Blackpool Teaching Hospitals
NHS Foundation Trust

Quality Accounts 2021/2022

“We are working to improve the lives of people who live, work and volunteer on the Fylde Coast and beyond”

Contents

1. Chief Executive's Statement

Welcome to the Blackpool Teaching Hospitals NHS Foundation Trust Quality Account. This provides a summary for anyone who wants to know more about the standards of care we have delivered over the last 12 months, and how we plan to improve care for our patients and their families in the future. It describes in detail why our priorities are important to us, how we will measure our performance and how through our Board of Directors we will closely monitor progress and support this at every level.

I would like to start off by thanking every single member of the Blackpool Teaching Hospitals team for the part they have played to make a difference to provide the best care possible for our patients and the communities we serve.

As we all know, the last few years have been immensely challenging for the NHS and this has had a wide-ranging impact on our staff and patients. Many of our staff have worked in incredibly challenging situations and our patients and their families have struggled with the impact of the restrictions we have had to put in place to reduce the risk of infection during the Covid-19 pandemic. As I write, we have started to ease some of these restrictions, and it has been great to be able to welcome visitors back on to our wards as we recognise how much this means to our patients and our staff.

In our Quality Account last year, we set ourselves a number of targets for improvement, these included reducing falls and pressure ulcers, improving our care of the deteriorating patient and working with our community partners to reduce the number of fractures in patients within care homes. Although we did not fully achieve the targets we set, we have made good progress and will continue with these quality improvement programmes during the coming year.

In December 2020, the initial findings of the Ockenden report into maternity services were published, this was followed in March 2021 with the final report which included 15 essential actions for maternity providers. The report was written following a review at another NHS Trust in response to a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. Recommendations were issued for all acute Trusts offering maternity care to be addressed as soon as possible. We undertook a review against the initial findings and a further review on the final report and will be continuing our actions to ensure we provide the best maternity care to the families we serve.

Continuing to make improvements to our estate remains a key part of our strategy, the work on our Emergency Village is on schedule and nearing completion, this includes a new Critical Care Unit and facilities for some of our most acutely ill patients.

In June 2022, we will be publishing our new five-year strategy setting out our ambitions for our patients, our staff and our community and, as we look to 2022-23, I am clear that our emphasis and

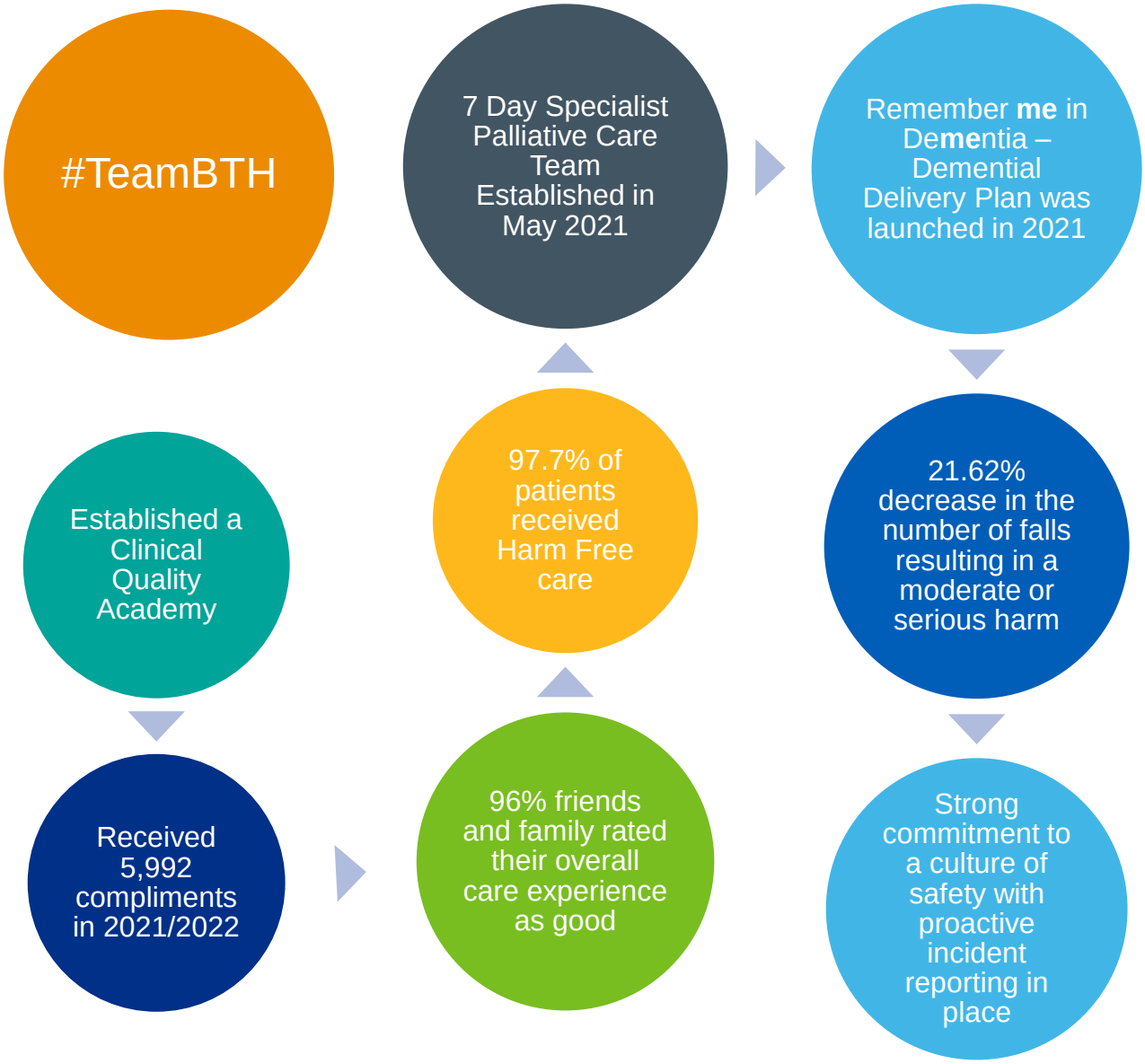
focus will continue to be to deliver high quality, efficient and effective care for all our patients.

