	✓	9	100%
30.	Rheumatoid and Early Inflammatory Arthritis	✓	✓	31	100%
31.	Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	454	100%

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

Table 34

List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2014/15

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	Tracheostomy Care Study	Yes	Yes	17	100%
2	Lower Limb Amputation Study	Yes	Yes	7 Data collection not due to complete at time of report	100%
3	Gastro Intestinal Haemorrhage Study	Yes	Yes	Data collection not due to complete at time of report	100%
4	Alcohol Related Liver Disease	Yes	Yes	7	100%
5	Sepsis	Yes	Yes	5	100%
6	Acute Pancreatitis	Yes	Yes	Awaiting Case Note selection from NCEPOD	Awaiting Case Note selection from NCEPOD

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

The reports of 2 national clinical audits were reviewed by the provider in 2014/15 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as shown in Table 5.

Table 5	
National Clinical Audits (Confidential Enquiries) presented for assurance to the Board of Directors	**Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
Sub Arachnoid Haemorrage Study – Report issued Nov 2013 Managing the Flow? A review of the care received by patients who were diagnosed with an aneurysmal subarachnoid haemorrhage.	All patients presenting with acute severe headache in a secondary care hospital should have a thorough neurological examination performed and documented. • All patients presenting to the emergency department with acute severe headache have a GCS recorded in the observations section of the electronic patient record by the initial assessment nurse. Documentation of full neurological assessment by a doctor is recorded in the hospital notes • A full audit of all patients admitted with a suspected sun arachnoid haemorrage will be part of a clinical audit undertaken by the Lead Consultant to determine neurological assessment in A&E A CT- scan should be performed immediately in this group of patients as defined by the 'National Clinical Guideline for Stroke'. • The Trust provides 24 hr CT scanning In hours, • The PACS system at Blackpool Teaching Hospitals NHS Trust is linked directly to the PACS system at Central Lancashire Teaching Hospitals NHS Trust. The images are therefore immediately available for review by the neurosurgical on call at Royal Preston Hospital prior to transfer. The nationally-agreed standard ('National Clinical Guideline for Stroke') of securing ruptured aneurysms within 48 hours should be met consistently and comprehensively by healthcare professionals who treat this group of patients. This will require providers to assess the service they deliver and move towards a seven-day-service. • Neurosurgical services at Royal Preston Hospital conveniently located within15 minutes of a "blue light" ambulance transfer. • Critical care support is provided for transfer of patients intubated or with airway concerns. Organ donor policy in place within the Trust with appointed Specialist Nurse – Organ Donation (BVH)
Alcohol Related Liver Disease Study Report issued June 2013 Measuring the Units A review of patients who died with alcohol-related liver disease	• The Trust has appointed a multi disciplinary Alcohol Care Team that is led by a Consultant. • The Alcohol Specialist Nurse Service offers a 7 day service. • Policies are in place re the identification and management of alcohol misuse. • All patients are assessed on admission using an approved tool – (Audit – C) • Antibiotics and terlipressin are offered to all patients with a history of alcohol abuse and gastro intestinal haemorrhage until the results of endoscopy are reviewed. • Escalation of care is actively pursued based on renal function of individuals and need.
Lower Limb Amputation Study	• Report received November 2014 • Action plan being completed to address all recommendations

Tracheostomy Study	• Report received June 2014 • Tracheostomy insertion is recorded and coded as an operative procedure. • Improved care planning allows for national and local review and audit. • Critical care units have a rapidly available difficult airway trolley/fibre optic laryngoscopy.) • Training programmes in blocked/displaced tubes/airways and difficult tube changes are delivered in accordance with clinical consensus guidelines as stated by the National Tracheostomy Safety Project and the Intensive Care Society. • Core competences for the care of tracheostomy patients, including resuscitation, are included in training and assessment. • Consent and WHO type (surgical) checklists have been adopted and are used prior to tracheostomy insertion, wherever it is performed where possible • All unplanned tube changes are reported locally as critical incidents and investigated to ensure that lessons are learned and reduce the risk of future events. • Training is provided for all bedside staff who care for tracheostomy patients, this ensures that staff are competent in recognizing and managing common airway complications including tube obstruction or displacements and as described by the National Tracheostomy Safety Project algorithms. • Quality of discharge documentation is being improved to include a structured and detailed summary between wards and between hospitals and the community at the point of transfer.
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions	

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

During 2014/15, 98% (266) of audits were completed or are running according to schedule for completion. The number of audits being monitored by the Clinical Audit Department is 65% (176). This includes all audits that have not been fully completed at end of Quarter 4.

The reports of 79 local clinical audits were reviewed by the provider in 2014/15 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 6 below). Additional information can be found in the Annual Clinical Audit Report 2014/15 which is published on the Trusts website and is available via the following link: http://www.bfwh.nhs.uk/about/performance/. A copy of the Annual Clinical Audit report of is available on request.

Table 6	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Enteral feeding in ITU patients	Crirical Care nutrition policy revised to provide consistant approach to calculating energy requirements and prescribing of enteral nutrition. Nutrition prescribing included in daily ward round check list. Presentation of revised policy at governance and sisters meeting.
Hpylori treatment and out of hours	European and UK guidelines for H-Pylori eradication to be monitored.
Audit of compliance with NICE Quality Standards for End of Life Care	55 of the 65 NICE QS milestones/outcomes have been achieved and 7 are in progress (one of these on hold). Actions to be completed; Implementation of information prescriptions for those patients with cancer Business plan submission to facilitate 7/7 working for the specialist palliative care team End of Life Training to be included in the Trust L+D strategy Business plan formulation for physio/OT support to palliative care team
Outpatient management of pulmonary embolism	Education programme for junior doctors in 'wells score' facilitated as part of their assessment for Pulmonary Embolism

Community Hospital Transfer audit	Develop electronic referral form. Regular reminder communication of referral criteria. Presentation delivery of process Plan re-audit after electronic referral has been in place for a period of time.
Peer review case note audit	Electronic GP notification form set up. All patients offered a copy of initial consultation letter where treatment options discussed. Increase CNS capacity to ensure patients are provided with appropriate information Documentation process to evidence of holistic needs assessment. All patients offered a copy of treatment plan.
Compliance with CG100 and CORP/PROC/487	Assessment documentation inclusion of AUDIT-C in Nursing Health Record Assessment Document. Improved access to CIWA Ongoing education in Alcohol Identification and Brief Advice (IBA) and Alcohol Withdrawal Syndrome (AWS).
Re-audit Assessment of compliance with NICE CG50 in Acutely ill patients in hospital	EWS system evaluated to address continuing failure to escalate hypoxia as cause for concern. Recognise and Act' course mandatory for RN's. Use of bay based care project. Trust-wide strategy identified for improving compliance and quality of fluid balance monitoring/use of charts. Continued training in completion of POTTS chart and GRS documentation. Continued review of all adult 2222 calls. Completion of CORP/PROC 627 document in order to drive forward improvements.
Acute upper gastrointestinal haemorrhage	Tutorials introduced for GI bleed training. Trust guidelines modified to incorporate NICE guidance. Form in gastro changed to include Blatchford score.
Audit of patient casenotes who have undergone Haemopietic Progenitor Cell	Transplant Nurse Specialist supported by Assistant Practitioner in collating relevant documentation from case notes. Mobilisation plans are signed off by Consultant. Record of review added to ward discharge check list. Discharge letters are dictated within two weeks.
NCEPOD Study- Caring to the end- A review of the care of patoents who died in hospital within four days of admission	All recommendations met from published report. Full report available.
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.
NCEPOD Study-Alcohol related liver disease - Measuring units. A review of patients who died with alcoholic liver disease	Audit C tool incorporated into Trust documentation. Dedicated Consultant led Multidisciplinary Alcohol Care Team established including Mental Health Nurse and Consultant availability 24 hours. Robust guidelines available for managing patients with alcohol related liver disease (CORP/PROC/487). Liver specialist available 24 hours on via call. CIWA score routinely used when Audit C score>8. Medication tailored to the needs of the individual (pharmacists on ward). All patients seen by specialist within 24 hours. MUST assessment of all patients within first 24 hours. Critical Care Outreach team available for active escalation. Support services available to all patients agreeing to referral.
Audit on Diagnosed Cases of VTE in Orthopaedic in Patients' (Previously VTE prophylaxis in medical and Orthopaedic patients)	No relation between diagnosed thromboembolism and VTE practices were identified as a result of udertaking this audit. Continued practice with current VTE policy.

Indication for implant cardiac resynchronisation device	Standardised follow up to include assessment of response, optimisation of medication and device introduced. Links with rehabilitation long term, established. Reliablilty of identification of deteriorating HF patients to go back to medical clinic enhanced.
North West Regional Urology - Renal Tumours Audit 2013	Documentation of the eGFR completed on all cases of renal tumours. Post operative eGFR is now formally documented in the notes.
Anticoagulation in patients with atrial fibrillation and stroke	Stroke medics completing discharge summaries. Community awareness campaign to alert patients to present themselves to A&E within thrombolysis therapy window. Awareness enhancement of clinical staff in use of stroke pro forma
Epidural documentation in obstetrics	Nexus BOAD used to log epidural data. Network printer linked to anaesthesia computer New trainees induction information reviewed to include epidural documentation process. Review of patient information leaflets facilitated.
Admission rates following day case bunion surgery	British day case surgery standards of over 85% has been met by this trust therefore no actions necessary
Results and outcomes of cataract surgeries performed by Mr Mishra at BVH	Results above National average therefore no actions.
Gentamycin as antibiotic prophylaxis in urology and orthopaedic surgery	New guidelines have been written incorporating a wide range of procedures and offering alternatives for patients with moderate/severe renal impairment
Assessment of use of telemetry in the Hospital against ACC guidelines	New Telemetry monitoring form now in use Policy updated to reflect all telemetry groups
Indications for tonsillectomy	Single listing prospective trial showed potential 100% compliance using dedicated listing pro forma. 100% compliance against local and national guidelines. Clinicians adherence to listing guidelines on dictating achieved.
Dental trauma during anaesthesia managing risks	AN1308 - Ongoing education within Anaesthetists on documentation of high risk dental damage during anaesthesia. Audit shows no dental damage occurred during this audit therefore no actions required.
Ticagrelor for treatment of ACS	No recommendations/actions due to compliance
Adequacy of medical records in Cardiothoracic surgical inpatients	Trial in progress of the regular use of ITU ward round sheets by Anaesthetists, Surgeons and Nursing staff. Ongoing education in relation to recording patient identifier details.
VTE prophylaxis in trauma patients	A VTE prophylaxis form developed and implemented forlower limb casts. Assessment form reflects identification of high risk patients.
Audit of cataract surgery	Cross checking process on accuracy set up through Theatre book documentation of Complications for cross reference with ORMIS.
Retrospective audit of the follow up practice for rectal cancer	No actions as compliant
Emergency surgery audit	Audit completed identifying comparable performance to the National Standards. Emergency surgery pathway development commenced.
Residual anaesthesia drugs in cannulae	Process in place for cannula flushed prior to patient leaving theatre Theatre documentation improved to reflect change in practise
Pre-operative fasting in adults	100% compliance.
Inadvertent perioperative hypothermia	Increased awareness/education of staff facilitated regarding importance of normothermia in surgical patients. Early identification of high risk patients in place. New charts introduced.

Cyclodiode Laser Outcome following Transscleral Cyclodiode Laser at eye Dept BVH	100% compliant
Rate of catherisation post total hip and knee replacement	Reduced inappropriate use of intrathecal opioids by keeping dose of bupincaine <2.75mls 0.5% . Use of urinary catheterisation in hip and knee arthroplasty minimised
Pre-operative airway assessment	Airway assessment completed and documented on all patients. Strategy is planned and documented for difficult intubation.
NCEPOD Study - Knowing the risk - A review of the peri-operative care of surgical patients	Strategies for the management of intra-operative low blood pressure in the elderly in place and training provided to all anaesthetists. Cardiac output measurement available for all major cases.
NCEPOD Study - Time to intervene A review of patients who underwent cardiopulmonary resuscitation as a result of in in hospital cardiao-respiratory arrest	Medical and Surgical Assessment documentation implemented. Monthly medical care indicators audited on a rolling programme.
The handling of clinical trials in Pharmacy Departments	Update of CORP/PROC/310 underway to include a mechanism for explicit and timely notification of Principal Investigator. Business case need identified for additional trial storage facilities. New policy written with reference to Q-Pulse AOPG18
NPSA 15	Action plan production and monitoring processes by Divisional heads
To evaluate the diagnostic adequacy and safety of percutaneous image guided liver biopsy	Proforma development for post procedure care for liver biopsy.
EL97(52) QCNW External Aseptic Unit Audit	All outstanding standard operating procedures reviewed and updated. Reports obtained following service visits. Monthly check reports provided on Air Handling Unit. Sink swab added to weekly environmental monitoring. Temperature mapping completed for refrigerators.
Blood transfusion consent/ clinical indication/recorded benefit audit	Audit results disseminated to clinical leads. Adequate supply of blood transfusion information leaflets are ordered Consent from patient is documented. Patient leaflets provided.
Prescribing medicines	Wide sharing of results and committee monitoring of action plans Policy under review to reflect changes in practice or procedure. Education and training in good prescribing principles is delivered to all prescribers.
Safe insulin prescribing and storage audit 2014	Dispensing of insulin pens reviewed to reflect safest practice Process in place to manage ward stocks. Safe storage requirements reinforced with ward staff
Reducing harm from omitted and delayed medicines in Hospital/correct use of omission codes	Results presented and discussed at Medicines management Committee. Critical medicines list provided to ward managers for display in clinical areas. Medicines Management training reviewed and updated. Development of Self-Administration of Medicines Policy commenced.
Entry techniques for Laparoscopic procedures	2 new consent forms in place supported by enhanced documentation of operative procedure
Fetal Blood Sampling	Proforma complexity under review. Verbal consent process for all patients in place.
Monitoring of care of women having vaginal birth after Caesarean Section	Dissemination of referral process information to midwives and medical staff facilitatied. Protocol reviewed in relation to induction and augmentation of labour. Audit proforma under review.

Severe Pre-Eclampsia	Blood pressure documentation requirements agreed. Discharge process, review by relevant clinician and follow up process agreed.
Shoulder dystocia	Proforma for audit redesigned.
Child Protection Supervision Documentation	Supervisee training sessions delivered to raise awareness of supervisee responsibilities. Supervision contract regularly reviewed every 12 months.
Re-audit of the Management of women with substance abuse in pregnancy	Guidance under review.
Febrile illness in children	Senior doctor presence as supervisor for junior staff New NICE guideline provided for all relevant clinicians.
Decision to delivery interval in Emergency LSCS	On call consultant presence on day 1 in place.
Audit of management of ruptured membranes	Current guidelines on PROM & PPROM under review
Management of pregnancy of unknown location	Process in line with this agreed and relevant documentation updated accordingly.
Placenta Previa - compliance to NPSA bundle	Care bundle being included into guidance
VTE prophylaxis in obstetric patients	Awareness process facilitated. Reminder posters developed and displayed on the ward/delivery suite MDU Clinic. Inclusion at induction for new doctors/staff
Assessment of maternity records	Redesign of pre printed hand held notes Redesign of document storage envelopes
Management of postpartum haemorrhage	Pro forma completion by midwives agreed. Risk assessed and monitored via risk committee.
Audit of GP discharge letters within 48 hours for newly diagnosed diabetes patients	Consultants assurance of GP letter completion on discharge to be audited
Operative vaginal delivery	Information provided to new doctors Proforma and consent form accessible
Review of TVT/TOT surgery and follow up	Extra Lists facilitated
Obesity in pregnancy	Process for Community Midwives to complete obesity assessment form agreed Assessment form amendments in progress.
Audit of outcomes of External Cephalic Version (ECV)	Further training re counselling on options for breech delivery under review Leaflet review under way Data collection and reliability assurance processes under review.
Management of croup	Doseage of related medications agreed Advice provision for parents agreed.
Best Practice - Management of NICE	Process to review established NICE guidance on a monthly basis in place.
Best Practice - Management of NCEPOD	NCEPOD Ambassador working with Executive / Divisional Directors to reinforce CORP/PROC/065 National Confidential Enquiries. Process for cascade, risk assessments and subsequent action plans in place.
Do not attempt cardio pulmonary resuscitation (CG1029, CG1301)	Training programme in place. DNAR CPR reviewed in line with Article 8 of the European Court of Human rights
Do not attempt pulmonary resuscitation	Process to raise failure to complete mandatory sections of the DNACPR order developed.
Resuscitation trolley audit	Redesign of monitoring form & weekly senior monitoring check system implemented. Dedicated area identified in all clinical areas for resuscitation equipment situated.
Aseptic non touch technique audit	Clean hands campaign implemented. Equipment cleaning guidance agreed and in place.

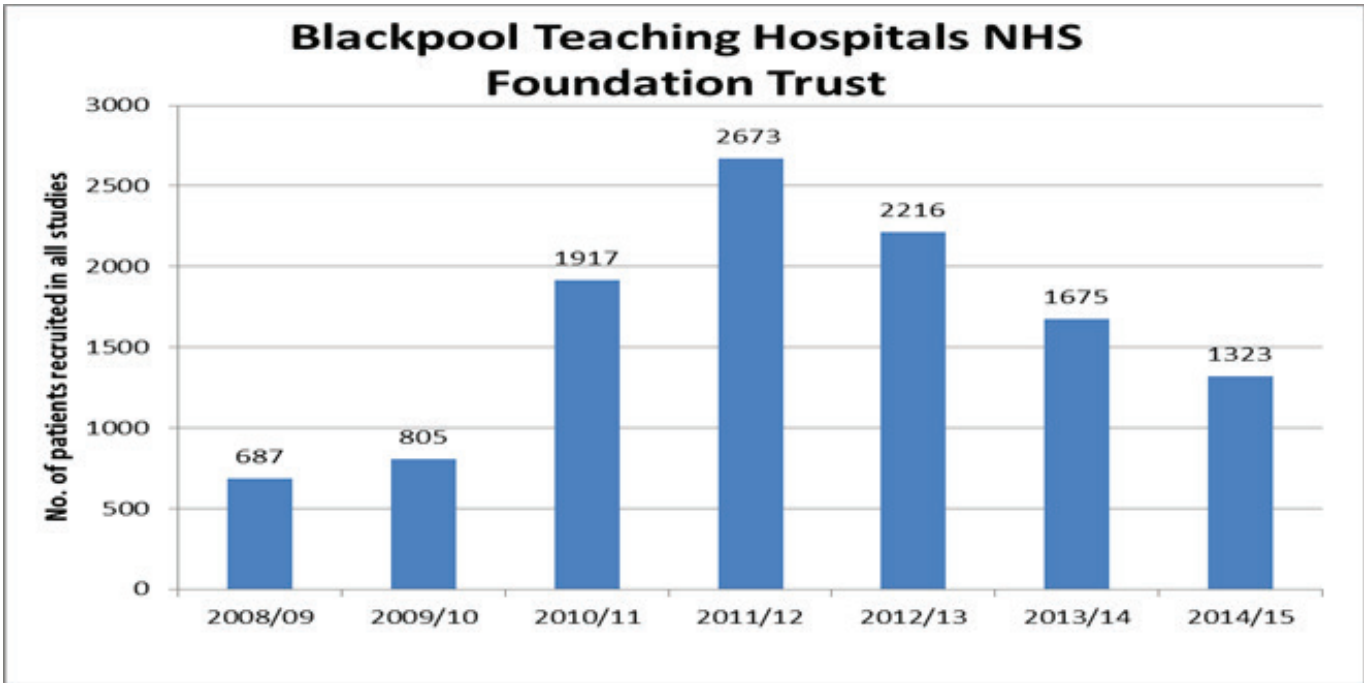
Isolation audit	Trust procedure awareness process facilitated. Barrier nursing policy revisited and re launched in ward teams.
Re-audit of the process for reporting and management of needlestick injuries and accidents involving exposure to blood or body fluids in staff	Occupational Health Resource information files provided to all clinical areas. Increase access to relevant policy and instructions on the intranet facilitated.
NCEPOD Study - Adding insult to injury	AKI Care pathway implemented. Guidance for junior doctors incorporated in pathway document.
Acute Health Record Folder Annual Retrieval Audit 2014	Audit findings disseminated. Health records management and Health records location training in place. Key performance indicators agreed.
Health Promotion in Hospitals	Targeted ward-based training planned. Training sessions in place and topic knowledge specific training planned.
Retrospective review of frequently admitted patients to establish whether any interventions could have prevented or shortened any admissions	Communication project commenced. In reach workers identified to support in reach project. Alternative management structure under trial.

2.3.3 Participation in Clinical Research in 2014/15

The number of patients receiving relevant health services provided or sub-contracted by Blackpool Teaching Hospitals NHS Foundation Trust in 2014/2015 that were recruited during that period to participate in research approved by a research ethics committee was 1,323, identified in Graph 1, of which the number of patients recruited to National Insitute of Health Research (NIHR) Portfolio Studies is 1,319. This figure was less than the number recruited in 2013/14 due to a number of high recruiting studies closing during 2014/15.

*it should be noted that 2014/15 NIHR Portfolio Study data is not signed off nationally until 30th June 2015. We therefore estimate the total patient recruitment total to be higher than currently reported (as at 16th April 2015).

Graph 1: Participation in Research



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

The National Institute of Health Research (NIHR) Portfolio studies are high quality research that has had rigorous peer review conducted in the NHS. These studies form part of the NIHR Portfolio Database which is a national data resource of studies that meet specific eligibility criteria. In England, studies included in the NIHR Portfolio have access to infrastructure support via the NIHR Comprehensive Clinical Research Network. This support covers study promotion, set up, recruitment and follow up by network staff. Participation in clinical research demonstrates Blackpool Teaching Hospitals NHS Foundation Trust's commitment to improving the quality of care offered and to making our contribution to wider health improvement. Our clinical staff remain abreast of the latest possible treatment possibilities, and active participation in research leads to successful patient outcomes.