To the best of my knowledge, the information we have provided in this Quality Report is accurate. I hope that this report provides you with a clear picture of how important quality improvement, patient safety and experience are to us at Blackpool Teaching Hospitals NHS Foundation Trust.

Trish Armstrong-Child

Chief Executive Officer

Our Achievements



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

Our Quality Improvement (QI) Strategy, 2019-2022, supports the Trust Board's primary focus at Blackpool Teaching Hospitals of consistently providing high quality care to all patients.

The organisational Strategic Framework already in place underpins the current QI Programme set out in this Quality Account for 2021/2022, and this continues to enable progress against the quality priorities set out in the Trust's QI strategy.

2.1 Rationale for the Selection of Priorities for 2021/2022

Looking back over the last few years its right to recognise that alongside the demands of dealing with a worldwide pandemic, we have gone through a number of organisational changes and challenges.

We had an unannounced CQC inspection in September 2021 which identified a number of areas where we need to improve. Blackpool Teaching Hospitals is rated as "Requires improvement" by the CQC, with ratings varying across our different sites. Ongoing action plans are in place to address key concerns raised and our key objective is to achieve a minimum rating of "Good" in the next five years.

We are also aware through our own metrics and feedback from our staff and patients that although we have made many improvements over the last few years, we still have much to do.

The Pandemic resulted in longer waiting times for patients referred to us for treatment. We are working with our commissioners and providers to reduce these waiting times, focusing first on the patients with highest clinical need and those with the longest waits.

In our new strategy we have set a number of priorities, this includes a key priority to "get the basics right". We will focus on achieving key quality standards, benchmarks, and accreditations by:

- implementing all actions aligned to Better Births, the Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust and the continuity of carer model for maternity services
- putting quality accreditations in place across all wards and services, with key action plans to address any concerns
- ensuring Getting It Right First Time (GIRFT) plans are in place for all identified specialties and included in regular performance reporting

In terms of the specific priorities for our Quality Account, we have decided to continue our ongoing programmes of work and will keep the Quality Improvement objectives agreed in our last report which are:

- Reduction in pressure ulcers
- Improving the identification and management of the deteriorating patient
- Reducing fractured neck of femurs (in partnership with local care homes)

We will oversee the work on these priorities through our Quality Assurance Committee and will report regularly to our Board of Directors and our Council of Governors on our progress.

2.2 A Review of Quality Improvement Programmes 2021/2022

The table below lists the Trust's current quality improvement programmes and their current status. An update for each programme has been provided within individual pages.

Quality Improvement Programme	**Status**	✓ 🟰 ↓
Reduction in Pressure Ulcers	Goal met/close to goal	✓ 🟰
Improving the Identification and Management of the Deteriorating Patient	Close to goal	🟰
Reducing Fracture Neck of Femurs *(In partnership with local care homes)*	Goal not met	↓

The programmes listed above form part of the Trust's current Quality Improvement (QI) strategy (2019-2022) that was launched towards the end of 2019. As highlighted in last year's Quality Accounts, all of these programmes have continued with pace, in spite of the challenges faced through the Covid-19 pandemic.

The strategy was described in the Quality Accounts submitted in 2021. As a reminder, the Trust developed a strategy to enable staff to provide high quality, safe and effective personal care to every patient, every time. This was through a targeted portfolio of programmes, which the Trust believed to have a significant impact on unintentional patient harm and mortality. The aims of the initiatives were all strongly linked to the Care Quality Commission (CQC) fundamental standards, and the high-level aims were to:

- Reduce preventable deaths
- Reduce avoidable harm
- Improve the last 1,000 days of life

To achieve our high-level aims, we focussed on a number of distinct improvement programmes, each with measurable outcomes:

- “Improving the Identification and Management of the Deteriorating Patient” has focussed on reducing preventable deaths
- “Eliminating Pressure Ulcers” has focussed on reducing avoidable harm “Preventing Fracture Neck of Femur (#NOF)” has focussed on improving the last 1000 days of life.

The programmes were delivered using the Institute for Healthcare Improvement’s Breakthrough Series Collaborative Framework. This is an evidence-based concept and provides a structure for learning and action that supports real, system-level changes that lead to improvements in care. This includes:

- Recruiting an expert faculty
- Identification and enrolment of participating teams
- Learning sessions and action periods with coaching
- The Model for Improvement, which identifies the four key elements of a successful improvement process
- Measurement and evaluation
- Ongoing support from Executive leaders and summative event

To support this work, the Trust established a QI Directorate, called the QI Hub, who support improvement from concept to delivery of outcomes. The QI Hub have also led on building QI capability within the Trust.