Blackpool Teaching Hospitals NHS Foundation Trust was involved in conducting 182 clinical research studies during 2014/15. There were over 85 clinical staff participating in research approved by a research ethics committee at Blackpool Teaching Hospitals NHS Foundation Trust during 2014/15. These staff participated in research covering 19 medical specialties as outlined in Table 7 below. Please note the data on the Table 7 is provided by the NIHR whose figures are not finalised until 30th June 2015.

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

Specialty	No. of Patients Recruited 2010/11	No. of Patients Recruited 2011/12	No. of Patients Recruited 2012/13	No. of patients recruited 2013/14	No. of patients recruited 2014/15
Ageing			10	17	
Anaesthesia, perioperative medicine & pain management		1			104
Cancer	141	420	299	214	103
Cardiovascular disease	276	448	549	456	381
Children	32	57	81	57	23
Critical care	964	359	8	6	10
Dementias & neurodegeneration	11	6		9	5
Dermatology	21	9	9	23	23
Diabetes	6	159	430	324	6
Ear, nose and throat	20	223	160	141	170
Gastroenterology	95	55	31	23	23
Genetics		171	177	29	
Health services & delivery research	7	133	4	5	
Hepatology	9	13	21	72	22
Infectious diseases & microbiology	24	6	25	47	76
Injuries & emergencies	14	10	93	50	73
Musculoskeletal disorders	19	1	9	12	48
Neurological disorders				7	3
Ophthalmology	1			23	25
Primary Care					14
Renal disorders	90				
Reproductive health & childbirth	52	38	28	27	38
Respiratory disorders	19	22	20	22	27
Stroke	94	116	44	37	13
Surgery	2			3	101

In addition, over the last three years, 481 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. The improvement in patient health outcomes in

Blackpool Teaching Hospitals NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatment for patients.

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

A proportion of Blackpool Teaching Hospitals NHS Foundation Trust's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between Blackpool Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at: http://www.bfwh.nhs.uk/about/performance/

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

The total planned monetary value of income of CQUIN in 2014/15 conditional upon achieving quality improvement and innovation goals is £7,030,779; The Trust achieved a monetary total value of £7,301,025 for the associated payment in 2013/14.

The main areas of risk are the Dementia (Screening, Assessment & Referral), Patient Experience and AQ (CABG, Stroke and Heart Failure), CQUIN themes; however performance against these measures will not be confirmed until August 2014/15.

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

Statements from the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Blackpool Teaching Hospitals NHS Foundation Trust during 2014/15.

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

Chief Inspector of Hospitals Inspection Visit

Announced visit to Blackpool Teaching Hospitals NHS Foundation Trust by the Care Quality commission (CQC)

In April the Trust received its report from the inspections of the Blackpool Teaching Hospitals acute services at Victoria Hospital, Clifton Hospital and Fleetwood Hospital as part of the Care Quality Commission's national programme of inspections. The CQC inspected acute services covering; Accident and Emergency, Medical Care, Surgery, Intensive/critical care, Maternity and family planning, Children's care, End of Life Care and Outpatients. The CQC focused on five areas of inspection. These were: Are services safe, effective, caring, responsive to peoples needs and are they well-led.

The CQC's final report, gave an overall rating to the Trust of "requires improvement" with the following ratings for each of the five key inspection questions:

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

Of the 68 individual ratings given 42 were good, two were outstanding, 22 were requires improvement and two areas were deemed

inadequate. Maternity Services were rated as 'inadequate' due to the ongoing review of PPH cases that had resulted in a hysterectomy, five cases in a six month period. The expected range for our Trust is two cases per year. The RCOG undertook a case review on 30th April and the CQC have received a copy of the case review report and subsequent completed action plan and the Trust await a date for re-inspection by the CQC.

One quality improvement action plan was formulated following the CQC visit, the implementation of which has been monitored via the Trust Board throughout 2014/2015 and progress has been reviewed by our Commissioners and the CQC. Through completion of each section of the action plan it is envisaged that all matters requiring improvement will be attained on re-inspection.

Special Reviews/Investigations

The Imaging Service Accreditation Sheme (ISAS)
In March 2015 the Trust received an Imaging Service Accreditation Scheme (ISAS) visit.

All areas and modalities within the department of Radiology were visited with an extension for the first time of the accreditation scope including Nuclear Medicine and Fleetwood Heath Centre.

Initial feedback has been very positive with findings being divided into mandatory non-compliances against the standards and recommendations for improvement. The mandatory findings, for both the existing scope and the extended scope areas requires further evidence. Once supplied this will enable clearance by the assessors who will then grant the department accreditation status.

The Trust is pleased to report that the assessment reflected that patients were very happy with the service and that they had nothing but praise for the way they were treated.

The Trust has welcomed this review to inform the maintenance of an ongoing quality cycle for improvement across the Radiology department.

The National Cancer Peer Review
The National Cancer Peer Review Programme is a quality assurance programme that is aimed at reviewing clinical teams and services to determine their compliance against national measures, as well as the assessment of quality aspects of clinical care and treatment. The programme encompasses a whole systems approach to ensuring safe, personal and effective care in relation to the patient experience and clinical outcomes.

The programme involves self-assessment by Multidisciplinary Teams (MDTs), validated self-assessments and external reviews of teams conducted by professional peers, against nationally agreed quality measures.

The programme aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible.
- improving the quality and effectiveness of care.
- improving the patient and carer experience.
- undertaking independent, fair reviews of services.
- providing development and learning for all involved.
- encouraging the dissemination of good practice.

The Trust completed self assessments across all tumour sites and the Lung team were chosen for an external peer review visit which took place on 16th July 2014. The Trust positively used this process to review its provision of care across all cancer sites, with eight areas noted as requiring no action. Key actions for six other sites were identified to further enhance quality of care and the MDT's have been proactively facilitating these actions throughout the year.

2.3.6 Information on the Quality of Data

Good quality information and data are essential for:

- The delivery of safe, effective, relevant and timely patient care, thereby minimising clinical risk.
- Providing patients with the highest level of clinical and administrative information.
- Providing efficient administrative and clinical processes such as communication with patients, families and other carers involved in patient treatment.
- Adhering to clinical governance standards which rely on accurate patient data to identify

areas for improving clinical care
- Providing a measure of our own activity and performance to allow for appropriate allocation of resources and manpower.
- External recipients to have confidence in our quality data, for example, service agreements for healthcare provisions.
- Improving data quality, such as ethnicity data, which will thus improve patient care and improve value for money.

NHS Number and General Medical Practice Code Validity

Blackpool Teaching Hospitals NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was:
- 99.6% for admitted patient care.
- 99.9% for outpatient care.
- 99.3% for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:
- 99.9% for admitted patient care.
- 99.9% for outpatient care.
- 100% for accident and emergency care.

*** based on provisional April 2014 – February 2015 SUS data at the month 11 inclusion date.*

Information Governance Assessment Report 2013/14

Blackpool Teaching Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2014/15 was 82% and was graded satisfactory (Green) from Information Governance Toolkit Grading Scheme.

For 2014/15 the grading system is based on:
- **Satisfactory** level 2 or above achieved in all requirements.
- **Not Satisfactory** minimum level 2 not achieved in all requirements.

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

Blackpool Teaching Hospitals NHS Foundation Trust will continue to work towards maintaining and improving compliance standards during 2015/16 monitored by the Health Informatics Committee.

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

Payment by Results (PBR) Clinical Coding Audit

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

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 a number of areas are being continually monitored on a daily, weekly and monthly basis by the Trust's dedicated data quality team. These are monitored through the use of local data quality reporting and the HSCIC's national secondary users service (SUS) data quality dashboard. Both local reports and national dashboards are reported to the Trust's divisions and to the Health Informatics Committee.
- The continued monitoring allows the team to identify areas of improvement, and take action where required to ensure and maintain the Trust's high quality standards, as reflected through the national HSCIC data quality dashboard.

2.3.7 Core Quality Indicators

From 2014/15 all Trusts are required to report against a core set of Quality indicators, for at least the last two reporting periods, using the standardised statement set out in the N*HS (Quality Accounts) Amendment Regulations 2013*.

Set out in Table 8 are the core quality indicators that Trusts' are required to report in their Quality Accounts. Additionally, where necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed in Table 8 with:

a) The national average for the same.
b) With those NHS Trusts and Foundation Trusts with the highest and lowest of the same, for the reporting period.

Table 8: Core Quality Indicators

The data made available to the Trust by the Information Centre is with regard to –
(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and
(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

	SHMI				Palliative Care Coding			
Period	**Trust**	**England Average**	**England Highest**	**England Lowest**	**Trust**	**England Average**	**England Highest**	**England Lowest**
January 2014 to December 2014	116	100	121	66	1.05%	1.35%	14.26%	0.00%
January 2013 to December 2013	119	100	119	56	0.91%	1.27%	14.35%	0.00%
January 2012 to December 2012	119	100	119	70	0.82%	1.14%	14.62%	0.00%

***Internally calculated data suggests the Trust's SHMI score on next release will be 117 following national rebase.*
**The palliative care indicator is a contextual indicator*

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

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

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

- The Trust has shown a sustained improvement in not only Risk Adjusted Mortality Index (RAMI) and marked improvements in HSMR and SHMI mortality measures that have historically portrayed the Trust in a poor light.

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

The data made available to the Trust by the Information Centre with regard to the Trust's patient reported outcome measures scores for:

(i) groin hernia surgery,
(ii) varicose vein surgery,
(iii) hip replacement surgery, and
(iv) knee replacement surgery,

during the reporting period.

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

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

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

The health status information captured from patients in this way provides an indication of the quality of care delivered. In the table overleaf a higher number shows that patients have experienced a greater improvement in their health.

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
Groin Hernia Surgery	2012/13	366	0.069	0.085	0.120	0.021
	2011/12	405	0.089	0.087	0.143	0.003
	2010/11	369	0.052	0.085	0.156	-0.02

*** Provisional scores for 2013/14 show Trust position as 0.045 to be verified in September 2015.*

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
Hip Replacement Surgery	2012/13	279	0.381	0.438	0.538	0.319
	2011/12	269	0.366	0.413	0.499	0.306
	2010/11	238	0.267	0.405	0.503	0.264

*** Provisional scores for 2013/14 show Trust position as 0.389 to be verified in September 2015*

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
Knee Replacement Surgery	2012/13	360	0.319	0.318	0.376	0.231
	2011/12	322	0.297	0.303	0.385	0.181
	2010/11	323	0.231	0.298	0.407	0.176

*** Provisional scores for 2013/14 show Trust position as 0.287 to be verified in September 2015*

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
Varicose Vein Surgery	2012/13	401	0.116	0.093	0.176	0.015
	2011/12	443	0.097	0.095	0.167	0.049
	2010/11	377	0.005	0.091	0.155	-0.007

*** Provisional scores for 2013/14 are not available yet for this category due to low number of modelled records.*
*** Provisional scores for 2014/15 are not yet available and will not be verified until September 2016.*

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

Scores for the Trust show that the perceptions of health gain among patients for groin or hernia repair and hip replacement procedures are slightly below average. We believe this is because:

- The number of patients completing a PROMs questionnaire needs to be increased as the low response rate in some areas has an impact on the reported results.
- We often treat patients with complex treatment needs and whose perception of health gain may be influenced by other health factors.

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

- Regularly reviewing scores at service and Trust level to increase our responsiveness to feedback from patients and so patient views can be incorporated into our quality improvement programmes.
- Increasing the involvement and understanding of staff in how we use the information received through PROMs, and working with staff to increase response rates and ensure expectations are clearer around pain management.
- Providing better support from our Patient Experience Department if patients need help to complete the questionnaire.

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

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

Age Group	2014/15	2013/14	2012/13	2011/12	England Average
0 to 15; and	Methodology under review	10.73	10.40	8.80	N/A
16 or over,	Methodology under review	12.04	6.30	6.51	N/A

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

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

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

- A clinically led review of readmissions to identify and implement actions required to reduce the number of avoidable admissions is planned for the 2015/16
- Joint work with Clinical Commissioning Groups to identify and implement health economy wide readmission avoidance schemes, including single point of access services to ensure patients access the most appropriate care, improvements to discharge and on-going care planning

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

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

Our composite score for the national inpatient survey's five questions relating to responsiveness to personal care in 2013/14 is above the Trust average in 2012/13 when compared with the trend data in the Department of Health's 'A tool for patient responsiveness to inpatients' personal needs'.

Year	Trust	England Average	England Highest	England Lowest
2013/14	67.1	68.7	84.2	54.4
2012/13	65.6	68.1	84.4	57.4
2011/12	67	67.4	85	56.5

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

- A number of initiatives have contributed to this improvement. The size of the corporate patient experience team has increased and individual patient experience action plans focussed on the five questions have been developed.
- In addition, Trust wide initiatives, such as the Tell Us campaign and the introduction of the listeners programme has helped patients to feel more involved in their care and have provided increased opportunities for them to raise any concerns they may have at a service level.

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

- Reviewing the responses to the individual questions that contribute to the overall score, as well as the Trust's local survey results, we recognise that there is room for further improvement. For example, we want to do more to ensure patients know who to speak to if they have any worries or fears once they have left our care, and for staff to explain their medication and any side effects more clearly.
- Continue to develop and implement action plans to respond to these issues. We are also planning further work to understand the issues that impact our patients' experience as they prepare to leave hospital so we can develop appropriate information resources and plans to improve these aspects of their care.

See section 3.4.2 - For further information regarding Priority 2: Quality of the Patient Experience and any actions taken to improve performance.

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

Year	Trust	England Average	England Highest	England Lowest
2012	63	63	98	35
2013	65	65	94	40
2014	72	67	100	12
2015	N/A	N/A	N/A	Data published 28th May 2015

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

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

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

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

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Quarter	Trust	England Average	England Highest	England Lowest
Q3 2014/15	99.87%	96%	100%	81%
Q3 2013/14	99.81%	96%	100%	77.7%
Q3 2012/13	99.40%	94.10%	100%	84.60%
Q3 2011/12	97.50%	90.70%	100%	32.40%

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

- The Trust has continued to implement current best practice guidelines in order to ensure that all adult inpatients receive a Venous Thrombo-Embolism Risk Assessment on their admission to the hospital, and that the most suitable prophylaxis is instituted. The Trust has embedded and improved the implementation of VTE guidelines within the Trust and has demonstrated this by achieving above the 90% compliance indicator. From 1st September 2011 - 31st December 2014 the Trust achieved above 90% compliance due to the hard work, commitment and the actions taken by staff. Since then we have been able to sustain this improvement as shown by latest figures March 2013 to 31st December 2014.

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

- A senior clinician and a senior nurse have been identified to provide leadership to facilitate ongoing improvements in compliance with trust processes and consequently improvements in patient care with regards VTE. The National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92) has been incorporated into easy to follow risk assessment forms across various specialties and is an integral part of clerking documents. This will not only ensure that VTE risk assessments are undertaken and embedded permanently in the admission pathway but also facilitates its documentation for subsequent analysis. The Thrombosis Committee monitors performance of individual clinical areas.
- The Trust meets the national requirement for compliance with undertaking VTE assessments. To ensure sustainability of this standard an annual audit is undertaken.

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

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

Year	Trust	England Average	England Highest	England Lowest
2013/14	9.8	13.9	37.1	0
2012/13	10.4	16.1	30.8	0
2011/12	20.4	21.8	51.6	0
2010/11	38.9	29.6	71.8	0

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

- There have been 54 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2014 and March 2015 of which 24 attributed to lapses in care and 30 attributed to no lapses in care. The total number of 54 cases is in comparison to 26 for the period April 2013 to March 2014, demonstrating an increase of 48%. The Trust was required to and achieved a trajectory of less than 28 lapses in care, a reduction of 1, based on the previous year's trajectory of 29 incidences of Clostridium Difficile. [Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms (available upon request)].

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following action to achieve the trajectory of 28 cases by undertaking the following action:

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

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

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

Please note that the data supplied by HSCIC is provisional.

	Incidents				Resulting in Severe Harm or Death			
Period	Trust Rate per 100	England Rate per 100 (Average)	England Rate per 100 (Highest)	England Rate per 100 (Lowest)	Percentage of Total (Trust)	Percentage of Total (England)	Percentage of Total (Highest)	Percentage of Total (Lowest)
01/04/2014 to 30/09/2014	2.17	N/A	N/A	N/A	0.23	N/A	N/A	N/A
01/04/2013 to 30/09/2013	3.99	N/A	N/A	N/A	0.347	N/A	N/A	N/A
01/04/2012 to 30/09/2012	8.3	6.7	13.61	1.99	0.1	0.7	2.5	0
01/04/2011 to 30/09/2011	5.92	5.99	10.08	2.75	0.2	0.8	2.9	0.1

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

- There has been a steady increase in the number of untoward incidents reported over the past four financial years. Patient Safety Incidents account for approximately 75% of all reported untoward incidents.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this 24 percent of patient safety incidents resulting in harm, and so the quality of its services, by undertaking the following actions:

- It is essential that lessons are learned from Serious Untoward Incident's in order to mitigate the risk of reoccurrence, these lessons are fedback to staff within the Divisions through training, ward meetings, SUI reports being uploaded onto the Risk Management site of the Intranet, the bi-monthly LIRC Committee meetings and the Trust wide monthly "lessons learned" newsletter.
- Engagement with the patient and their relatives is very important to the Trust to embed an open and honest culture, and to the patient and their family as a healing tool. Patients and relatives are informed when an incident has occurred and that an investigation is to be undertaken. They are also offered feedback in relation to the investigation findings.
- The new Duty of Candour Regulation 20 has been incorporated into the Serious Untoward Incident process and into the Safeguard Incident Reporting system, to ensure that we are capturing the communications between staff and patients/relatives/carers when harm to a patient has occurred. This ensures that we are working to a culture of openness and transparency and that we are offering apologies and support when things go wrong.

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

Part 3: Other Information - Review of Quality Performance

The Quality Account has provided an overview of the Quality Improvement work which has taken place across the organisation. There are a number of projects which will be taken forward into the coming year.

3.1 An Overview of the Quality of Care Based on Performance in 2014/15 with an Explanation of the Underlying Reason(s) for Selection of Additional Priorities

Table 1 in Part 2 sets out the priorities for improvement which were identified in the 2013/14 report and none of these priorities changed in 2014/15 because they were all considered to be of importance by the Board of Directors. Additional information regarding the rationale for the priority selection is detailed in 2.2.2 and 2.2.3. We also identified four additional priorities for quality improvement for monitoring in 2014/15 in relation to improving patient pathways with our service users. The additional priority has been identified and included and monitored during the reporting period 2014/15 as set out below:

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

- Pathways.
- Waits.
- Workforce.

Improving Patient Pathways in:-

- Pneumonia.
- Sepsis.
- Stroke.
- Cardiac Chest pain.
- Acute Kidney Injury.
- Acute Abdominal Pain.
- Fractured Neck of femur.
- Chronic Obstructive Pulmonary Disease.

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

The pathways identified and developed to date are for conditions that impact most on our mortality and morbidity. Eight pathways have been implemented to date and a work plan for 2015/16 agreed to address other high mortality areas.

Care Pathway data is collected real time and fed back to clinicians and teams to allow immediate improvements to be made. All pathways have seen an improvement in compliance with the mission critical points of the pathways, and there has been a downward trend in mortality for pneumonia, chest pain, Acute Kidney Injury and Acute Abdominal pain.

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

100 Day Pathway Campaign

The Fylde Coast Scheduled Care vision is committed to introducing end-to-end pathways for specific conditions to maximise safety for patients and overall efficiency. The introduction of these standardised clinical pathways helps ensure that patients receive appropriate, timely and evidence-based care.

The 100 day pathway workstream focused on introducing standardised pathways across the health community for the top elective procedures that the Trust performs on a yearly basis. Consultants and Specialist Nurses from the Trust joined with GPs representing local Clinical Commissioning Groups, to design and launch

over 40 patient pathways in areas such as general surgery, gynaecology, ear, nose and throat, ophthalmology, orthopaedics, urology and cardiac surgery. All of these pathways were made available on every GP's clinical system and also via the Trust's website.

One of the workstreams that came from this was to focus on improving compliance with interventions of limited clinical value (ILCVs). As part of this, a GP referral criteria was introduced into their clinical system (EMIS Web) that prompts them to ensure that they follow the correct criteria before referring a patient to the Trust.

Enhanced Recovery Pathways

Further work has been undertaken in 2014/15 to embed the Enhanced Recovery Pathways. A pathway has been trialled for the first time on Patients undergoing Cardiac Artery Bypass Grafting (CABG). The Trust has demonstrated through patient satisfaction surveys and patient focus groups that the patients feeling of involvement has increased and their patient experience has been enhanced. The trial also demonstrated an average saving of 1.5 bed days per patient which has supported the case to for a further roll out to all first time CABG patients by September 2015.

The Trust now facilitates all planned hysterectomy patients on the enhanced recovery pathway and all bowel resection patients are on a pathway following planned surgery. This has enabled the Trust to collect data and benchmark against other trusts to inform improvements in our service.

Future pathways are under development including the elective hip and knee replacements pathways.

3.2 Performance Against Key National Priority Indicators And Thresholds

The NHS Outcomes Framework for 2014/15 sets out high level national outcomes which the NHS should be aiming to improve. The Board of Directors monitors performance compliance against the relevant key national priority indicators and performance thresholds as set out in the NHS Outcomes Framework 2014/15. This includes performance against the relevant indicators and performance thresholds set out in the Risk Assessment Framework 2014/15 which can be accessed via the following link: http://www.monitor-nhsft.gov.uk/sites/default/files/publications/RAF_Update_AppC_1April14.pdf.

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

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

Part 3, Section 3.2 and detailed in Table 9 sets out the relevant indicators and performance thresholds outlined in Appendix A of Monitor's *Risk Assessment Framework*. Unless stated in the supporting notes, these are monitored on a quarterly basis. Please note: where any of these indicators have already been reported on in Part 2 of the Quality Report, in accordance with the Quality Accounts Regulations, they will not be repeated here. Only the additional indicators which have not already been reported in Part 2 will be reported here to avoid duplication of reporting.

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

Table 9 shows the results from the Trust's self assessment of performance against the relevant key national priority indicators and thresholds over the past 4 years.

Table 9: Performance against Relevant Key National Priority Indicators and Thresholds				
Quality Standard	**Trust Self Assessment 2011/12**	**Trust Self Assessment 2012/13**	**Trust Self Assessment 2013/14**	**Trust Self Assessment 2014/15**
All Cancers: one month diagnosis to treatment:				
First Treatment (target >= 96%)	Achieved Q1 99.5% Q2 99.6% Q3 99% Q4 99.8%	Achieved Q1 99.3%, Q2 99.4%, Q3 98.5%, Q4 98.9%	Achieved: Q1 98.9% Q2 98.9% Q3 99.8% Q4 99.3%	Achieved: Q1 98.8%, Q2 98.9%, Q3 99.8% Q4 99.5%
Subsequent Treatment – Drugs (Target >=98%)	Achieved Q1 100% Q2 100% Q3 99.3% Q4 99.3%	Achieved Q1 100%, Q2 100%, Q3 99.2%, Q4 98.6%	Achieved: Q1 99.2% Q2 100% Q3 100% Q4 100%	Achieved: Q1 100%, Q2 100%, Q3 100 % Q4 100%
Subsequent Treatment – Surgery (Target >=94%)	Achieved Q1 100% Q2 100% Q3 100% Q4 100%	Achieved Q1 100%, Q2 95.8%, Q3 96.7%, Q4 100%	Achieved: Q1 100% Q2 98.7% Q3 96.3% Q4 97.3%	Achieved: Q1 100%, Q2 100%, Q3 100% Q4 96.6%
Subsequent treatment – Radiotherapy (Target >=94%)	Not applicable	Not applicable	Not applicable	Not applicable
All Cancers: two month GP urgent referral to treatment:				
62 day general (target >=85%)	Achieved Q190.8% Q2 87.2% Q3 92.3% Q4 87%	Achieved Q1 85.1%, Q2 89.5%, Q3 85.5%, Q4 83%	Achieved: Q1 86.6% Q2 89.4% Q3 85.2% Q4 86.6% Annual percentage Excluding rare cancer 86.5%	Achieved: Q1 87.1%, Q3 88.7% Under achieved: Q2 76.7% Q4 82.4%
62 day general (target >=85%) Including Rare Cancers	Not applicable	Not applicable	Achieved: Q1 86.8% Q2 89.4% Q3 85.4% Q4 86.7% Annual percentage 87.1%	Not applicable
62 day screening (target >=90%)	Achieved Q1 90.5% Q2 93.7% Q3 86.8% Q4 96.7%	Achieved Q1 94%, Q2 91.3%, Q3 98%, Q4 96.6%	Achieved: Q1 89.1% Q2 91.7% Q3 90.1% Q4 94.7%	Achieved: Q1 95.1%, Q2 92.9% Under achieved: Q3 74.2% Q4 74.4%
62 day upgrade (Target TBC)	Achieved greater than 94% in all 4 quarters	Achieved Q1 91.4%, Q2 90.9%, Q3 92.2%, Q4 95.6%	Achieved: Q1 85.4% Q2 95.9% Q3 93.6% Q4 92.6%	Achieved: Q1 93.3%, Q3 92.3% Q4 95.8% Under achieved: Q2 86.5%

Breast Symptoms – 2wk wait (Target 93%)	Achieved Q1 94.1% Q2 94.7% Q3 93.2% Q4 96.4%	Achieved Q1 93.8%, Q2 96.5%, Q3 97.2%, Q4 93.4%	Achieved: Q1 94% Q2 94.8% Q3 96.7% Q4 93%	Achieved: Q1 96.6%, Q2 93.7%, Q3 94.3% Q4 98.0%
Reperfusion – Primary PCI	Achieved	Achieved	Achieved	Achieved (Apr-Feb, March data not available)
Delayed Transfers of Care (target <3.5%)	Achieved	Achieved	Achieved	Achieved
Percentage of Operations Cancelled (target 0.8%)	Achieved 0.56%	Achieved 0.45%	Under Achieved 0.92%	Under Achieved 1.76%
Percentage of Operations not treated within 28 days (target 0%)	Achieved 0%	Achieved 0%	Achieved 0%	Achieved 0%
National In-Patient Experience Survey	Under-achieved	Under-achieved	Achieved	Achieved
Quality of Stroke Care	No longer measured	No longer measured	No longer measured	No longer measured
Ethnic Coding Data quality	Achieved	Achieved	Achieved	Achieved
Maternity Data Quality	Achieved	Achieved	Achieved	Achieved
Staff Satisfaction	Achieved	Achieved	Data published 28th May 2015	Data published May 2016
18 week Referral to Treatment (Admitted Pathway) (target >=90%)	Achieved 91.89%	Achieved 94.66%	Achieved 92.02%	Under-achieved 88.75%
18 week referral to treatment Patients on an incomplete pathway (Target >+92%)	Not Applicable	Achieved 94.37%	Achieved 94.78%	Ⓐ Achieved 92.03%
18 week Referral to Treatment (Non-Admitted Pathways [including Audiology]) (Target >=95%)	Achieved 95.76%	Achieved 97.51%	Achieved 96.78%	Achieved 95.24%
18 week Referral to Treatment (non admitted pathways) 95th percentile (target 18.3 weeks)	Achieved	No longer measured	No longer measured	No longer measured
18 week Referral to Treatment (admitted pathways) 95th percentile (target 23 weeks)	Achieved	No longer measured	No longer measured	No longer measured

Incidence of MRSA	2 (target <=3)	3 (target <=3)	1 (target 0)	3 (Target 0)
Incidence of Clostridium Difficile	53 (target <=86)	28 (target <=51)	26 (target <=29)	54 (Target <=28)
Mixed Sex Accommodation (Target 0)	5 breaches	12 breaches	15 breaches	6 breaches
Total time in A&E (target 95% of patients to be admitted, transferred or discharged within 4hrs)	Achieved 95.93%	Achieved 96.61%	Not updated on National website as yet	Achieved 96.15%
Total time in A&E (95th percentile) (Target 240 minutes)	Under-achieved	Under-achieved	Under-achieved	Under achieved
Total time to initial assessment (95th percentile) (Target 15 minutes)	Under-achieved	Under-achieved	Under-achieved	Under achieved
Time to treatment decision (median) (Target 60 minutes)	Under-achieved	Achieved	Under-achieved	Under achieved
Unplanned re-attendance (Target 5%)	Achieved	Achieved	Not updated on National website as yet	Achieved
Left without being seen (Target 5%)	Achieved	Achieved	Not updated on National website as yet	Achieved
Ambulance Quality (Category A response times)	Not applicable	Not applicable	Not applicable	Not applicable
Waiting times for Rapid Access Chest Pain Clinic	100%	100%	100%	Achieved 100%
Access to healthcare for people with a learning disability	Achieved	Achieved	Achieved	Achieved
Participation in heart disease audits	Achieved	Achieved	Achieved	Achieved
Smoking during pregnancy	24.59%	24.56%	23.2%	22.9%
Breast-feeding initiation rates target (average rate within 48 hrs)	60.47%	56.35%	65.7%	65.3%
Emergency Preparedness	**	**	**	**
Where needed the criteria for the above indicators has been included in the Glossary of Terms (available upon request).				

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

The Trust has a suite of emergency plans to satisfy the Emergency Preparedness, Resilience and Response Core Standards; this includes a Pandemic Influenza Plan, a Major Incident Plan and a Trust wide Business Continuity Plan ratified by the Board of Directors, and in addition several other plans ratified by the Emergency Planning Steering Committee including the Severe Weather Plan, Ebola Procedure and Decontamination Plan. These documents define the key management systems and responsibilities of staff. Beneath the Trust wide Business Continuity Plan are two Workforce, two Diagnostics, two Estates and Strategy, three Scheduled Care, five Unscheduled Care, 27 Adults and Long Term Conditions, 15 Nursing and Quality, five ICT, two Finance and eight Families Business Continuity Plans (total 71) with operational information on alternative options to deliver their services.

The Trust has participated in several training and exercising opportunities, the main events being the EMERGO exercise delivered by Public Health England (PHE) to test the Major Incident Plan and the 'live' simulation to test the Ebola Procedure. Furthermore training has been provided for decontamination by the North West Ambulance Service to Trust staff within Radiology, Security and the Emergency Department on how to use PPE and by PHE for Ebola precautions to Infection Prevention and Emergency Department staff. The Emergency Planning Manager and Local Security Management Specialist continue to undertake group training sessions on the internal management of major incidents for the on call or duty staff, this includes Duty Directors, Duty Managers (Acute and Adults and Long Terms Conditions), members of the Acute Response Team, Associate Directors of Nursing, Senior Nurses covering bleep 002, On Call Consultant Haematologists and Loggists.

The Trust has undertaken a self-assessment in 2014 against the 51 NHS Core Standards for Emergency Preparedness, Resilience and Response; it was determined in November the Trust was 'Fully Compliant' with 44, 'Not compliant but evidence of progress' with three, 'Not compliant with core standard and not in the EPRR work plan' with zero and four were 'Not Applicable', since that assessment a work plan has been completed and the Trust is 'Fully Complaint' with all the standards.

Readmissions within 28 days

The Trust has been working with its health economy partners to implement strategies to reduce readmissions. However the percentage of all readmissions 2014/15 is unable to be measured against peer average as CHKS data is no longer used. Work continues to improve the performance of patients readmitted following an elective procedure as shown in Table 10 below.

Table 10: 28 Day Readmissions

Indicator	Trust 2012/13	Peer 2012/13	Trust 2013/14	Peer 2013/14	Trust 2014/15	Peer 2014/15
All Admissions	6.4%	6.8%	8.2%	6.6%	8.2%	Ⓐ CHKS data no longer available
Non-elective	10.8%	10.7%	13.1%	10.4%	13.0%	
Elective	3.3%	3.1%	3.4%	3.1%	3.7%	

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

62 day Cancer Waiting Time Standard

Delivery of the 62 day Waiting Time standards for both GP urgent and screening programme referrals continued to require significant work and pathway development across the Trust, local health economy and cancer network during 2014/15. The year end figure was 84% (excluding Rare Cancers). The overall annual performance figure increases to 84.1% when Rare Cancers are included (as required by Monitor). A significant amount of work was undertaken to understand and address the issues within pathways and across organisations for the benefit of patients. [Information on the criteria for this indicator is detailed in the Glossary of Terms. (available upon request)]

Learning from Patients and Carer's

We are committed to ensuring that patients their carers and families are involved in developing, planning and monitoring services.

The aim of the Trust's Patient Experience Department is to develop and support a culture that places the quality of the patient experience at the very heart of all that we do, following the principle of "no decision made about me, without me".

Patients and their families and carers, want to be supported and listened to so that they can make decisions and choices about their care and a comprehensive feedback system is in operation across the Trust so we can use their opinions to make sustainable improvements to services.

During the financial year 1st April 2014 to 31st March 2015 we received 4,644 thank you letters and tokens of appreciation from patients and their families, this is a 23% increase from the previous year.

The number of formal complaints received by the Trust during the same period was 501 this includes 418 written complaints registered via the Trust and 83 verbal e-complaints. The numbers of formal complaints received shows an overall decrease of five cases compared to the previous year as shown in Table 11 below.

Table 11: Complaints	
Date – Financial Year	**Complaints**
2014/2015	**501 Total** (428 Trust + 73 Community)
2013/2014	**506 Total** (439 Trust + 67 Community)
2012/2013	**457 Total** (376 Trust + 81 Community)
2011/2012	**483 Total** (399 Trust + 84 Community)

The main categories of complaints for 2014/15 are related to:

Table 12		
Issues	**Number of complaints**	**% Overall**
Access	3	0.50%
Aids & Equipment	4	0.75%
Administration	38	7.50%
Bed Management	18	3.50%
Communication	56	11%
Equality And Diversity	6	1.25%
Hospital Acquired Infection	3	0.75%
Information	2	0.50%
Premises And Facilities	4	0.75%
Staff Attitude	62	12.50%
Treatment Issues	258	51.50%
Waiting Times	47	9.50%

To help reduce the number of complaints within the Trust in 2014/15, lessons learned were discussed within the Divisional Governance meetings, the Learning from Incidents and Risks Committee and the Trust's monthly Complaint Review Panel to ensure recommended action plans were embedded in practice across the divisions, to support practice improvement and learning.

Divisions were also actively encouraged to arrange more face to face meetings with complainants so they could directly see and hear how their actions affected the patient. During 2014/15 92 meetings were held with complainants (11 after a final response and 81 before a final response), an increase of 19 from the previous year.

An e-complaint referral form was also introduced, encouraging staff to note down people's concerns at the point of origin so they could be resolved whilst they were still receiving treatment. This has led to an increase in the number of verbal complaints received in 2014/15 with 47% of the complaints coming from acute services, and 53% coming from community health services.

In cases where local resolution was exhausted the Trust would inform the complainant they had the right to contact the Health Service Ombudsman for an independent review of their complaint. During 2014/15 18 complaints were considered by the Ombudsman. Of these 18, the Ombudsman decided one case to be reported as partially upheld, one case not upheld, one case resolved via local resolution and 15 are still under consideration and classed as being 'referred to the second stage'.

Patient Relations Team Informal Complaints and Contacts

The aim of the Patient Relations Team, previously known as Patient and Liaison Service (PALS) is to offer a signposting service as well as to facilitate the resolution of concerns with services at the first stage of the complaint process.

There has been a 20% increase in the number of contacts the Patient Relations Team have had since they have moved to the main entrance foyer of Blackpool Victoria Hospital.

Table 13 below shows the number of issues dealt with by the by Patient Relations Team over the last few years.

Table 13: Informal Complaints

Date - Financial Year	Number of Informal Complaint Cases	Number of contacts overall
2014/2015	1,724	4,211 (3,825 were general enquiries)
2013/2014	1,798	3,517 (3,384 were general enquiries)

The number of informal complaints handled by the Patient Relations Team this year has decreased by 12%, when compared to 2013-14. However, the number of issues dealt with within individual informal cases has increased by 17% in comparison to the previous year, showing that more complex matters are being resolved at an informal level.

Of the 1,724 informal complaints received only 3% (45 cases) went through the formal complaint investigation process, with 97% of the cases received completed to the complainants satisfaction preventing the time, cost and resource required for the in-depth investigations. To help reduce the number of informal complaints within the Trust in 2015-16, a database has been set up internally so divisions can monitor and respond to enquiries from the Patient Relations Team electronically within 24 hours to prevent them from progressing to a formal complaint and being resolved sooner.

Out of the 3,825 general enquiries 3,727 have been resolved satisfactorally and 93 cases are ongoing or require final closure. The themes that have emerged from the all the general enquiries recorded are:

Table 14

Issues	Number of enquiries	% of enquiries overall
Access	45	1.00%
Administration	408	10.50%
Aids & Equipment	15	0.25%
Bed Management	44	1.00%
Bereavement Related	4	0.10%
Communication	170	4.00%
Equality & Diversity	9	0.25%
Hospital Acquired Infection	4	0.10%
Information	39	1%

Miscellaneous	2100	55%
Premises & Facilities	27	0.70%
Social Issue	3	1.00%
Staff Attitude	94	2.50%
Treatment	369	9.50%
Waiting Times	494	13%

3.4 Detailed Description of Performance on Quality in 2014/15 against Priorities in 2013/14 Quality Accounts

This section provides a detailed description regarding the quality initiatives that have been progressed by the Trust including both hospital and community services information based on performance in 2014/15 against the 2013/14 indicators for the following priorities:

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

3.4.1 Priority 1: Clinical Effectiveness of Care

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

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

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

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

- Improving the process of consultant sign-off for coding of deaths. The purpose of this is to ensure that all diagnoses attributed to a patient accurately reflects the prevalent condition. This allows us to identify areas of high mortality and plan appropriate action.
- Improved documentation processes to ensure safer handover of clinical care and ensure information is available to attribute accurate clinical codes.
- Engagement with Northwest area AQUA team to develop a definitive action plan for mortality improvement.
- Development of enhanced informatics tools for early identification of mortality issues
- Initiated a review of the compliance with agreed care pathways and care bundles within clinical areas.
- Detailed review of all mortality indicators with Chief Executive involvement.
- Developed new care pathways in areas identified within mortality metrics.
- Staff piloting new tools for identifying avoidable deaths in hospitals.

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), reduction in falls prevalence and reduction in hospital acquired pressure ulcers. Progress on all these objectives has been reported to the Board on a regular basis. The emphasis has been on improving processes so that the improvements are local, measurable and immediate and are owned by the team providing the care.

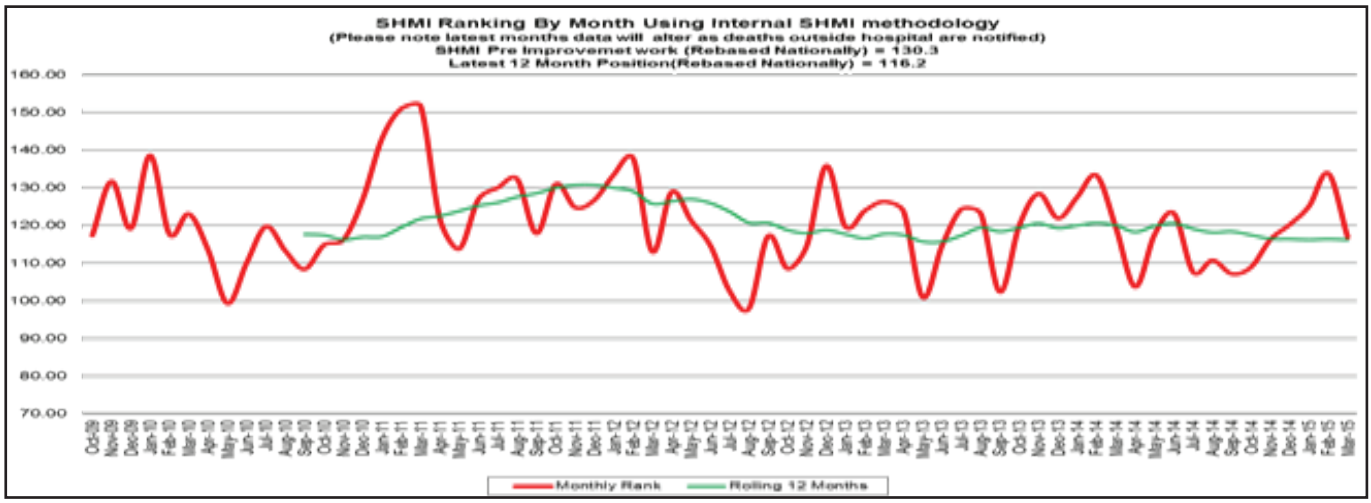
The Trust continues to be part of a North West Collaborative Programme for mortality reduction and has implemented programmes specifically around the care of patients with pneumonia and patients with severe sepsis. In addition to this work hospital mortality has been improved by the implementation of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

and improving the management of deteriorating patients and increased nurse to patient staffing levels.

Blackpool Teaching Hospitals was one of 14 Trusts identified for review in 2013 / 2014 by Sir Bruce Keogh as a persisting outlier on the national SHMI measure based on data from pre March 2012. The Trust welcomed this review and has continued its work on reducing mortality and improving care pathways which was commended when the Trust was inspected by the Care Quality Commision (CQC) in 2014.

Throughout 2014/2015 the organisation has worked through a focused action plan for improving patient care around the key themes of Governance and Leadership, Mortality, Patient Experience and Workforce and Safety.

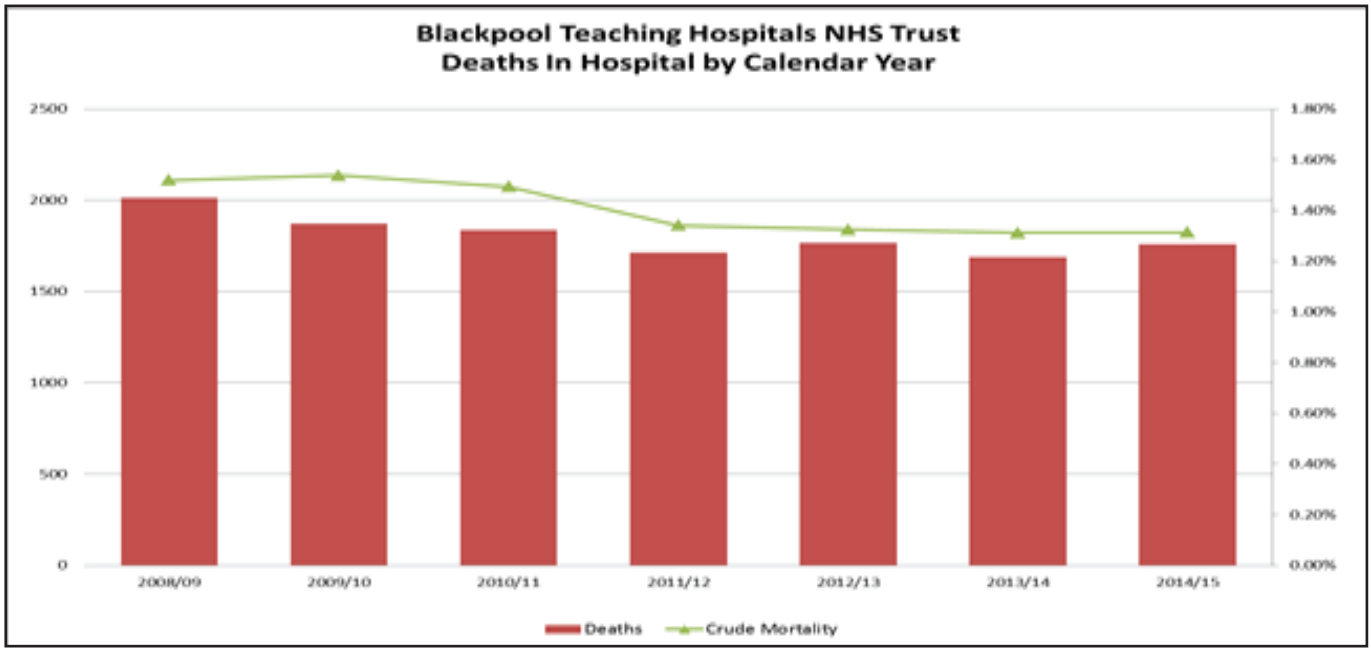
Graph 2



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

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

Graph 3



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

Graph 3 demonstrates that not only have improvements been made in Risk Adjusted Mortality Indicators but also the Trust has managed a reduction in the overall number of deaths and more significantly a reduction in the crude mortality rate (the percentage of patients that died in hospital compared to the total number of discharges from hospital).