2.2.1 Reduction in Pressure Ulcers – Acute / Community Collaborative

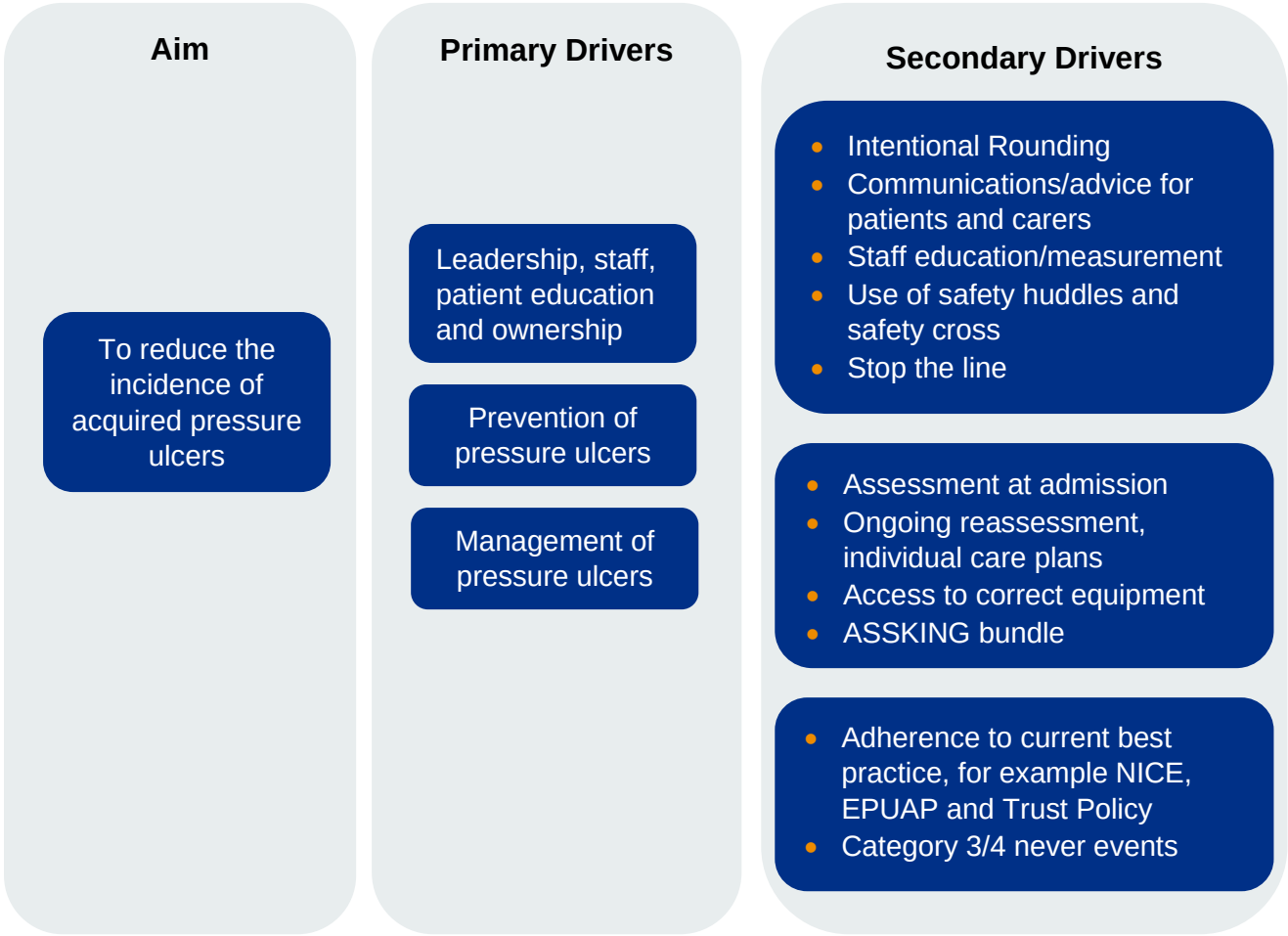
What?	To reduce the number of patients experiencing harm as a result of a pressure ulcer
How Much?	• A 50% reduction in Category 2 hospital acquired pressure ulcers • A 50% reduction in community acquired pressure ulcers • An 80% reduction in Category 3 and 4 hospital acquired pressure ulcers

A pressure ulcer can be defined as:

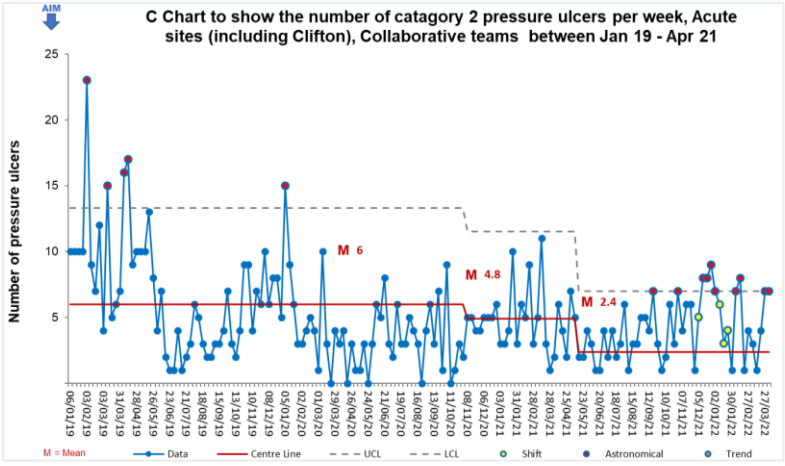
“localised damage to the skin and/or underlying tissue, usually over a bony prominence or related to a medical or other device”

Pressure ulcers cause pain and distress to patients and may also increase the time that patients must remain in care.

“Eliminating Pressure Ulcers” continues to be one of the Trust’s main quality improvement priorities and the Trust has continued to support both acute and community teams to reduce pressure ulcers through a bespoke collaborative programme. The aim and drivers for this programme are summarised by the driver diagram below:

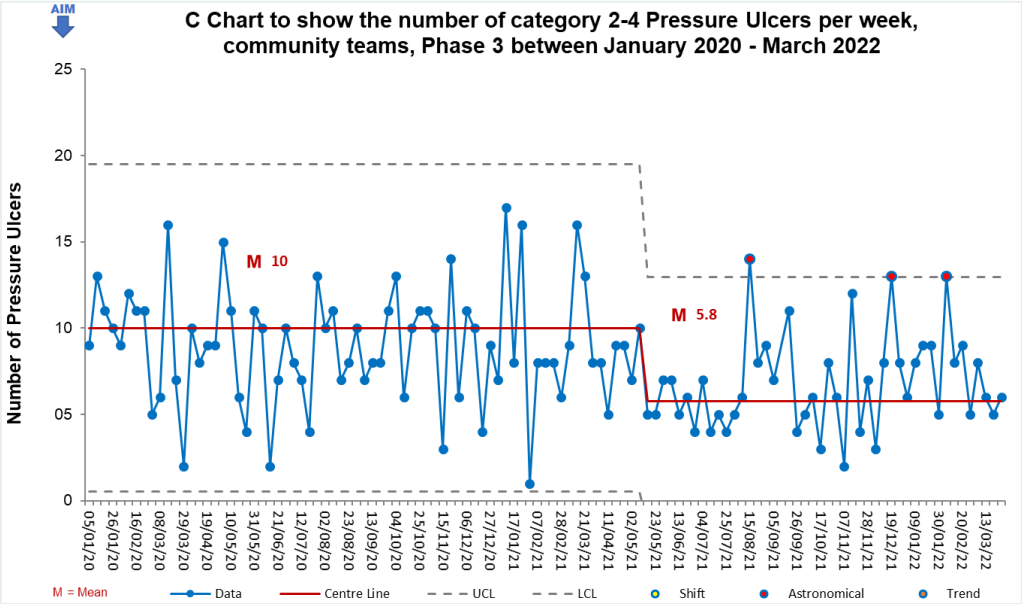


Although the collaborative has taken place at a challenging time, during the COVID-19 pandemic, the Trust has successfully reduced pressure ulcer related harm within the collaborative teams and statistically significant improvements have occurred. The chart to the right highlights that prior to the launch of the QI strategy, on average, 6 pressure ulcers a week were reported by the acute teams who have taken part in the collaborative. Furthermore, there was wide variation in reported pressure ulcers every week. For example, In February 2019, over 20



pressure ulcers were reported by the teams in just one week. However, since May 2021, on average there are now 2.4 pressure ulcers reported a week within collaborative teams, a reduction of 60%, compared to the start of strategy, and there has been much less variation.

Improvements have also been seen within collaborative teams from community settings. The chart below highlights there has been a 42% reduction in community acquired pressure ulcers since May 2021 and sustained since (target 50%).



Outcome	Goals partially met, to date the Trust has achieved: • 60% reduction category 2 hospital acquired pressure ulcers • 42% reduction in community acquired pressure ulcers • 13.5% reduction in category 3 & 4 hospital acquired pressure ulcers
Progress	The Trust is currently focussing on the sustaining the improvements and spreading learning from this collaborative. The change package that has guided improvements has been updated and is available for all teams.

2.2.2 Improving the identification and management of the deteriorating patient – Acute

What?	To reduce the number cardiac arrests (outside of critical care units)
How Much?	By 50% by February 2022.