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

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

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

Applying all the interventions will support our goals of reducing hospital mortality, reducing preventable harms and improving patient outcomes, thereby improving the quality of patient experience. Approximately 5,000 patients a year will benefit from this programme.

Table 15

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

Scheme	Threshold	Collection Period
Acute Myocardial Infarction (Heart Attack)	88.08%	Discharges which occur between 1st April 2013 and 31st March 2014
Hip and Knee Replacement Surgery	83.17%	
Coronary Artery By-pass Graft (CABG)	95%	
Heart Failure	77.85%	
Community Acquired Pneumonia	64.58%	
Stroke	54.80%	

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

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

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

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

Acute Myocardial Infarction (Heart Attack)
The Trust has always performed well against the advancing quality measure for Acute Myocardial Infarction (Heart Attack). A number of measures have been introduced to ensure compliance with all performance measures. The Trust achieved the CQUIN with a score of 89.89% as shown in Table 16.

A number of measures have been introduced to ensure that we meet all performance measures

which highlights that the Trust is working to a world class service. The Cardiac Specialist Nurses have ensured that all relevant data is collected and uploaded into the database and they check compliance with all measures.

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

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

Table 16

Acute Myocardial Infarction (Heart Attack)	Trust Performance			
Measure	**Apr 10 – Mar 11**	**Apr 11 – Mar 12**	**Apr 12 – Mar 13**	**Apr 13 – Mar 14**
Antiplatelet at arrival	100.00%	99.78%	99.65%	98.89%
Antiplatelet prescribed at discharge	100.00%	100.00%	99.74%	99.50%
ACEI or ARB for LVSD	100.00%	100.00%	98.91%	99.08%
Adult smoking cessation advice/counselling	96.61%	95.12%	96.73%	95.75%
Beta Blocker prescribed at discharge	98.79%	99.54%	99.01%	99.59%
Fibrinolytic therapy received within 30 minutes of hospital arrival			66.67%	
Primary Coronary Intervention (PCI) received within 90 minutes of hospital arrival	95.12%	91.50%	92.88%	91.71%
Evaluation of left ventricular function				97.48%
Statin prescribed at discharge				98.88%
Referral to Cardiac Rehab service				96.50%
Survival Index	90.80%	96.52%	98.52%	
Acute Myocardial Infarction (AMI) Composite Quality Score (CQS)	**97.98%**	**98.17%**	**98.54%**	
AMI - ACS				**89.89%**
CQUIN Threshold	95%	95%	95%	88.08%
The Trust had to achieve the CQUIN Threshold of 88.08%. The Trust met the CQUIN Threshold – we scored 89.89% (green)				

Hip and Knee Replacement Surgery

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

Both antibiotic and Venous Thrombo-Embolism prophylaxis is the subject of a set of departmental protocols.

Table 17

Hip and Knee Replacement Surgery	Trust Performance			
Measure	**Apr 10 – Mar 11**	**Apr 11 – Mar 12**	**Apr 12 – Mar 13**	**Apr 13 – Mar 14**
Prophylactic antibiotic received within 1 hour prior to surgical incision	97.96%	94.97%	93.13%	95.42%
Prophylactic antibiotic selection for surgical patients	99.59%	97.18%	91.06%	95.15%

Prophylactic antibiotic discontinued within 24 hours after surgery end time	96.64%	95.63%	97.13%	96.53%
Recommended Venous Thrombo-Embolism prophylaxis ordered	100.00%	99.11%	98.73%	99.60%
Received appropriate Venous Thrombo-Embolism (VTE) prophylaxis w/I 24 hrs prior to surgery to 24 hrs after surgery	100.00%	98.96%	98.73%	99.60%
Appripriate duration of VTE therapy post surgery				99.86%
Readmission (28 Day) avoidance index	92.50%	91.98%	94.78%	
Hip and Knee Composite Quality Score (CQS)	**97.78%**	**96.25%**	**95.54%**	
H&K - ACS				**91.11%**
CQUIN Threshold	95.00%	95.00%	95.00%	83.17%
The Trust had to achieve the CQUIN Threshold of 83.17%. The Trust met the CQUIN Threshold – we scored 91.11% (green).				

Coronary Artery Bypass Graft (CABG) Surgery
There are four Trusts undertaking Coronary Artery Bypass Graft Surgery within the North West, all of which have scored highly.

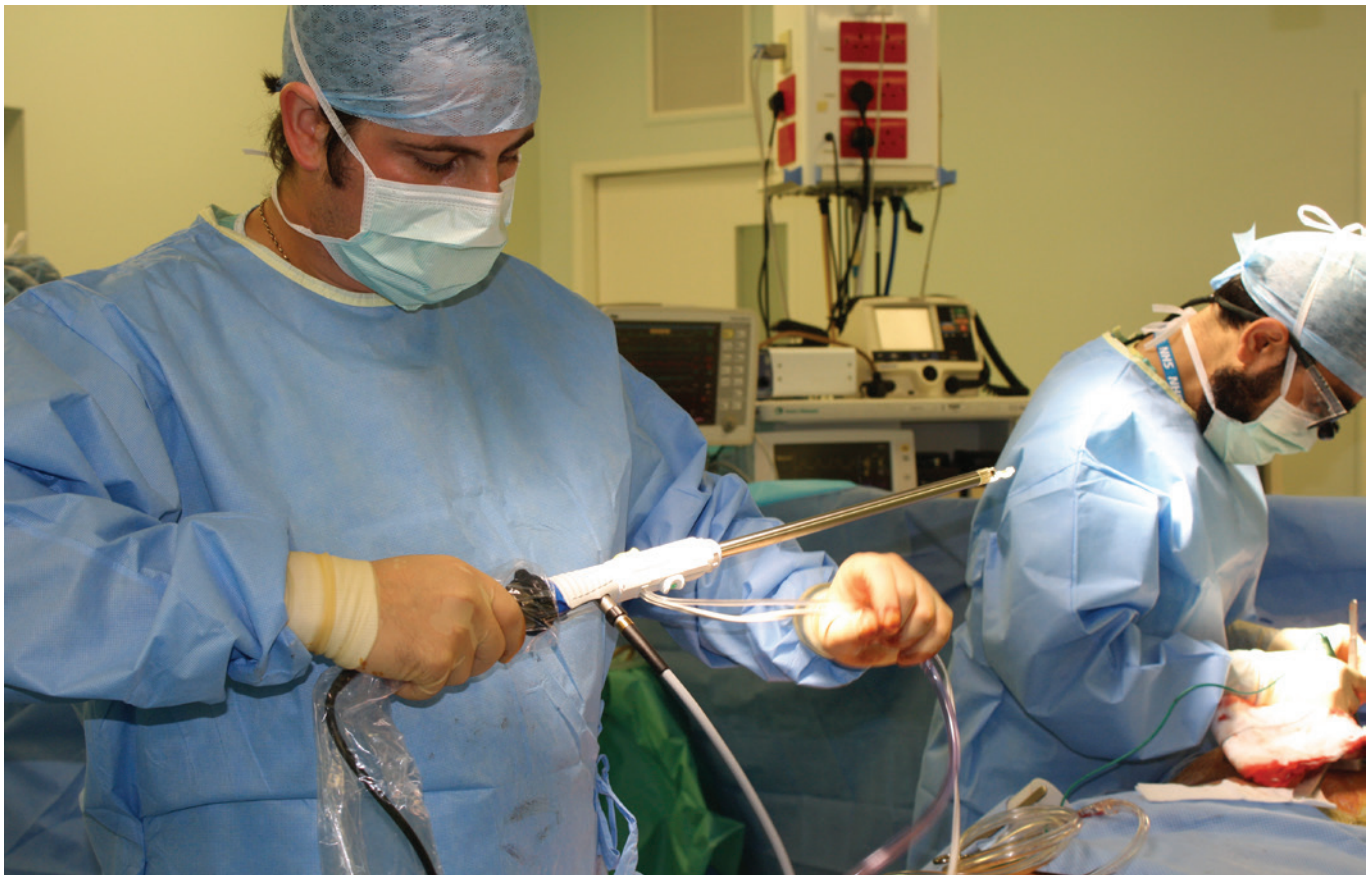
A number of actions have been introduced to further improve performance against the measures. Compliance with all measures has been sustained at over 90% - with the exception of Surgical Checklist Completed where we scored 88.36%. All data is collected and uploaded by a member of the administrative team working closely with the clinical lead.

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

All data is shared with the Consultant Team and Health Professionals at the monthly Directorate meeting and in the Divisional Governance meeting. The Trust failed the CQUIN target with a score of 80.59%, as shown in Table 18.

Table 18

Coronary Artery Bypass Graft Surgery	Trust Performance			
Measure	**Apr 10 – Mar 11**	**Apr 11 – Mar 12**	**Apr 12 – Mar 13**	**Apr 13 – Mar 14**
Antiplatelet prescribed at discharge	98.68%	99.30%	100%	99.85%
Prophylactic antibiotic received within 1 hr prior to surgical incision	95.59%	99.68%	98.52%	96.38%
Prophylactic antibiotic selection for surgical patients	98.30%	99.68%	99.59%	99.73%
Prophylactic antibiotic discontinued within 24 hrs after surgery end time	93.62%	90.42%	94.52%	94.20%
Internal mammary artery graft used				99.28%
Surgical checklist completed				88.36%
Statin prescribed at discharge				99.85%
Coronary Artery Bypass Graft Composite Quality Score (CQS)	**96.54%**	**97.23%**	**98.19%**	
CABG - ACS				**80.59%**
CQUIN Threshold	95.00%	95.00%	95.00%	95%
Year 3 - The Trust had to achieve the CQUIN Threshold of 95%. The Trust failed the CQUIN Threshold – we scored 80.59% (red)				



Heart Failure

The Trust has shown a continuous improvement in AQ performance in relation to the management of patients with Heart Failure - meeting the challenge of a move to measuring the appropriate care score (ACS) that asks that all measures are delivered to every patient.

The Heart Failure team ensure data is collected in a timely fashion, applying clinical expertise in the validation of clinical codes and discussing with coders and clinicians to improve diagnostic accuracy. They review notes of patients who have not been referred to them during an inpatient stay, resulting in failed AQ measures, ensuring that best practice is put in place for the benefit of patients at follow up.

Heart Failure Specialist Nurses attend the Acute Medical Unit (AMU) on a daily basis to identify any patients who have been admitted with Heart Failure. Previously many patients had moved through AMU before their review and were not always referred by the medical team on other wards managing the next stage of the patient journey.

The introduction of a rule out test for heart failure has lowered the threshold for diagnosis by clinical teams at admission and since the Heart Failure team review all patients with a positive result has significantly increased the chances of any patient with that diagnosis being seen by the specialist team early in their in-patient stay. The team are able to deliver initial assessment and advice in the majority of cases which ensures the delivery of AQ measures.The Consultant Cardiologist team provides clinical support to the nursing team.

Patients are triaged to a specialist cardiology ward or Coronary Care Unit (CCU) if not responding to standard treatment or critically unwell. This relies on the medical team who are managing the inpatient stay bringing this to the teams attention. It is hoped that in the future investment in the Heart Failure team will ensure that all patients admitted with heart failure are managed by the specialist team throughout their inpatient stay either in a cardiology ward or in reach to another ward in the presence of significant co morbidity. This would be in line with NICE guidance for acute Heart Failure published in October 2014.

New AQ measures are expected to recognise the importance of NICE guidance and improve the correlation between AQ compliance and patient outcome.

All data is shared with the Heart Failure team and Consultant Cardiologist with an interest in Heart Failure who provides feedback to clinical teams with regard to failed measures. The Trust was one of few trusts in the North West to achieve the CQUIN target with a score of 80.20% as shown in Table 19.

Table 19				
Heart Failure	**Trust Performance**			
Measure	**Apr 10 – Mar 11**	**Apr 11 – Mar 12**	**Apr 12 – Mar 13**	**Apr 13 – Mar 14**
Discharge instructions	34.43%	76.79%	81.01%	80.46%
Evaluation of LVS function	87.70%	96.40%	96.18%	99.20%
ACEI or ARB for LVSD	84.84%	92.88%	97.65%	96.04%
Adult smoking cessation advice / counselling	28.13%	76.79%	97.50%	92.31%
Beta blocker licensed for HF prescribed at discharge				96.35%
Patient reviewed by a HF specialist				91.06%
Heart Failure Composite Quality Score (CQS)	**65.94%**	**88.37%**	**91.14%**	
HF - ACS				**80.20%**
CQUIN Threshold	65.34%	75.08%	82.24%	77.85%
The Trust had to achieve the CQUIN Threshold of 77.85%. The Trust met the CQUIN Threshold – we scored 80.20% (green)				

Community Acquired Pneumonia

The figures in Year 13/14 clearly show that the Trust has continued to make significant progress compared to year one. A number of improvement measures have been implemented including the introduction of Advancing Quality Pneumonia Quality Cards, which is a credit card sized reminder for all medical staff of what is required in terms of ensuring high quality patient care for patients suspected of having Community Acquired Pneumonia. An e-learning tool has also been launched for all medical staff to complete ensuring that they are fully aware of the need to deliver Advancing Quality measures for pneumonia.

Multidisciplinary meetings continue with nurses and managers from the Accident and Emergency Department, the Acute Medical wards and the Medical specialties. Performance is openly discussed at these meetings and recent clinical cases are reviewed in order that areas for improvement can be identified.

The Trust achieved the CQUIN target with a score of 79.38% as shown in Table 20.

Table 20				
Community Acquired Pneumonia	**Trust Performance**			
Measure	**Apr 10 – Mar 11**	**Apr 11 – Mar 12**	**Apr 12 – Mar 13**	**Apr 13 – Mar 14**
Oxygenation assessment	99.81%	100%	100%	100%
Blood Cultures performed in A&E prior to initial antibiotics received in hospital	80.35%	77.82%	81.97%	
Adult smoking cessation advice / counselling	39.26%	50.00%	58.67%	82.12%
Initial antibiotic received within 6 hrs of hospital arrival	79.24%	83.60%	87.53%	83.37%
Initial antibiotic selection for Community Acquired Pneumonia in immune-competent patients	99.68%	100%	99.48%	99.51%
CURB-65 score		75.63%	87.25%	86.56%

Community Acquired Pneumonia Composite Quality Score (CQS)	**86.29%**	**85.74%**	**90.77**	
Pneumonia - ACS				**79.38%**
CQUIN Threshold	78.41%	84.81%	87.39%	64.58%
The Trust had to achieve the CQUIN Threshold of 64.58%. The Trust met the CQUIN Threshold – we scored 79.38% (green)				

Stroke

In 2014/15, the target for Blackpool Teaching Hospitals was an Appropriate Care Score (ACS) of 62%. Between April 2014 and February 2015, the Trust's performance was 63.4%, achieving the CQUIN target in the year to date. There have been considerable improvements across each of the measures and a robust system is in place to monitor performance on a weekly basis, allowing individual teams to make improvements based on real time patient information. In 2013, the Stroke Ward was relocated to a purpose developed unit with specialist equipment and therapy areas. In order to further improve the performance for these measures and ensure that patients get the best possible care throughout their pathway, new models of care are being developed to improve staffing and joint working across medical, nursing and therapy teams on the Stroke Unit.

Data for Advancing Quality measures is three months in arrears and therefore 2014/15 data is not available.

Performance for 2013/14 of Blackpool Teaching Hospitals NHS Foundation Trust shows Appropriate Care Score (ACS) as 46.00%, which is below the CQUIN target of 54.80% as shown in Table 21 below.

Table 21

Stroke (New Target Introduced October 2010)	**Trust Performance**			
Measure	**(1.10.2010 – 31.3.2011)**	**(Apr 11 – Mar 12)**	**Apr 12 – Mar 13**	**Apr 13 – Mar 14**
Stroke Unit Admission	41.92%	74.19%	66.67%	73.48%
Swallowing Screening	97.77%	97.96%	95.73%	88.77%
Brain Scan	68.15%	84.41%	95.21%	84.07%
Received Aspirin	90.71%	99.09%	96.32%	74.77%
Physiotherapy Assessment	98.48%	96.69%	95.81%	91.99%
Occupational Assessment	97.01%	95.47%	92.88%	77.23%
Weighed	98.15%	98.49%	95.99%	92.68%
Stroke Composite Quality Score (CQS)	**83.65%**	**92.07%**	**89.34%**	
Stroke Appropriate Care Score (ACS)	**34.27%**	**68.11%**	**57.74%**	**46.00%**
CQS - CQUIN Threshold	90%	90%	90%	
ACS - CQUIN Threshold	50%	50%	50%	54.80%
Year 1 – The Trust had to achieve two CQUIN Thresholds – CQS target of 90% and ACS target of 50% The Trust did not achieve the CQUIN Threshold – we scored 83.65% (CQS) and 34.27% (ACS) (red = no payment received). This was due to patient's not being admitted to the Stroke Unit within 24 hours of suffering a TIA and not having a brain scan within the appropriate timescale.				
Year 2 – The Trust met the CQUIN Threshold – target 90% / 50% and we scored 92.07% / 68.11%.				
Year 3 – The Trust achieved the ACS CQUIN target but failed the CQS CQUIN target.				
2013/2014 – The Trust failed the ACS target				

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

Dementia is a progressive condition which may include memory loss, confusion, difficulties with thinking, problem solving or language abilities. As a consequence people suffering from dementia are less able to care for themselves. Dementia can also be a lonely and frightening condition, often devastating for the patient who may be acutely aware of all those areas in which they are no longer competent.

In England, dementia currently affects over a half a million people and it is expected that this number is set to rise considerably as people live longer and the occurrence of dementia increases with age. Dementia accounts for over sixty thousand deaths a year, and the current cost to the NHS is estimated at £1.3 billion a year. It is however thought the actual figure is considerably higher because a large proportion of people with dementia are undiagnosed or are admitted to hospital with a diagnosis not related to their dementia and so the dementia is not coded.

The importance of dementia care has been highlighted in recent Government policy and has reflected the need for increased awareness of healthcare professionals to effectively care and support dementia sufferers and their carers. The importance of this has been reflected by the appointment of a national clinical director for dementia and the publication of the first national dementia strategy in 2009.

The national dementia strategy highlights the need to improve care for people with dementia in hospital. At the Trust, we take the care needs of people with dementia and their carers seriously. We want to do our best to ensure that patients and their carers are given the understanding and support they need by everyone they come into contact with. This is reflected in the work we have taken, and continue to take, to improve the care experience for our patients.

The Trust has a three year Care and Compassion Strategy which sets out a professional direction for Nurses, Midwifes, Health Visitors and Therapists and also reflects our local adoption of the Chief Nursing Officer, NHS England Strategy – 'Our Culture of Compassionate Care'.

Since 2013 colleagues have been involved in the development of the Compassionate Care Strategy through conversation and workshops and this has been an important time to ensure that our strategy reflects our shared ambitions to develop and improve care for all our patients.

The delivery of compassionate and safe care is driven by a shared and 'common' set of values that all staff can identify with and ensure they role model in day to day practice. This is supported by delivery of the "6 C's – Care, Compassion, Communication, Courage, Competence and Commitment" within the framework of five key areas:

- Patient Safety.
- Patient Experience.
- Clinical Quality.
- Leadership.
- Workforce and Education.

Delivery of care within this framework has supported the Trust to drive forward and improve the care of people with dementia and their carers.

Improvements to date

- Identification of a lead clinician for Dementia Care.
- Development and implementation of our Vision and Strategy – An Approach for Dementia Care.
- Development of our Dementia Advisory Board to facilitate the implementation of quality improvements.
- Implementation of the Butterfly Scheme – to identify and support patients with dementia during their hospital stay.
- Comfort boxes on each ward to support cognition.
- Paint me a picture initiative – to support staff 'know' the patient behind the dementia, their likes, dislikes etc.
- A 72 metres memory corridor with triggering scenes and sounds.
- Collaborative working with the Blackpool Carers' Centre to support carers of people with dementia.
- Collaborative working with the Social Enterprise 'Pictures to Share'.

- Introduction of the National Dementia Screening Tool for all patients over 75 years of age admitted to the hospital.
- Registration in the RCP National Audit of Dementia Care.
- Utilisation of pop up reminiscence rooms (rem pods) which turn any care space into a therapeutic and calming environment.

Improvements in 2014/15

- Implementation of guidance on the use of pharmacology in dementia care.
- Identification of a 'Dementia Champion' for each ward and department.
- Identification of dementia buddies for each ward and department.
- Introduction of 'twiddle muffs' for people with dementia.
- Training for staff in dementia awareness and care.
- Collaborative working with the Institutes of Higher Education to support skills and competency of 'Dementia Champions'.
- Environmental enhancements to provide dementia friendly environment at Clifton Hospital.
- Revision and review of processes to improve assessment of all admitted patients over 75 years of age.

Training Undertaken in 2014/15

- Tier 1 training has been undertaken and recorded on the OLM system for 251 staff.
- Collaborative work with Unison in the delivery of 'Dementia Day' to 50 staff.
- 20 staff trained at level 6/7 with University of Cumbria in Dementia Awareness and Care.
- Dementia care training incorporated into the extended induction for all overseas nurses on commencement (29 staff).
- Two sessions of Dementia Care training provided by Dr Mark Taylor for medical staff.
- Dementia Care training for all junior medical staff on induction.

Dementia Assessment Performance 2014/15

Table 22

Quality – Patient Safety	2013-14 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Target
% of dementia assessments completed – screening question	65.20%	58.90%	64.50%	75.60%	77.60%	58.80%	65.70%	91.90%	91.70%	91.30%	91.30%	93.50%	92.2%	90%
% of initial dementia assessments completed – dementia assessment (AMTS10)	77.60%	58.50%	50%	58.60%	85.30%	100%	93.80%	97.00%	97.60%	93.80%	95.00%	92.30%	100%	90%
% of initial dementia assessments completed – referral for memory clinic	0%	53.80%	33.30%	26.30%	23.10%	12.50%	100%	100%	100%	100%	100%	100%	100%	90%

Improvements planned for 2015/16

- Review and revision of the Dementia Care strategy.
- Further Tier 1 training for all staff groups.
- Two further Unison 'Dementia Care' sessions.
- A further 40 staff trained at level 6/7 in dementia Awareness and Care at our local Institutes of Higher Education.
- Dementia Champions to carry out further training of the implementation of the Butterfly Scheme.
- Review of e-learning availability/feasibility to promote widespread awareness and training.
- Align of recording of all staff undertaking dementia awareness and care training with OLM.
- Introduction of the 'Dementia Friend' scheme.
- Enhanced cross organisational working with Alzheimer's Society.
- Dementia Awareness Campaign linked to

Dementia Awareness Week.

- Completion of RCP National Audit of Dementia Care.
- Improvements to patient ward environments

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

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

The results are obtained from a monthly spot prevalence audit which rotates between specialities. Each speciality is audited twice a year, with six months between each audit. This enables us to review a sufficient sample size of case notes for each consultant (typically 40 sets).The Indicators are based on a set of common questions combined with a few questions that are related to each particular speciality. The common questions relate to medical documentation, antibiotic prescribing, DNARCPR, Consultant review and care planning, VTE risk assessment and mortality.

Reports are circulated to the Medical Director, Divisional Management Teams and the individual speciality teams. They are reviewed at the Clinical Policy Forum and the results are used to drive improvement.

Between April 2014 and October 2014 the number of criteria audited were increased. It is therefore not feasible to compare trends between audits, hence the overall range of scores and median score given by speciality, are presented below in Table 23.

Table 23

Speciality	Number of Consultants	Score range		Score median
Orthopaedics	11	54%	89%	80%
Ophthalmology	6	59%	99%	91%
Cardiology	13	51%	84%	73%
Urology	5	61%	92%	74%
Acute	5	73%	82%	78%
Care of the Elderly	4	73%	86%	74%
Endo & Diabetes	3	72%	78%	75%
Gastro	5	59%	79%	73%
Gen Med	1	67%	67%	67%

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

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

By benchmarking our nursing care across the Trust, we can increase the standard of nursing care that we provide, so that best practice is shared across all wards and departments. The measures are made visible in the ward environment and therefore by using this system we can ensure that accountability is firmly placed on the nurses providing bedside care. We have learned from this process and as a result have made significant reductions in patient harms. Compliance with nursing care indicators such as recording of observations and completion of risk assessments associated with the development of pressure ulcers have ensured that our frontline nurses can see the efforts of their work and make the link

between the effective assessment and treatment of patients and improved outcomes. By improving the monitoring of vital signs we have reduced harms from deterioration and failure to rescue rates. By including the care of the dying indicators we have improved our referral times to palliative care services and the way that our staff interacts with relatives at this difficult time.

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

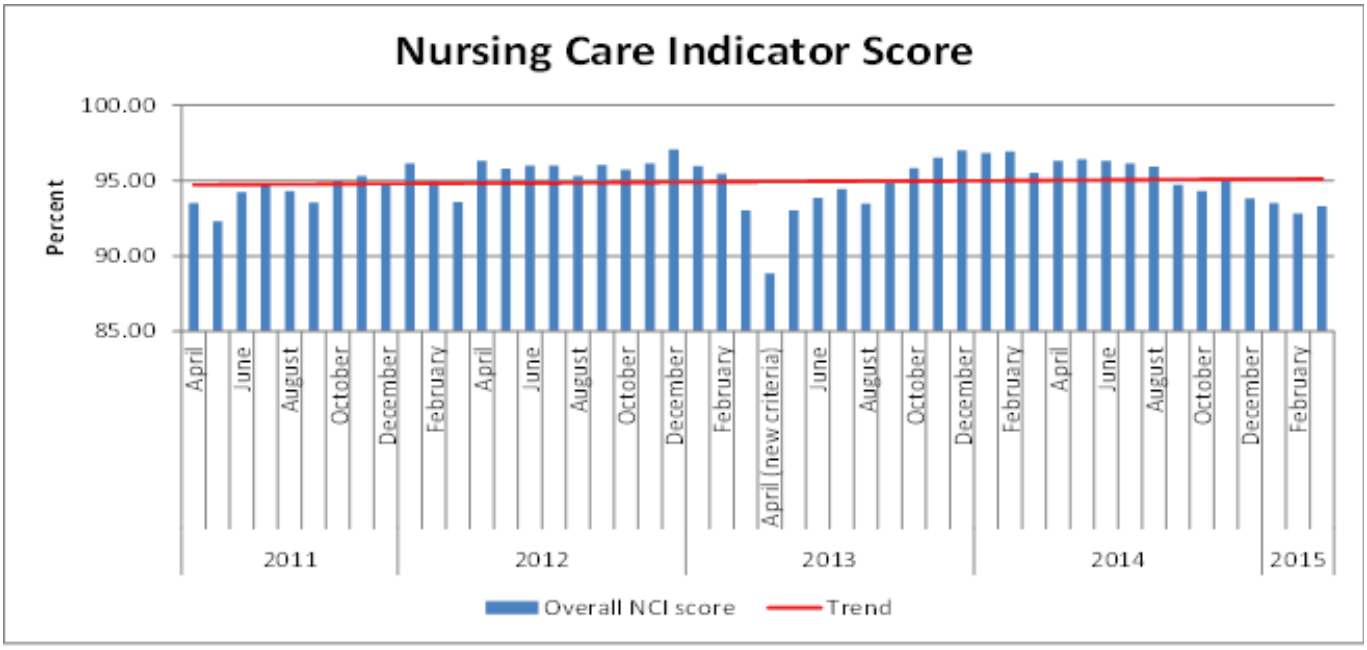
In the development of the Nursing Care Indicators, key themes for measurement were identified from complaints, the Patients' Survey, the Trust documentation audit, the benchmarks held within the essence of care benchmarking tool, and assessments against Trust nursing practice standards. Measurement of the Nursing Care Indicators is an evolving process and is subject to annual internal review to ensure the indicators reflect current best practice and they are expanded into non ward based areas. In 2014 the criteria for all the indicators was reviewed and amended to reflect changing best practice.

The following themes are measured monthly:

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

Graph 4 shows the overall Trust performance, expressed as an average percentage of all 11 nursing care indicators, for 2014/15. The variation in scores seen is the type expected in a normal process.

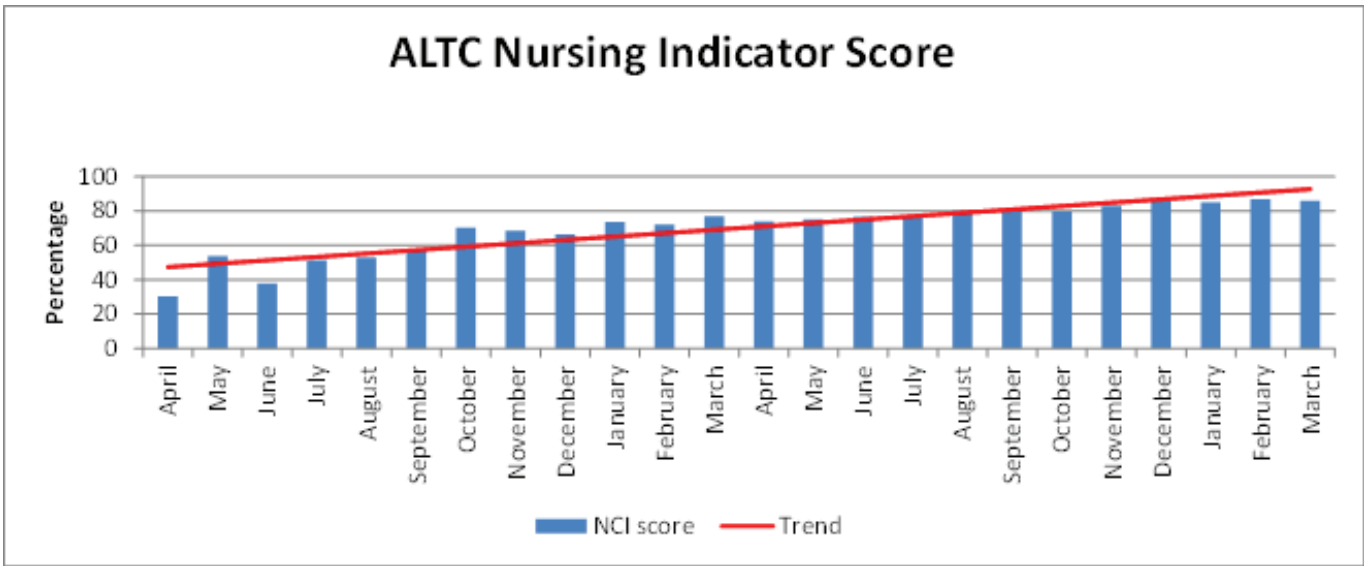
Graph 4



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

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

Graph 5



Data source: Ward-based prevalence audit of clinical records. This data is governed by standard national definitions
The trend shows an overall improvement over the period.

Improving Outcomes from Planned Procedures

Patient Reported Outcome Measures (PROMS)
Patient Reported Outcome Measures (PROMs) have been collected nationally since April 2009. Trusts who provide four key elective surgeries for the English NHS invite patients to complete questionnaires before and after their surgery. The PROMs programme covers four common elective surgical procedures: groin hernia operations, hip replacements, knee replacements and varicose vein operations.

The Trust Participation rates in the PROMS surveys are shown in Table 24.

Table 24: Participation Rates		
Date	**Trust participation rate (full year)**	**National participation rate (full year)**
2011/2012	70.50%	74.7%
2012/2013	66.10%	75.5%
2013/2014*	45.90%*	77.7%*
2014/2015*	24.00%*	76.7%*

** Provisional figures – participation data not completed yet.*

The comparison data for PROMS between 2012 -13 (April 2012 - March 2013) and Provisional PROMs Data 2013-2014 (April 2013 - March 2014) is shown in Table 25. The positive scores are highlighted in green and the negative scores are highlighted in red.

Table 25:									
Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2012 -13 (April 2012 - March 2013) and Provisional PROMs Data 2013 - 2014 (April 2013 - March 2014)									
Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2012 -13 (April 2012 - March 2013) and Provisional PROMs Data 2013 - 2014 (April 2013 - March 2014)									
Percentage Improving	Measure								
	EQ-5D Index 2012-13	EQ-5D Index 2013-14	Variance	EQ-VAS 2012-13	EQ-VAS 2013-14	Variance	Condition Specific 2012-13	Condition Specific 2013-14	Variance
Groin Hernia	44.8%	42.90%	-1.9%	39.0%	37.70%	-1.3%	N/A	N/A	N/A
Hip Replacement	86.0%	80.90%	-5.1%	65.4%	57.00%	-8.4%	95.50%	94.80%	-0.7%
Knee Replacement	79.6%	74.50%	-5.1%	58.2%	47.80%	-10.4%	89.40%	90.90%	1.5%
Varicose Vein	50.0%	43.50%	-6.5%	38.9%	13.00%	-25.9%	88.20%	81.80%	-6.4%

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2012 -13 (April 2012 - March 2013) and Provisional PROMs Data 2013 - 2014 (April 2013 - March 2014)									
Percentage Getting Worse	Measure								
	EQ-5D Index 2012-13	EQ-5D Index 2013-14	Variance	EQ-VAS 2012-13	EQ-VAS 2013-14	Variance	Condition Specific 2012-13	Condition Specific 2013-14	Variance
Groin Hernia	19.8%	38.10%	18.3%	42.6%	42.0%	-0.6%	N/A	N/A	N/A
Hip Replacement	2.8%	12.40%	9.6%	22.6%	33.70%	11.1%	4.50%	3.1%	-1.4%
Knee Replacement	10.8%	8.50%	-2.3%	27.8%	32.60%	4.8%	9.00%	9.10%	0.1%
Varicose Vein	11.6%	34.80%	23.2%	47.8%	73.90%	26.1%	11.80%	18.20%	-6.4%

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

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

The Trust has been working with its health economy partners to implement strategies to reduce readmissions.

The Trust considers that this data is as described for the following reason in that it shows that the work being undertaken across the health economy has started to impact on the percentage of readmissions.

The Trust has taken the following actions to improve this percentage and so the quality of its services:

- Joint work with Clinical Commissioning Groups to identify and implement health economy wide readmission avoidance schemes, including single point of access services to ensure patients access the most appropriate care, improvements to discharge and on-going care planning.
- A clinically led review of readmissions to identify/implement actions required to reduce the number of avoidable admissions is planned for the 2015/16 financial year.

Table 26: 28 Day Readmissions						
Indicator	Trust 2012/13	Peer 2012/13	Trust 2013/14	Peer 2013/14	Trust 2014/15	Peer 2014/15
All Admissions	6.4%	6.8%	8.2%	6.6%	8.2%	CHKS data no longer available
Non-elective	10.8%	10.7%	13.1%	10.4%	13.0%	
Elective	3.3%	3.1%	3.4%	3.1%	3.7%	

3.4.2 Priority 2: Quality of the Patient Experience

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

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

National inpatient surveys are carried out on an annual basis as part of the Care Quality Commissions NHS survey programme, to look at trends in health care organisations over time and to help to focus attention on improvements and on those areas where performance might be slipping. Each year surveys are sent from the Picker Institute Europe between June-August to 850 recent inpatients at each NHS Trust. The number of responses received from our Trust in the last few years is:

Table 27

Year	Number of responses	National response rate
2014	344 (42%)	45%
2013	369 (45%)	49%
2012	426 (53.5%)	48%

The Trust has risen in performance by 19 places in this period to the 22nd position out of 78 Trusts who are surveyed by Picker as part of the national survey programme. Whilst the survey has been adapted to include new locally important questions over the years five questions have remained consistent which relate to key issues that are of great importance to the Trust Board and/or have been identified by our patients' as being the most important to them.

Table 28 shows a comparison of data for these five questions from 2012 to 2015 and progress remains consistent.

Table 28: Care Quality Commission National Inpatient Survey

Indicator	2011/12 Results	2012/13 Results	2013/14 Results	2014/15 Results	Comparison to last year's results
Were you involved as much as you wanted to be in decisions about your care and treatment?	87.3% said yes often or yes sometimes	82.6% said yes often or yes sometimes	84.8% said yes often or yes sometimes	90% said yes definitely or yes to some extent	↑
Did you find someone on the hospital staff to talk to about your worries and fears?	52.2% said yes definitely or yes to some extent	75.4% said yes definitely or yes to some extent	76.9% said yes often or yes sometimes	76% said yes definitely or yes to some extent	↓
Were you given enough privacy when discussing your condition or treatment?	89.2% were always or sometimes	91.3% were always or sometimes	89.9% were always or sometimes	96% said yes definitely or yes to some extent	↑
Did a member of staff tell you about medication side effects to watch for when you went home?	55.7% said yes completely or yes to some extent	51.5% said yes completely or yes to some extent	57.4% said yes completely or yes to some extent	61% said yes definitely or yes to some extent	↑
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67.3% said yes	66.7% said yes	73.7% said yes	73% said yes	↓

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

Improve Staff Survey Results in the Following Area

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

The Trust implemented the Staff Friends and Family Test (FFT) in June 2014. The association between engaged staff and positive patient experiences is clear. Research has shown a strong relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the Trust generally.

The Trust has developed a Workforce Strategy which has a focus on staff engagement. This has been developed with our staff and has resulted in the launch of revised Trust Vision and Values. In order to share, enhance and integrate the Trust values, a Best Place to Work group has been set up with representation from across the organisation. Four sub-groups have been established to focus more intently on the following elements: Culture change – two way engagement; Dynamic and effective leadership; Recruitment and Retention; Open culture. These groups will be responsible for ensuring we maximise our opportunities with the Staff FFT and staff survey and work together to devise action plans to drive improvements.

The latest results from the Staff FFT (Quarter 2) demonstrate that 76% of our staff would recommend the Trust to their family and friends if they needed care or treatment. This has increased from 73% in Quarter 1.

Table 29: Staff FFT

Indicator	Quarter 1 Trust Result	Quarter 1 National Average	Quarter 2 Trust Result	Quarter 2 National Average
Percentage of staff who would recommend the Trust to their friends or family if they needed care or treatment	73%	79%	76%	N/A Data not published until 28th May

Data source: Staff Friends and Family Test carried out by Picker Institute Europe, an independent organisation. This data is governed by standard national definitions.

Report on Friends and Family Test

The NHS Friends and Family Test (FFT) was first introduced in April 2013 to acute inpatient areas, and the Emergency Department, and then was implemented across all maternity services in October 2013, as part of NHS England's (2014) business plan 'Putting People First'.

The Test was launched to improve patient care and identify the best performing hospitals in England by asking patients "How likely are you to recommend our ward/ accident and emergency department / maternity service to friends and family if they needed similar care and treatment?" Followed by a follow up question to obtain patient feedback that can be used to help drive improvements in services.

The FFT is an overarching indicator of patient experience, which when combined with the follow up question can be used to drive cultural change and result in an increased focus on the experiences of patients.

By the end of December 2014, the FFT was rolled out to all of our mental health and community services, and by 31st March 2015 it was implemented across all of the Trust's outpatient and day case areas, children and young people's services and local dental care, ensuring every patient now has the opportunity to provide feedback on the care they have received in real time.

In 2014/15 patients have commented on the treatment and care they have received by filling in a paper survey and placing it in a comments box before discharge or completing a survey electronically via the Trust website, interactive voice messaging, SMS texting or using the specialist app which was developed initially in the community.

Between April 2014 to October 2014 the Trust was marked monthly for FFT using a net promoter score from minus 100 to plus 100, based on the following calculation:

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

The Trust scores and response rates for this period are detailed in Table 30 below.

Table 30: Friends and Family Test

Month	Trust Overall score	Responses	Inpatient Response Rate	Emergency Department Response Rate	Maternity Response rates
April	72	2563	43.8%	22.2%	22%
May	72	2019	33.5%	16.7%	21.8%
June	73	2131	40.7%	17.2%	19.45%
July	74	1908	44.3%	13.2%	14.2%
August	75	1890	43%	13.7%	17.8%
September	76	2162	48.7%	17.7%	14.3%

In October 2014 there was a move away from the Net Promoter Score (NPS) and the introduction of a simpler scoring system in order to increase the relevance of the FFT data for NHS staff, patients and members of the public.

The Trust now calculates and presents the FFT results as a percentage of respondents who would/ would not recommend the service to their friends and family. The Trust scores and response rates from this period are detailed in Table 31 below.

Table 31: Friends and Family Test

Month	% who would recommend	Responses	Inpatient Response Rate	Emergency Department Response Rate	Maternity Response rates	Community response rates
October	91%	2190	37.5%	22.9%	18.5%	91%
November	95%	1883	44.45%	15.8%	14.9%	95%
December	95.97%	1740	40.2%	16.4%	5.7%	95.97%
January 15	95.57%	1982	40.7%	19.8%	23.7%	95.57%
February 15	94%	3435	45.6%	19.6%	27%	94%
March 15	93.84%	3007	45.9%	19.3%	19.2%	93.84%

There was no baseline response rate or financial incentives attached to community and mental health services like for other areas as NHS England wanted to give the new system time to bed in and to deal with any issues that may arise. However their performance is summarised below in Table 32.

Table 32

Month	% who would recommend	Responses
January 15	96.4%	332
February 15	93.77%	1128
March 15	93.36%	994

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

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

As part of the Trust wide ward based training project Transforming End of Life Care we are asking for feedback from patients and their families about their experiences of care whilst in hospital. In particular, we are asking about whether they were involved in decisions about their care and asked whether they are getting the care that matters to them. Most patients felt that they were involved in decisions about their care and that their personal wishes were taken into account.

Feedback from the survey has indicated that patients feel that staff treated them with compassion and with dignity. The majority of families surveyed felt that they were involved in their loved ones care. We are continuing to support staff to provide holistic patient and family centred care.

As part of our work to improve care for the dying person we are developing diaries to give families the opportunity to record their feelings and thoughts which can facilitate further discussion with staff.

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

The Trust wide ward based training project Transforming End of Life Care has the overarching aim to increase the quality of end of life care for patients and their families. As an integral part of this we are training staff to identify patients who may be within the last few months of life. This allows patients the opportunity to discuss their preferences for their future care, which may include whether they would like to be cared for in their usual place of residence which could be home or a care home.

On the wards where training has been implemented there has been an increase in the number of patients discharged to their preferred place of care and a significant reduction in the number of patients re-admitted as an emergency in their last 100 days of life.