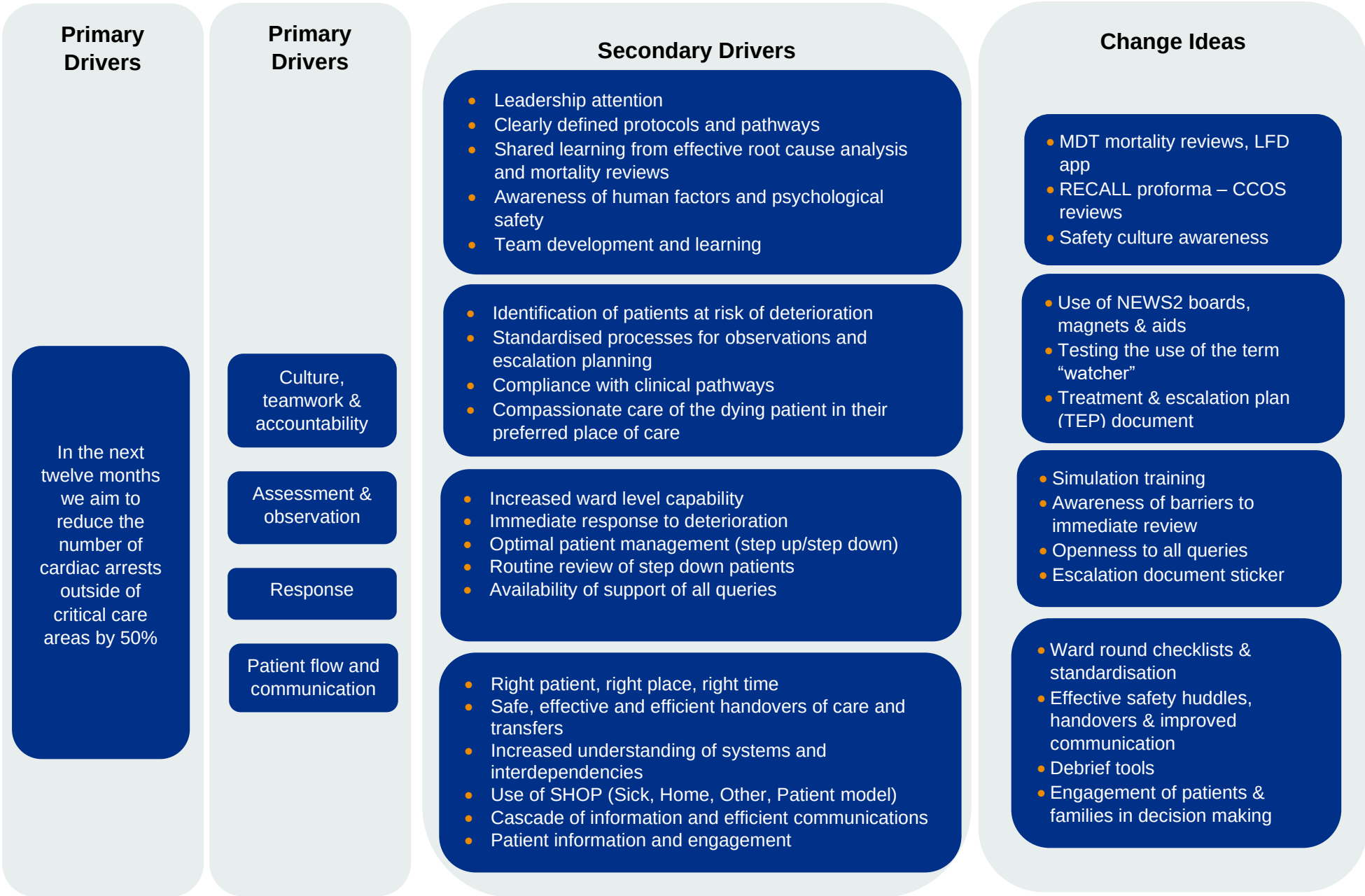
Patient deterioration can be defined as:

"an evolving, predictable, and symptomatic process of worsening physiology towards critical illness".

Patients of all ages are known to suffer harm if deterioration in their condition is not detected or acted upon in a timely and effective manner. Inadequate clinical monitoring and failure to act on deterioration is associated with preventable deaths and severe patient harm, such as cardiac arrests.

Analyses of nationally collected data have highlighted the need for improving identification and management of deteriorating patients. In 2015, around 7% of patient safety incidents reported nationally in England were related to a failure to recognise or act on deterioration