Patient Led Assessment Of The Care Environment (PLACE)

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

Our aim is to deliver the best environment for our patients to ensure that the patient experience exceeds the standards set by the Health and

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

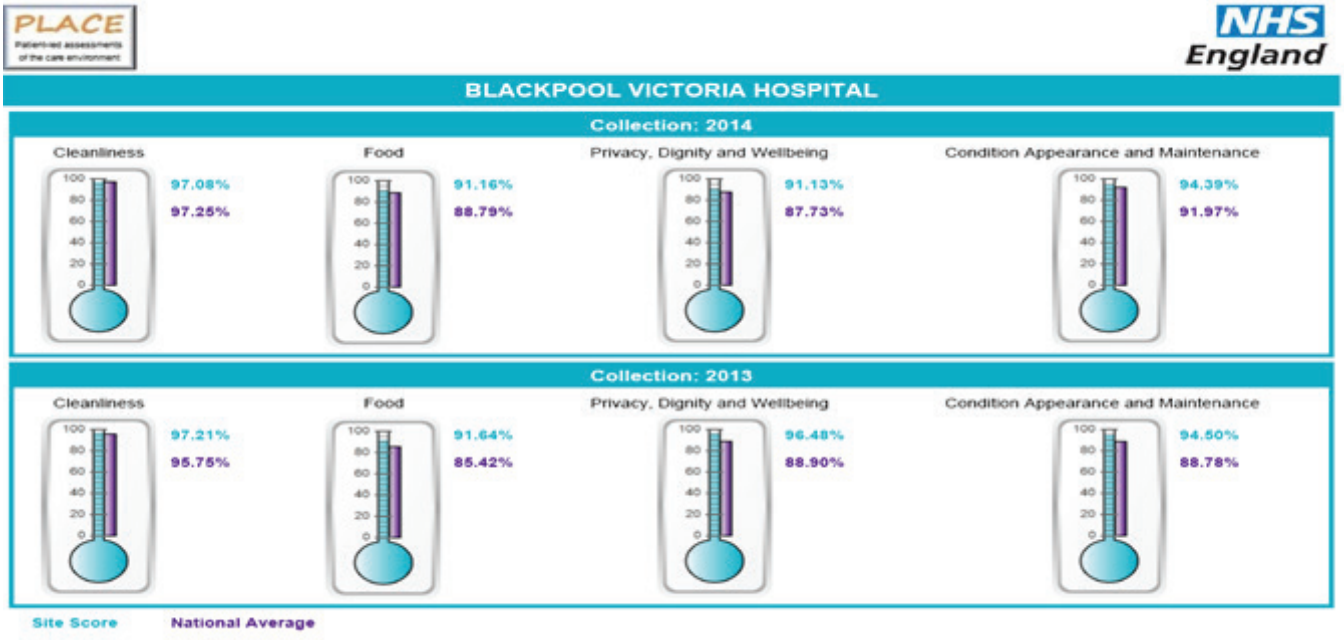
The teams comprise of a multidisciplinary team, led by patient representatives who conduct annual audits regarding the quality of standards we provide to our patients. The key areas which are audited are:

- Cleanliness.
- Specific bathrooms/toilet cleanliness.
- Food and Hydration.
- Condition, Appearance and Maintenance.
- Infection Prevention.
- Privacy and Dignity and Wellbeing.

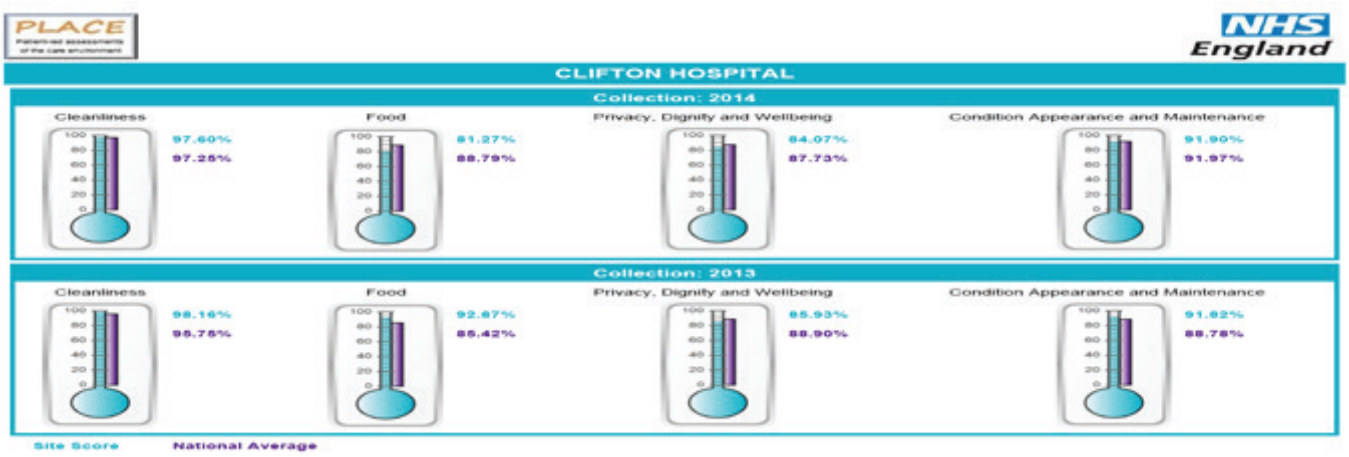
The audit follows guidelines set by the Health and Social Care Information Centre and the results are publicised nationally on an annual basis. In 2014, PLACE audits were extremely encouraging across all hospital sites resulting in excellent standards achieved. The results in Graph 6 and Graph 7 demonstrate 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.

PLACE audits for 2015 have been undertaken at Blackpool Victoria Hospital and Clifton Hospital. The scores have been submitted for validation. Final scores will be shared with the Trust in July and published in September 2015.

Graph 6: Patient Led Assessment of the Care Environment (PLACE)



Graph 7: Patient Led Assessment of the Care Environment (PLACE)



Key: Blue data indicates Trust scores, purple data indicates National Average.
Data source: Local data from the Patient – Led Assessment Care Environment survey. This data is governed by standard national definitions set by the Health and Social Care Information Centre

3.4.3 Priority 3: Patient Safety

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

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

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

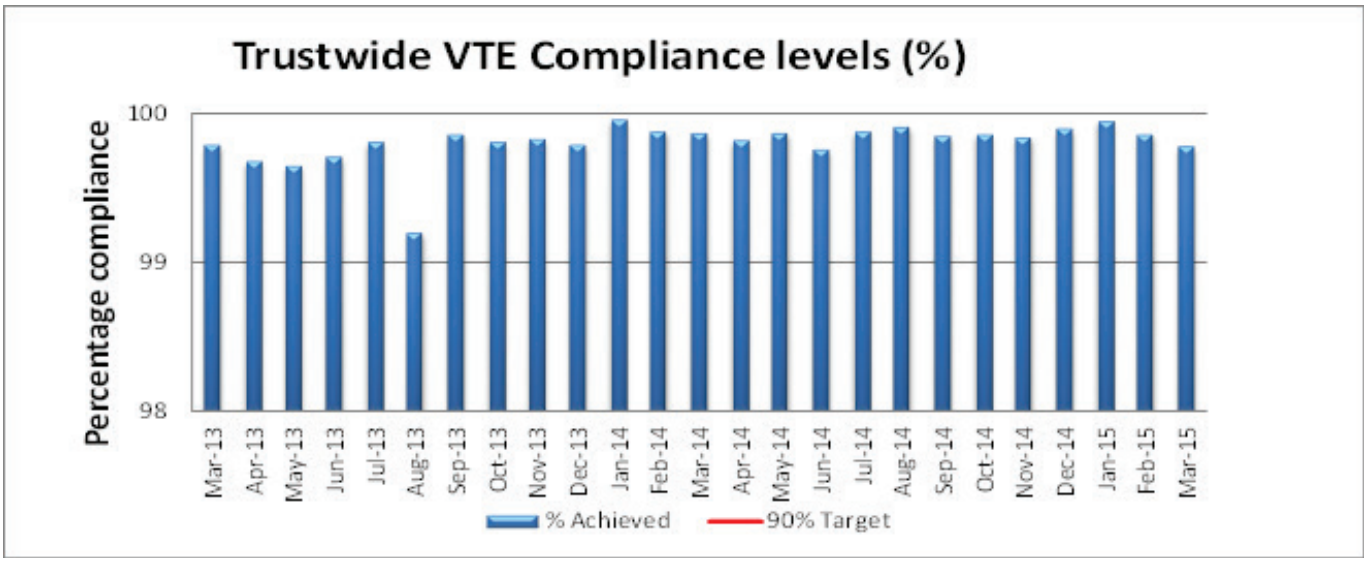
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has aimed to implement current best practice guidelines in order to ensure that all adult inpatients receive a Venous Thrombo-Embolism Risk Assessment on their admission to the hospital, and that the most suitable prophylaxis is instituted. The Trust has embedded and improved the implementation of VTE guidelines within the Trust and has demonstrated this by achieving above the new 95% compliance indicator. We have been able to sustain previous improvement as shown by latest figures from March 2013 to March 2015 as shown in Graph 8.

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

- A senior clinician and a senior nurse have been identified to provide leadership to facilitate ongoing improvements in compliance with Trust processes and consequently improvements in patient care with regards VTE. The National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92) has been incorporated into easy to follow risk assessment forms across various specialties and is an integral part of clerking documents. This will not only ensure that VTE risk assessments are undertaken and embedded permanently in the admission pathway but also facilitates its documentation for subsequent analysis.
- The Trust meets the national requirement for compliance with undertaking VTE assessments. To ensure sustainability of this standard an annual audit is undertaken.

Graph 8



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

- **Compare the VTE national average for the above percentages**
  - The national average proportion of patients reported as having VTE risk assessed from the national Safety Thermometer 2014/15 is 45.8%. The average proportion of acute patients reported as having VTE risk assessed from the BVH Safety Thermometer is 93.7%.
- **Achieve a 10% reduction on the previous year in all VTE**
  - In 2013/14, based on Safety Thermometer data, 285 out of 9,054 hospital in-patients were reported as having an Old or New VTE (3.15%). In 2014/15, 289 out of 8,830 hospital in-patients were reported as having an Old or New VTE (3.27%). The increase in the proportion of patients reported as having an Old or New VTE from last year to this year is therefore 3.8%.
  - In 2013/14, based on Safety Thermometer data, 65 out of 9,054 hospital in-patients were reported as having a New VTE (0.72%). In 2014/15, 56 out of 8,830 hospital in-patients were reported as having a New VTE (0.63%). The reduction in the proportion of patients reported as having a new VTE from last year to this year is therefore 12.5%.

A senior clinician and a senior nurse have been identified to provide leadership to facilitate ongoing improvements in compliance with Trust processes and consequently improvements in patient care with regards VTE. The National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92) has been incorporated into easy to follow risk assessment forms across various specialties and is an integral part of clerking documents. This will not only ensure that VTE risk assessments are undertaken and embedded permanently in the admission pathway but also facilitates its documentation for subsequent analysis.

Reduce the Infection Rate of Clostridium Difficile and MRSA Bacteraemia

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

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

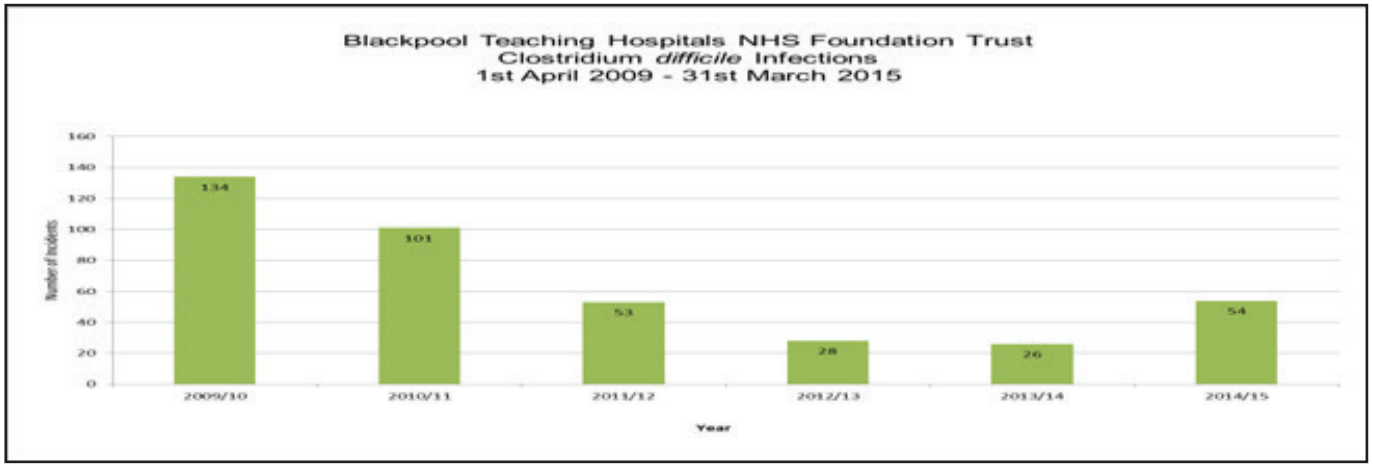
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Clostridium Difficile cases are reviewed with commissioners as set out in NHS England 2014/15 guidance to determine if each case is due to lapses in care or if no lapses in care is agreed. The Trust was required to achieve a trajectory of less than 28 cases of clostridium difficile that were due to lapses in care. This was achieved for, although the Trust experienced 54 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2014 and March 2015 in total, only 24 of these were agreed with our commissioners as being due to lapses in care. Rates in total for April 2014-March 2015 are as shown in Graph 9. [Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms (available upon request).]

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

- To mitigate the risk of breaching the Trust's infection prevention target, we continued to deliver a wide ranging programme of work which emphasises to all staff that remaining compliant with the requirements of the Code of Practice for Healthcare Associated Infections is everyone's responsibility. Ongoing actions included:
  - o Review and re-launch of Antibiotic Formulary to raise awareness of antibiotic stewardship.
  - o Review of current practices to identify where improvements in practice can be made, in line with other high performing Trusts.
  - o Probiotic drinks prescribed for those patients considered to be at high risk for C.difficile by consultant clinicians.
  - o Decontamination of patient environment and equipment as and when possible by using hydrogen peroxide fogging system.
  - o Ensuring cleanliness of patient environment by ATP bioluminescence testing.
  - o Proactive management of GDH positive, who are likely colonised with C.difficile by the infection prevention team.
  - o Continuing to raise awareness and leading by example.
  - o Ongoing audits of compliance to ensure all infection prevention measures and control policies and procedures continue to be implemented, including in particular hand hygiene, environmental and decontamination standards.
  - o Training on all aspects of infection prevention continues to be delivered.
  - o Outcomes were assessed by reviewing progress with the Clostridium Difficile target, and auditing compliance with national standards/regulations.
  - o Root cause analysis meetings with Clinicians to identify lapses in care and agree action plan of shared learning.
  - o Working with the CCG's to identify current trends and shared learning to improve quality care across the whole health economy.
  - o Root cause analysis review process across the Health Economy to promote sharing of learning and improvement.
  - o External peer review facilitation and subsequent action plan developed to be implemented during 2015/16.

Graph 9



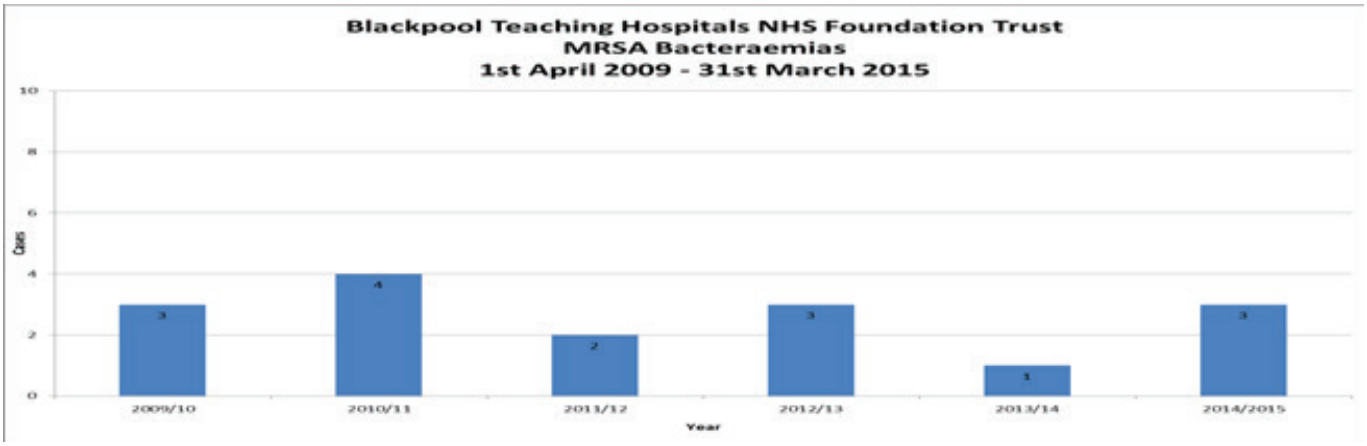
Data source: Department of Health M.E.S.S. This data is governed by standard national definitions

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

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

The delivery of the MRSA Bacteraemia target remains a clinical risk, in relation to Monitor's Compliance Framework which identifies an MRSA trajectory of zero cases for the reporting period. The Trust has reported three cases for this year, which is above trajectory and against Monitor's Compliance Framework target, as detailed in Graph 10. [Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms (available upon request).]

Graph 10



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

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

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

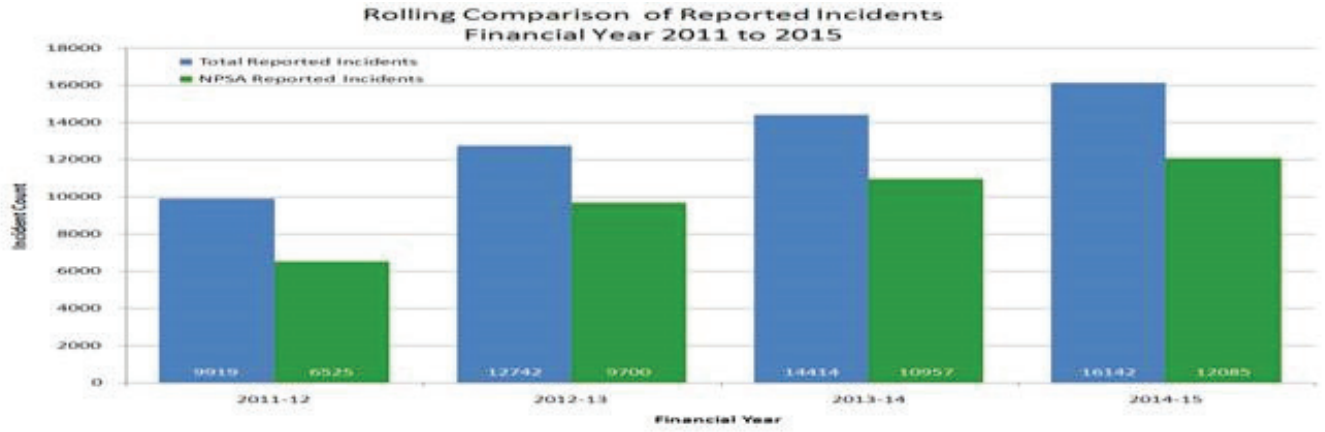
[Further information can be found in the Glossary of Terms (available upon request).]

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

- There continues to be a steady increase in the number of untoward incidents reported over the past four financial years (Graph 11). Patient Safety Incidents account for approximately 75% of all reported untoward incidents. In the year 2014/2015 there have been 16,142 untoward incidents reported and of these 12,085 were patient safety incidents and as such were reported to the National Patient Safety Agency. Of these 12,085 patient safety incidents, 2,855 or 24% resulted in harm to the patient and in comparison to the number of attendances at the Trust (559,548) there is a patient safety incident reported for every one in 46 patients.

However only one patient safety incident resulting in harm was reported for every one in 196 patients during 2014/15.

Graph 11



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

Since 2013/2014 there has been a decrease in the number of patient safety incidents that have resulted in severe patient harm (Graph 12 and Table 33). This continues to be monitored through analysis of trends and themes, lessons being learned and actions being taken at lower level incidents. The Trust has a policy of reporting incidents within 24 hours of occurrence and 70% of severe harm or death incidents were reported within 24 hours of occurrence. In order to address this shortfall all induction, clinical, mandatory and specific incident reporting and investigation training highlights the importance of contemporaneous reporting. The message being communicated is that if an incident has occurred action needs to be taken promptly to prevent a reoccurrence especially if the incident has resulted in severe harm or death. The Trust is currently reviewing its policies and procedures in relation to holding staff accountable for actions or omissions in care which may impact on patient safety.

Graph 12

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

Table 33: Patient Safety Incidents That Resulted In Severe Patient Harm/Death

Financial Year	Severe/Major Harm	Disaster/Death	Total
2004-05	22	5	27
2005-06	6	3	9
2006-07	10	2	12
2007-08	8	1	9

2008-09	7	2	9
2009-10	8	4	12
2010-11	24	0	24
2011-12	12	0	12
2012-13	13	4	17
2013-14	28	10	38
2014-15	21	6	27
Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions			

In 2014/15 there have been zero incidents where following a serious untoward investigation it has become evident that the cause of death was as a direct consequence of the incident.

Two 'Never Event' incident(s) were reported in the 2014/15 year which were investigated under the Serious Untoward Incident investigation process.

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

The Trust has taken the following actions to help reduce the rate of 24% of patient safety incidents resulting in harm and to improve the quality of its services, by undertaking the following actions:

- It is essential that lessons are learned from SUI's in order to mitigate the risk of reoccurrence, these lessons are fedback to staff within the Divisions through training, ward meetings and the Trust wide monthly "lessons learned" newsletter. Lessons learned are also discussed at the bi-monthly Learning from Incidents and Risks Committee, through a new Divisional reporting process. All completed SUI reports are published on the Trust's Risk Management site on the intranet so that any member of staff can access and use it as a learning tool. Links with the Learning and Development Team have been adopted so that training and development can be tailored around real life incidents and patient experiences. The Trust's Simulation Centre has undertaken several sessions where staff who were involved in an incident have the opportunity to re-enact the scenario, reflect on the events and evaluate what went wrong and why. Feedback from staff has been extremely positive especially from those staff who have been involved in an incident where the patient was severely harmed or died.
- Engagement of the patient and their relatives/carers is very important to the Trust in developing an open and honest culture. Patients and relatives are informed when a serious incident has occurred and that an investigation is to be undertaken. In some cases they are asked for their version of events and this has been reflected within the report. Following completion of the investigation report they are given the opportunity to discuss the findings and any actions taken to prevent further occurrence. The new Duty of Candour Regulation 20 has been incorporated into the SUI process and updates have been made to the Safeguard Incident Reporting system to capture staff communications with patients/relatives/carers when harm has occurred. This ensures that we are working to a culture of openness and transparency and that we are offering apologies and support when things go wrong.

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

Patient falls are one of the most common patient safety incidents reported. The majority of slips, trips and falls result in low or no harm to patients physically. However, any slip, trip or fall can result

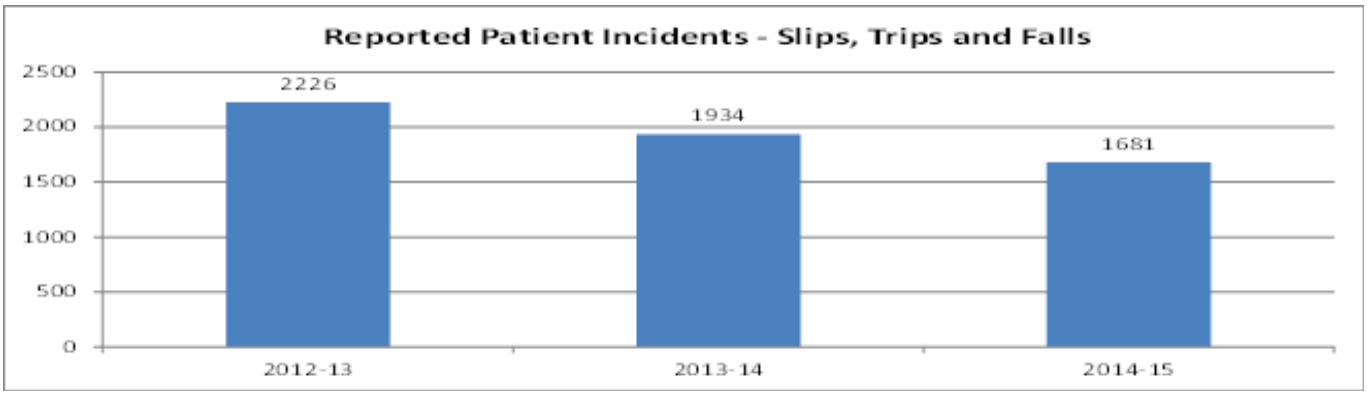
in the patient losing their confidence. There have been significant improvements within all areas of the Trust in reducing the numbers of falls as shown in Graph 13 and 14 below. There have been a number of initiatives introduced during 2014/15 to promote the reduction in falls resulting in harm;

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

In 2013/14 there were 1,934 falls with harm compared with 1,681 in 2014/15 as demonstrated in Graph 13. This represents a reduction of 9.51%. However, the Trust recognises that there has been improved reporting of falls which has impacted on the achievement of recuing harm due to falls by 30% in 2014 /15. Measures have been put into place as outlined above to ensure that the Trust will see a downward trend for patient falls in 2015/16 and this will be further supported by the Trusts new safety programme 'Sign up to Safety'.

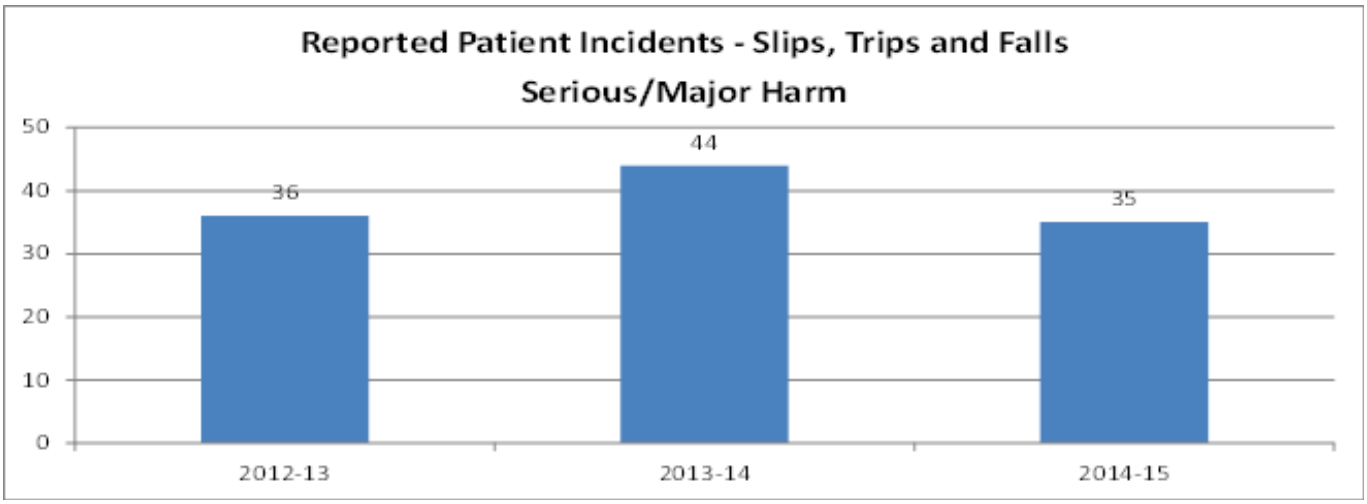
Please note that the data for the last two months of the year is unvalidated and all falls totals are liable to change.

Graph 13: Patient Slips, Trips and Falls



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

Graph 14: Patient Slips, Trips and Falls



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

Reduce the Incidence of Medication Errors by 30% Resulting in Moderate or Severe Harm – Medicines and medicine safety are an integral part of care provision within the Trust. The Trust continues to engage both staff and patients in the safe usage of prescribed medicines within all Specialities. Medicines are the most frequently and widely used NHS treatment and account for over 12% of NHS expenditure. The Trust maintains current and coherent medicines policies, protocols and guidance that aim to increase patient access to medicines and safety. The Trust's policies on medicines and medicine safety cover every step of the journey from the development of medicines to their use by the patient.

The provision of Medicines Management Mandatory training continues to re-inforce the safe management of medicines within the Trust for all professionals to reduce the risk of medication errors. Medication incidents /errors are reported through the Trust Ulysses system which is fed into the National Reporting and Learning System. Currently medication errors reported by the Trust are identified in Graph 15.

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

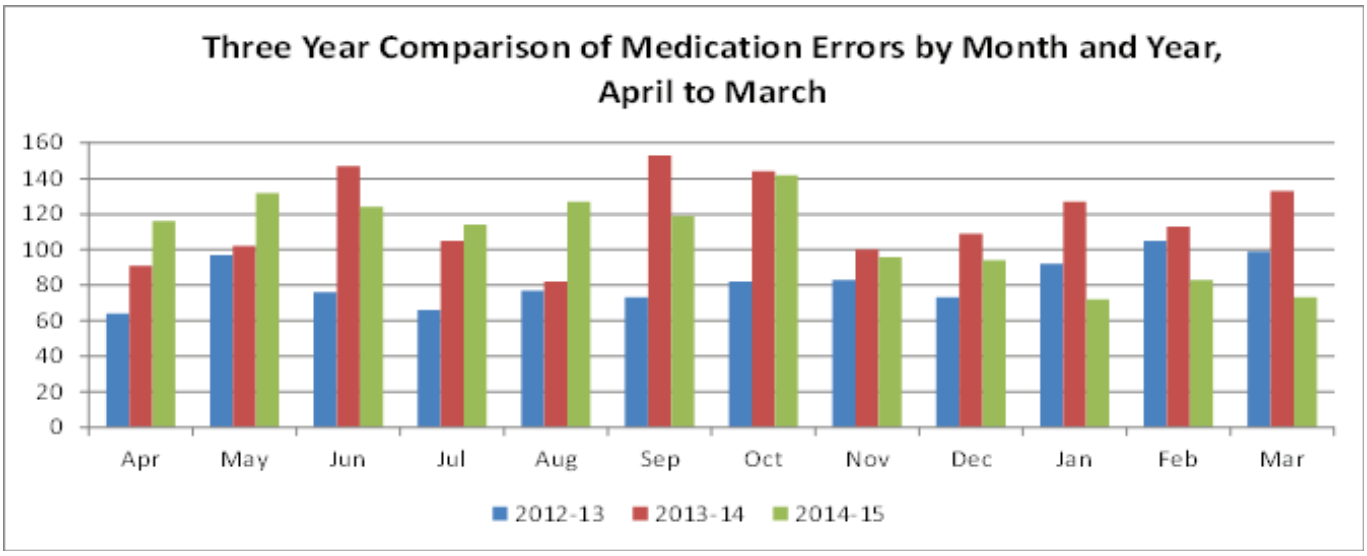
The Medicines Management Committee meets bi-monthly. A report is supplied by the risk department which details all medication errors, drug type, level of harm to the patient, cause group and area. A trend and theme analysis is completed with the aim that target areas can be highlighted and action plans devised to mitigate the risk. Several areas now have dedicated pharmacist cover, this has been found to reduce medication errors in these areas, it is hoped that this service will be extended over the coming year. The Trust has introduced Specialist Nurse Practitioners who are able to prescribe a set group of medications; this has been shown to reduce prescription errors and waiting times for discharge medication. Drug administration has been shown to be consistently the highest cause group as demonstrated in Graph 16, further analysis of the incidences indicated that many of these incidences were as a result of staff being interrupted whilst completing drug rounds, all nurses are now required to wear 'do not disturb' tabards when completing drug rounds.

Medication incidents

A total number of 14,266 incidents were reported by the Trust. 1,291 were medication errors and this equates to 9.75% of all incidents. The total number of medication errors was 8.1% lower in 2014/15 than 2013/14. The number of drug administration errors with serious and above harms was 24 in 2013/14 and this remained at the same level in 2014/15. The number of drug administration errors with minor or less serious harms decreased by 29.7% over the same period. (It should be noted that the data for February and March are yet to be validated at the time of writing and may change).

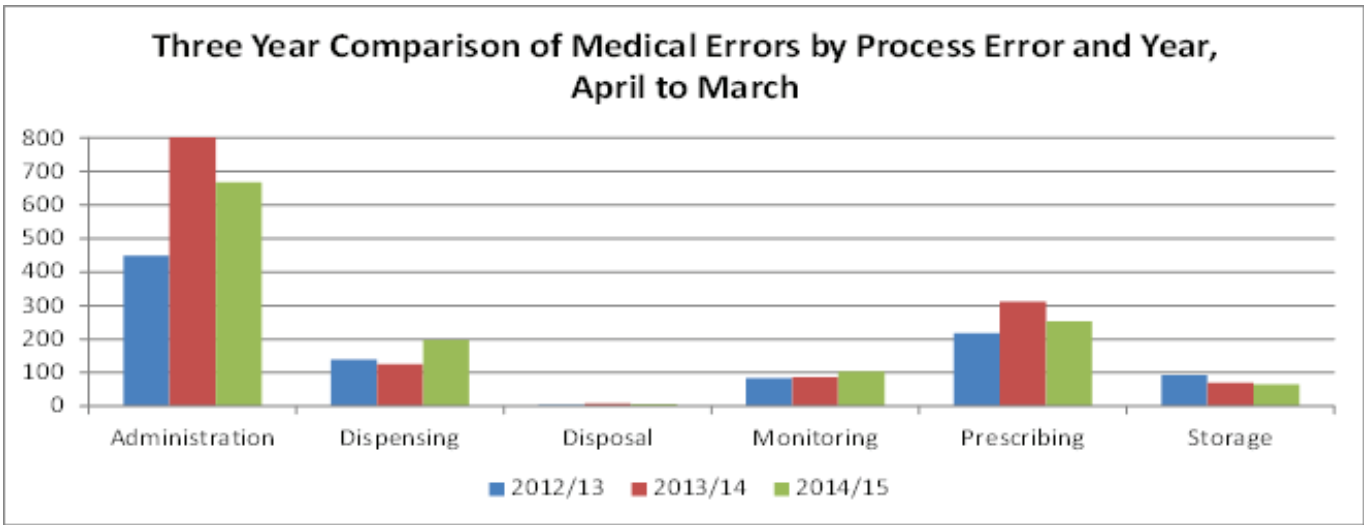
The Trust is able to report an improvement in the number of incidents reported by staff with a marked reduction in low level harm incidents however, the target of 30% reduction of medication errors resulting in moderate or severe harm remained static. This emphasises the need for ongoing focus on improvement strategies in relation to medication errors which the Trust is committed to making a priority in 2015/16.

Graph 15 Medication Errors



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

Graph 16 Medication Errors



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

Much work has been carried out over the last 12 months to detect report and learn from patient safety incidents involving medication. The Trust is fully compliant with the Patient Safety Alert NHS/PSA/D/2014/005 – Improving medication error incident reporting and learning - in having the relevant personnel and systems in place. Errors continue to be recorded and monitored for trends and themes via the Medicines Management Committee chaired by the Director of Pharmacy.

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

The majority of pressure ulcers are avoidable through simple actions by frontline healthcare staff, patients and carers. As well as causing long-term pain and distress for patients, treatment for each pressure ulcer costs an average of £4,638 - which causes a financial burden on the NHS of between £1.4 and £2.1 billion per year. Avoidable pressure ulcers are a key indicator of patient safety and good quality care and preventing them from happening will improve all care for vulnerable patients. As a Trust we take the development of pressure ulcers which occur in our care seriously, and are working hard to reduce the incidence of these. The Trust is committed to reducing the prevalence of pressure ulcers occurring in our care and embedding cultural change through clinical ownership at ward and team level.

The reduction of pressure ulcers has been identified as a priority indicator to enable the Trust to meet national healthcare directives and current local quality improvement priorities for 2014/15. To improve the quality of care provided, the Trust made a commitment to ensure that all patients who suffered a hospital acquired pressure ulcer stage 2, 3 or 4 would have a root cause analysis undertaken.

Through the implementation of a quality improvement initiative programme the Trust has demonstrated how pressure ulcers have been reduced and targets met due to the initiative being implemented over the last 12 months as shown in Graph 17.

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

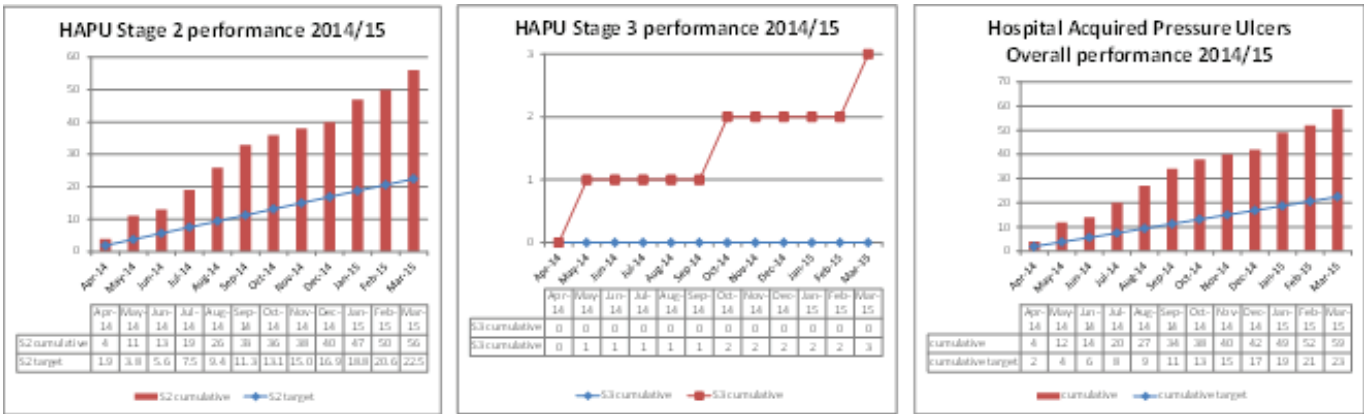
Work will continue to ensure that changes are embedded into practice and the improvements in performance are sustained. During 2013, the acute site integrated with Community Health Services. Collaborative working between the staff has seen an improvement in the reporting of pressure ulcer incidents in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

In 2014/15 the number of stage 2 hospital acquired pressure ulcers exceeded trajectory (56 reported against a trajectory of 22.5; in 2013/14 there were 45 stage 2 pressure ulcers reported) and the

number of stage 3 hospital acquired pressure ulcers was three reported against a trajectory of zero (in 2013/14 there were six stage 3 pressure ulcers reported).

There were zero stage 4 hospital acquired pressure ulcers; hence despite seeing a reduction overall in year compared to 2013/14, the Trust has not achieved to meet its internal target for pressure ulcers.

Graph 17

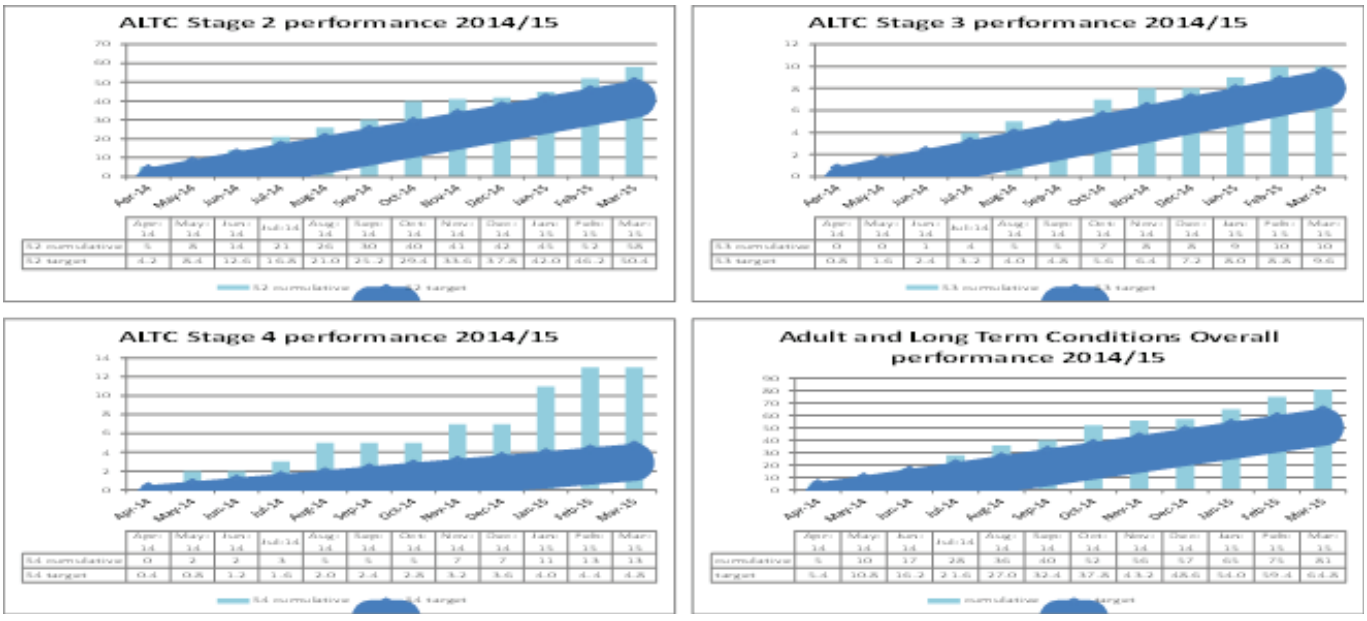


Data source: Ward-based prevalence audit. This data is governed by standard national definitions.

Target - Reduce stage 2, 3 and 4 pressure ulcers acquired whilst the patient is under the care of the community services by stage 2 and 3 (30%) and stage 4 (50%)."

In 2014/15 there were 58 stage 2 pressure ulcers reported, a decrease of 19.4% from 2013/14 but less than the target of 30%. The prevelance of pressure ulcers across the hospital and community teams has been influenced by the increase in the acuity of patients the Trust cares for and the subsequent increase in risk from pressure area breakdown of those patients. Despite this the ten stage 3 pressure ulcers reported equated to a reduction of 28.6% on the previous year. There were however, thirteen internal stage 4 pressure ulcers compared with five from the previous year hence, the internal targets were not met despite that Trust demonstrating a reduction in total from 96 to 81 reported pressure ulcers, an overall decrease of 15.6%.

Graph 18



To Introduce the Think Glucose Programme
Think Glucose campaign was commenced in 2014 to highlight the needs and care for patients with diabetes. The aim of the "Think Glucose" project was to improve patient care by promoting proactive care for patients who have diabetes as a secondary diagnosis. This was supported by a rolling education programme and was commenced on the endrocrinology wards.

The "Think Glucose" Clinical Nurse Specialist lead implemented base line audits on the management of diabetes on the wards and used the audit outcomes to tailor the training programme accordingly. The outcome of the programme is to improve staff knowledge on diabetes, reduce insulin errors, provide an e-referral system and provide a better patient experience.

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

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

3.5 Quality Account Production

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

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

3.6 How to Provide Feedback on the Quality Account

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

Telephone: 01253 655520

Website: www.bfwh.nhs.uk

3.7 Quality Account Availability

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

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

3.8 Our Website

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

Part 4: Appendices

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

1.1 Statement from Blackpool Clinical Commissioning Group - dated 21/05/15 and Fylde & Wyre Clinical Commissioning Group – dated 22/01/2015

Blackpool Teaching Hospitals NHS Foundation Trust Quality Account for 2014/15

F&WCCG Commentary regarding BTH 2014/15 Quality Account

We would like to commend the trust on a very readable Quality Account. The report describes a continuous drive to attract, train and retain a motivated and caring workforce and recognises the staff contribution to the improvements achieved. This is a necessary foundation on which to respond to the challenges, including for example, mortality. Whilst the trust statement is correct about mortality indicators having improved in the last 12 months, it should be acknowledged that this is an area in which the trust and commissioners are continuing to strive for a better understanding and speedier improvement. Employing more coding staff and improving the first 24-36 hours of patient care are evidence of the trust's commitment. Further work is required to make it as easy as possible for all relevant staff, including temporary staff, to understand and maintain the quality and safety standards agreed for each pathway eg stroke. The individuals in care teams must receive regular feedback about their contribution to the team's level of compliance with the standards described within a pathway, with an explicit expectation of continuous improvement at personal and team level.

To complement the results of nursing and medical care indicators, it would be helpful to see an evaluation of how useful the workforce finds these care indicators as a means to measure and feedback good care and what level of commitment individuals feel to achieving improved indicator scores within their service areas over time.

This Quality Report positively describes the delivery of more out of hospital care through a number of initiatives. In addition, the trust has recognised a need to consider the impact of hospital care and smooth the patient journey, thereby improving the patient's confidence to continue self-management of their condition, for example by explaining their medication and any side effects more clearly and knowing who to contact if identified warning signs or triggers occur when people go home. There is a need for equal focus on high quality, safe, evidence-based care for people who always access care in the community, not just for those who access services which contribute to admission/re-admission avoidance and early discharge.

The trust is receiving positive patient feedback in the main. Learning from patient experience feedback including complaints is important and we would like to see the 55% of complaints coded as miscellaneous, being described more accurately in future reports along with some examples of how feedback has directly affected changes in practice and the culture being promoted. It is encouraging to see that more complex complaints are being resolved at an informal level to the complainants' satisfaction. The use of the simulation centre to draw out and focus on the learning from serious incidents is to be commended. It will be interesting to understand the added benefit to learning and whether this makes a longer term impact on practice than traditional methods of learning from incidents. It is also essential that having embedded Duty of Candour in policies, the trust ensures this is real and meaningful, informative and supportive for those affected by incidents.

Blackpool CCG Statement on the 2014-2015 Quality Accounts:

Blackpool CCG as Lead Commissioner welcome the opportunity to appraise the content of the Quality Account for 2014-2015 and are pleased to acknowledge that there is a clear focus on the key quality elements and Blackpool Teaching Hospital NHS Foundation Trust has clearly referenced its organisational objectives, The Quality Account is clear and concise given the breadth of information

it is required to reference, well presented and reflects the new requirements to benchmark against its 'peers.

Quality Priorities 2015/2016
We note the improvements in hospital mortality rates in 14-15, however despite improvements the Trust continue to be an outlier in this respect. Blackpool Teaching Hospitals NHS Foundation Trust needs to maintain its focus on mortality in order to see the Hospital Mortality Rates achieve a sustainable reduction. BCCG will continue and are committed to supporting further improvement in 2015-16 in specific care pathways, including independent specialist support and scrutiny. We welcome the continued review and monitoring of internal clinical pathways and support the implementation of the heart failure pathway in 2015-16. We would recommend that this pathway is also included in the Trusts priority indicators for quality improvement in 2015-16.

Blackpool CCG and FWCCG have worked in partnership with the Trust to review incidences of Health Care Acquired Infection. The Trust takes all cases very seriously. Each C Diff case has been reviewed by case, and 24 lapses in care of the 53 total cases were identified. A health economy approach was developed in 14-15 to promote reduction in community cases and help reduce those cases outside of the Trusts control.
NHS England has set a new trajectory for 15-16 for the Trust, this being 40 lapses in care. BCCG will ensure this is closely monitored and continue to work with all parties to develop and implement joint improvement plans.
There were 3 MRSA cases reported by the Trust in 2014- 2015, however, the CCG would note these were not all hospital acquired and therefore not directly attributable to the Trust. In each case an improvement plan has been developed to reduce the possibility of a recurrence.

We want to see a reduction in long trolley waits in 2015-16. Unfortunately there were 2 incidents in early 2014 that led to detailed review and investigation. We are however confident the Trust takes all waits seriously and have taken comprehensive actions to reduce the possibility of recurrence.

Pressure ulcers are the most frequently reported serious incident (as is the case with most hospital trust reporting) We note the increased reporting of grade 3 pressure ulcers in 2014-15 and note that the Trust included all the Community related pressure ulcer incidents in this data. We fully support the Trusts review of pressure ulcer lessons learned and actions to reduce the incidence of newly acquired pressure ulcers. We do however; expect to see a reduction in these during 2015-16.

Blackpool Teaching Hospital NHS Foundation Trust continues to be a high reporter of patient safety incidents together with an associated decrease in reported levels of harm from these, particularly relating to medication incidents. The CCG view is that this as a positive indicator which clearly demonstrates an organisation with an open transparent culture, and clear and accessible reporting mechanisms. We also commend the ongoing work to promote harm free care within the Trust.

The CCG do however want to see an improvement in initial reporting times related to serious incidents in 2015-16.

The CCG recognise the achievement of significant improvements in dementia screening and assessment by the Trust during 2014-15.

The CCG is pleased to note that the Trust FFT responses are very good and have achieved above the national average ratings, with many patients recommending the Trust to their friends and family. The CCG recognises the improvement activities led by the patient relations team within the Trust to promote improvement in the patient experience and patient satisfaction.

The CCG statements are based on an early draft version of the Quality Accounts and at the time of comment responses to data queries are not available.

The CCG are satisfied that, on the whole, this is an accurate account of progress in a challenging year.

1.2 Statement from Governors – 07/05/2015

As Governors, our role is to represent the interests of the Trust's members and the public that the

Trust serves. Additionally, the Council of Governors hold the Non-Executive Directors to account for the performance of the Board of Directors. In order to do this, the Council needs to have access to the appropriate information, resources, and people within the Trust. The Quality Accounts Report is an aggregation of very many activities and processes that occur throughout the year, to which the Council of Governors has access and is able to comment and influence as appropriate.

The following comments from Governors are intended to provide assurance that the Council of Governors is focussed on fulfilling its duty of care.

"The Board communicates well with the Governors and is open about the challenges the Trust faces as well as its successes."

"The Governors will continue to press the Board to ensure that the Safety and Quality of care provided to Patients remains the top priority against a difficult background of increasing demand and financial stringency."
"As Governors, we will continue to challenge NEDs to ensure processes and practices are in place so that patient care and quality is the number one priority and is of the highest standard, not to be compromised by the challenges the Trust will be addressing."

In relation to some of the specific quality measures and activities seen during this last period, the following comments have been made by Governors;

"During 2014/2015 the Trust managed to maintain a high level of care for patients whilst successfully meeting the challenge of delivering £20million in cost savings. Standardised pathways have continued to be introduced for the highest mortality conditions and these have made a significant contribution to reducing mortality."

"The Trust is putting significant effort into recruitment and retention of staff, as historically this has been a challenging area for the Trust."

The Council of Governors supports the strategy and direction of the Trust, whilst constantly monitoring activities and performance to ensure the very best interests of the members and the public are maintained, at all times.

1.3 Statement from Local Healthwatch Blackpool – 22/05/2015

Blackpool Healthwatch would like to thank the Trust for providing the opportunity to view and comment upon their Quality Accounts Report 2014/15. Blackpool Healthwatch welcome such a detailed and comprehensive report, as an organisation we commit to our continued support for the Trust in delivering quality healthcare whilst advocating with, for and on behalf of those who use these services.

The report reflects Healthwatch Blackpool's knowledge of the Trust and the experiences expressed by those people who use the service. It is positive to read that patient and public engagement is an area of focus for the Trust. The Friends and Family Test receives its first formal finding within this report with a measure set against a national average, whilst it is disappointing to note such a low attainment is it positive to note that the percentage of responses has increased over the last 12 months. We would encourage and actively support the Trust to focus upon the findings within the Friends and Family Test in combination with finding within some of the Patient Reported Outcome Measures (PROM) and the identified complaints, with a particular focus upon Issues relating to "treatment issues", "Communication" and "staff attitudes" (Page 37) which received the top three highest number of complaints accounting for over 70% of complaints. The PALS office moving to a more central and visible location in the atrium has been a positive step and is evident in the increased number of contact it has made since moving.

The work and emphasis that the Trust has focused upon Dementia is a positive step forward, especially as prevalence rates in dementia are increasing nationally and as Blackpool has a higher than normal reported prevalence rate of people with Dementia related conditions. Dementia screening across the Trust has been an excellent step forward which has been demonstrated by the Dementia

screening figures supplied. We would welcome the Trust developing dementia related services and studies further, this could include contributing to the next submission of the National Audit of Dementia.

The last Care Quality Commission (CQC) visit highlighted some positives in the Trust although it recorded a number of "Requires Improvement" (page 22). This has been a regular focus of attention to a large number of people who use and support the Trust. It is positive to read that a plan of action has been developed, which is reviewed by the Trust Board and the local Clinical Commissioning Board, with the anticipation that "all matters requiring improvement will be attained on re-inspection".

Blackpool Healthwatch look forwards the coming year and working with the Trust, with patients and the wider public to achieve an excellent local health service.

1.4 Statement from Local Healthwatch Lancashire

No comments received

1.5 Statement from Lancashire Health Scrutiny Committee – 01/05/2015

The role of the Lancashire Health Scrutiny Committee is to review and scrutinise any matter relating to the planning, provision and operation of the health service in the area and make reports and recommendations to NHS bodies as appropriate.

The Committee undertake this responsibility through engagement and discussions with the Trust, addressing any areas of concern as they arise. It is the intention of the Committee that this methodology of ensuring that the Trust improve patient safety and deliver the highest quality care to the residents of Lancashire will continue by having an oversight of how the Trust evidence the provision of quality and safe services. In addition the Health Scrutiny Committee will seek reassurance that every effort is being made to ensure; financial stability, reasonable waiting times and the safeguarding of the most vulnerable.

1.6 Statement from Blackpool Health Scrutiny Committee – 13/05/2015

The Health Scrutiny Committee would like to thank Blackpool Teaching Hospitals NHS Trust for the opportunity to view and comment on the Trust's draft 2014/15 Quality Account. Due to the period of 'purdah' leading up to the local and general election on May 7th, the Committee has been unable to formally comment in relation to the process this year. However, the Committee has been satisfied with the level of engagement and information it has received from the Trust throughout the year and is pleased with the way that the Trust has dealt with queries, requests for information and attendance at Committee meetings.

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

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

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

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

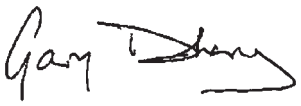
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance:
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2014 – March 2015;
  - Papers relating to Quality reported to the Board over the period April 2014 to March 2015;
  - Feedback from the commissioners - Blackpool Clinical Commissioning Group dated 21/05/2015; and Fylde & Wyre Clinical Commissioning Group – dated 22/05/2015;
  - Feedback from Governors dated 07/05/2015;
  - Feedback from Local Healthwatch organisations – Local Healthwatch Blackpool dated 22/05/2015;
  - Feedback from the Blackpool Council's Health Scrutiny Committee dated 13/05/2015;
  - Feedback from Lancashire Health Scrutiny Committee dated 01/05/2015;
  - The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21/04/2015;
  - The 2014 national patient survey published February 2015;
  - The 2014 national staff survey published February 2015;
  - The Head of Internal Audit's annual opinion over the Trust's control environment approved 21/04/2015;
  - The CQC Intelligent Monitoring Report dated July 2014, Dec 2014.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual).

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

SIGNED: 

Ian Johnson
CHAIRMAN:

DATE: 28th May 2015

SIGNED: 

Gary Doherty
CHIEF EXECUTIVE

DATE: 28th May 2015

Annex C: Glossary of Abbreviations And Glossary Of Terms

Table 35 Glossary of Abbreviations	
Abbreviation	**Meaning**
AMI	Acute Myocardial Infarction
AQ	Advancing Quality
ACEI	Angiotension Converting Enzyme Inhibitors
ARB	Angiotension Receptor Blocker
BVH	Blackpool Victoria Hospital
CABG	Coronary Artery Bypass Graft
CAP	Community Acquired Pneumonia
CC	Clinical conditions.
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile Infection
CDU	Clinical Decisions Unit
CEMACH	Confidential Enquiry into Maternal and Child Health - This is a national enquiry to improve the health of mothers, babies and children by carrying out confidential enquires on a nationwide basis and by disseminating the findings and recommendations as widely as possible.
CHKS	Name of the Company which is used for benchmarking
CHP	Combined Heat and Power
CRC	Carbon Reduction Commitment
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQS	Composite Quality Score
CQUIN	Commissioning for Quality and Innovation
DoH	Department of Health
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
ERIC	Estates Returns Information Collections
GHG	Green House Gas
GP	General Practitioners
HCAI	Healthcare Acquired Infection
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HRG	Healthcare Resource Group
HSMR	The Hospital Standardised Mortality Ratio
IRMER	Ionising Radiation Medical Exposure Regulations 2000
LAC	Looked After Children
LSCB	Local Safeguarding Children's Board
LVSD	Left Ventricular Systolic Dysfunction
LVS	Left Ventricular Systolic Function Assessment
Medusa	Electronic version of the Injectable Medicines Guide
MRSA	Methicillin Resistant Staphylococcus Aureus
NCEPOD	National Confidential Enquiries into Perinatal Outcomes of Death
NICE	National Institute for Health and Clinical Excellence
NCI	Nursing Care Indicators
NHSLA	National Health Service Litigation Authority

NIHR	National Institute for Health Research
NHS OF	The NHS Outcomes Framework
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
PbR	Payment by Results
PCI	Primary Coronary Intervention
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
RAMI	Risk Adjusted Mortality Index
SBAR	Situation Background Assessment Recommendations
SHMI	Summary Hospital Level Mortality Indicator
SUS	Secondary Uses System
TIA	Trans Ischemic Attack
VTE	Venous Thromboembolism

Table 36: Glossary of Terms	
Abbreviation	**Glossary of meaning**
Antibiotic Prophylaxis	Antibiotic Prophylaxis is preventive treatment given to patients in order to protect them from developing an infection.
Cardiac Arrest	Cardiac arrest, (also known as cardiopulmonary arrest or circulatory arrest) is the cessation of normal circulation of the blood due to failure of the heart to contract effectively.
Clinical Commissioning Group	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in NHS England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs will operate by commissioning (or buying) healthcare services including: • Elective hospital care • Rehabilitation care • Urgent and emergency care • Most community health services • Mental health and learning disability services
Clinical Conditions	JD042: Minor Skin Disorders category 3 without CC "CC" means clinical conditions. Therefore in this context the patient had no other clinical conditions or co-morbidities.
Clinical Divisions	Unscheduled Care Division comprises of Medicine, Adult Medical Assessment Unit, Intensive Therapy Unit and Accident and Emergency Department and Community Team Adult Long Term Conditions. Scheduled Care comprises of the Cardiac Unit and the Surgical Unit Women's Health comprises of the Women and Children's unit, Paediatric Unit, Community Midwives, School Nurses and Health Visitors.
Clostridium Difficile	Clostridium Difficile (C. diff) is a bacterium that is present naturally in the gut of around two thirds of children and 3% of adults. C. diff does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. diff bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. At this point, a person is said to be 'infected' with C. diff.
Endoscopy Accreditation	Accreditation within Endoscopy is enabling the Trust to prove that all processes around the use of endoscopes within Gastroenterology, Cardiac Directorate and ENT are conducted to the highest standard. Systems are now in place to prove that all areas, within the Trust, conform to the same standards and Trust has passed the second stage which shows that we do what we have documented. Extremely good feedback was received during all visits by the inspector.
Evidence Based Practice	Evidence based practice (EBP) is: "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research"
Friends and Family Test	The test will provide us with a simple, easily understandable headline matrix which combined with other information, patient feedback and follow up questions can support the trust in pinpointing areas for improvement, and will inform and empower the ward, and the board, to tackle areas of weak performance and enhance areas of excellent practice. The test will be designed to be a single matrix and we will still need to supplement this with other methods of capturing, responding and understanding the patients experience data. It is not designed to replace more local operational level information, yet will be designed to act as an opener for deeper organisational work across all patients pathways. The test will help us quickly flag issues, which will be easily responded to. Effective, targeted improvements will quickly show up as the score will improve, validating and incentivising further improvements across the Trust. Further information can be located at the following link: http://transparency.dh.gov.uk/2012/11/28/nhs-friends-and-family-test

Healthcare Resource Groups	Developed by The Case mix Service, Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource. Healthcare Resource Groups offer organisations the ability to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time. Healthcare Resource Groups are currently used as a means of determining fair and equitable reimbursement for care services delivered by Health Care Providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the NHS. They improve the flow of finances within - and sometimes beyond - the NHS. HRG4 has been in use for Reference Costs since April 2007 (for financial year 2006/7 onwards) and for Payment by Results (PbR) since April 2009 (for financial year 2009 onwards). HRG4 was a major revision that introduced Healthcare Resource Groups to new clinical areas, to support the Department of Health's policy of Payment by Results. It includes a portfolio of new and updated HRG groupings that accurately record patient's treatment to reflect current practice and anticipated trends in healthcare.
Hospital Standardised Mortality Ratio	The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death for example, heart attacks, strokes or broken hips. For each group of patients we can work out how often, on average, across the whole country, patients survive their stay in hospital, and how often they die.
Investors In People Gold Standards	Investors in People is all about business improvement to help transform the organisation's performance by targeting chosen business priorities
JACIE Accreditation	The Joint Accreditation Committee is a non profit body established in 1998 for the purpose of assessment and accreditation in the field of haematopoietic stem cell (HSC) transplantation. JACIE's primary aim is to promote high quality patient care and laboratory performance in haematopoietic stem cell collection, processing and transplantation centres through an internationally recognised system of accreditation.
Joint Advisory Group (JAG) Accreditation on our Endoscopy Unit	Joint Advisory Group (JAG) Accreditation and Global Rating Score (GRS) The Endoscopy Global Ratings Scale (GRS) is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. Accreditation definition: Usually a voluntary process by which an independent agency grants recognition to organisations which meet certain standards that require continuous improvement in structures, processes and outcomes. Quality improvement and accreditation offers a risk reduction strategy that an endoscopy service is doing the right things and doing them well; thereby significantly reducing the risk of error in the delivery of services. What is JAG Accreditation intended to accomplish? Stimulate continuous improvement in processes and patient outcomes Strengthen endoscopy services Provide a knowledge base of best practices Increase patient confidence in services Improve the management and efficiency of services Provide education on better/best practices The GRS & accreditation pathway will assist you to both achieve and demonstrate this
Methicillin Resistant Staphylococcus Aureus	MRSA stands for Methicillin-Resistant Staphylococcus Aureus. It is a common skin bacterium that is resistant to some antibiotics. Media reports sometimes refer to MRSA as a superbug. Staphylococcus Aureus (SA) is a type of bacteria. Many people carry SA bacteria without developing an infection. This is known as being colonised by the bacteria rather than infected. About one in three people carry SA bacteria in their nose or on the surface of their skin. MRSA bacteraemia – An MRSA bacteraemia means the bacteria have infected the body through a break in the skin and multiplied, causing symptoms. If SA bacteria.

Microbial Contamination	Inclusion or growth of harmful microorganisms (such as clostridium botulinum) in an item used as food, making it unfit for consumption.
NHS Outcomes Framework	The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on: • Domain 1 Preventing people from dying prematurely • Domain 2 Enhancing quality caring of life for people with long-term conditions • Domain 3 Helping people to recover from episodes of ill health or following injury; • Domain 4 Ensuring that people have a positive experience of care; and • Domain 5 Treating and caring for people in a safe environment • Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance
Risk Adjusted Mortality Index	Risk Adjusted Mortality Index – is a measure of the outcomes of care for patients. Risk Adjusted Mortality compares us to what is expected from the types of cases we manage and compares us to other similar hospitals in the country.
Summary Hospital Level Mortality Indicator	The Summary Hospital-level Indicator (SHMI) reports mortality at trust level across the NHS in England using standard and transparent methodology. The Summary Hospital Level Mortality Indicator measures whether mortality associated with hospitalisation was in line with expectations. http://www.ic.nhs.uk/CHttpHandler.ashx?id=10664&p=0
Trans Ischemic Attack	Trans Ischemic Attack – A transient stroke that lasts only a few minutes. It occurs when blood to the brain is briefly interrupted
Venous Thrombo embolism (VTE)	Venous Thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and Pulmonary Embolism (PE). A DVT is a blood clot that forms in a deep vein, usually in the leg or the pelvis. Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE).We can avoid many VTEs by offering preventative treatment to patients at risk.
VTE Prophylaxis	Venous Thromboembolism (VTE) Prophylaxis is preventive treatment given to patients in order to protect them from developing a blood clot that forms in a deep vein.
62 day cancer screening waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days referral from the screening programme as a percentage of the total number of patients receiving first definitive treatment for cancer following a referral from the screening programme.
Mortality Rate	Location of the latest published data can be accessed from: http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/summary-hospital--level-mortality-indicator-shmi
Patient Reported Outcome Scores	The patient reported outcome scores are for i) groin hernia surgery, ii) varicose vein surgery, iii) hip replacement surgery, and iv) knee replacement surgery http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/patient-reported-outcome-measures-proms
Emergency readmissions to hospital within 28 days of discharge	Location of the latest published data can be accessed from: http://www.ic.nhs.uk/pubs/hesemergency0910
National Patient Survey Results	The patient survey question to be monitored by the Trust is in relation to 'Responsiveness to inpatients' personal needs' http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_126972
National Staff Survey Results	The staff survey question to be monitored by the Trust is in relation to the 'Percentage of staff who would recommend the provider to friends or family needing care'. Location of the latest published data can be accessed from: http://www.nhsstaffsurveys.com/
Percentage of admitted patients risk-assessed for Venous Thrombo-Embolism	Location of the latest published data can be accessed from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539
Clostridium. Difficile Target	Number of patients identified with positive culture for C. Difficile

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

Together we care

Blackpool Teaching Hospitals NHS
NHS Foundation Trust