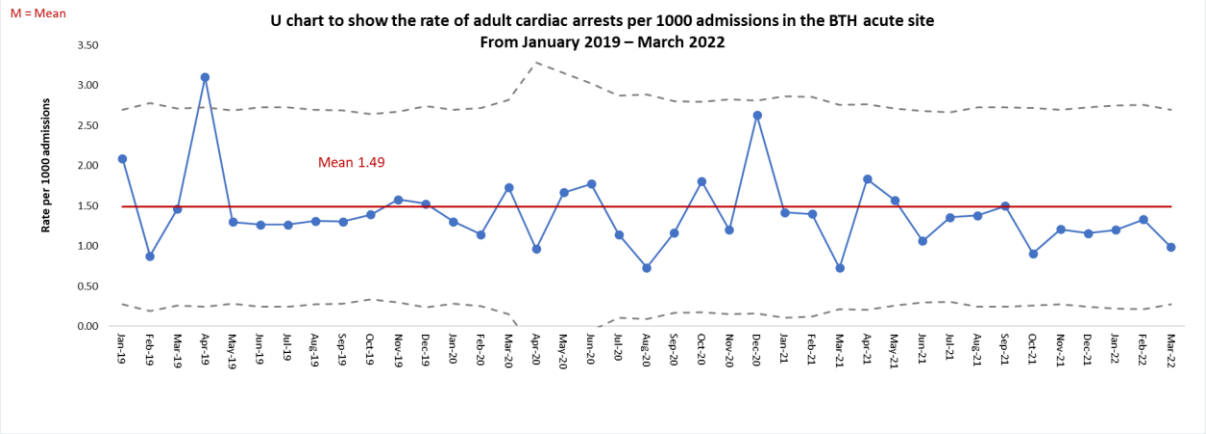
With the above in mind, the Trust launched the "Improving the Identification and Care of the Deteriorating Patient" Collaborative in February 2021. When planning the collaborative, ward data was reviewed, including the capacity and readiness of each team. A change package was developed to guide the teams and a driver diagram was created to focus ideas, shown over the page.


Primary Drivers
In the next twelve months we aim to reduce the number of cardiac arrests outside of critical care areas by 50%
Primary Drivers
Culture, teamwork & accountability
Assessment & observation
Response
Patient flow and communication
Secondary Drivers
Leadership attention
Clearly defined protocols and pathways
Shared learning from effective root cause analysis and mortality reviews
Awareness of human factors and psychological safety
Team development and learning
Identification of patients at risk of deterioration
Standardised processes for observations and escalation planning
Compliance with clinical pathways
Compassionate care of the dying patient in their preferred place of care
Increased ward level capability
Immediate response to deterioration
Optimal patient management (step up/step down)
Routine review of step down patients
Availability of support of all queries
Right patient, right place, right time
Safe, effective and efficient handovers of care and transfers
Increased understanding of systems and interdependencies
Use of SHOP (Sick, Home, Other, Patient model)
Cascade of information and efficient communications
Patient information and engagement
Change Ideas
MDT mortality reviews, LFD app
RECALL proforma – CCOS reviews
Safety culture awareness
Use of NEWS2 boards, magnets & aids
Testing the use of the term “watcher”
Treatment & escalation plan (TEP) document
Simulation training
Awareness of barriers to immediate review
Openness to all queries
Escalation document sticker
Ward round checklists & standardisation
Effective safety huddles, handovers & improved communication
Debrief tools
Engagement of patients & families in decision making

During this collaborative, clinical teams were supported to undertake projects which aim to improve the recognition and management of the deteriorating patient, supporting the use of improvement methodology and shared learning, virtual learning sessions, Microsoft Teams shared channels, improvement coaching and virtual drop in collaborative cafés have been utilised.

Several change package interventions tested by teams during the collaborative process have shown promising signs of scale and spread for example, Safety Huddle templates, NEWS2 boards, escalation documentation stickers, Shortness of Breath Boxes, Rapid Evaluation after Cardiac Arrest for Lessons Learned (RECALL) reviews and Treatment Escalation Plan Documentation.

Over the course of the collaborative, it was identified that it was appropriate to use Trust cardiac arrest rate data as an outcome measure using a u-chart to allow for the variation in admission numbers, as seen in the chart below.



Although the aim of a 50% reduction in cardiac arrest numbers has not been met it is encouraging that the monthly cardiac arrest rate per 1000 admissions has been below the mean for the last nine out of ten data points since June 2021. The time between data (days between 2222 activated cardiac arrests) is now also reviewed, and the combined collaborative inpatient teams have demonstrated a statistically significant improvement from a median of 5 days to a median of 10 days has occurred in June 2021 which sustained through winter pressures.

Outcome	Aim not yet achieved, however process improvements have been seen
Progress	Programme continues, and times between event data are also reviewed (days between 2222 activated cardiac arrests). In the combined collaborative inpatient teams, a statistically significant shift from a median of 5 days to a median of 10 days has occurred since the start of the collaborative

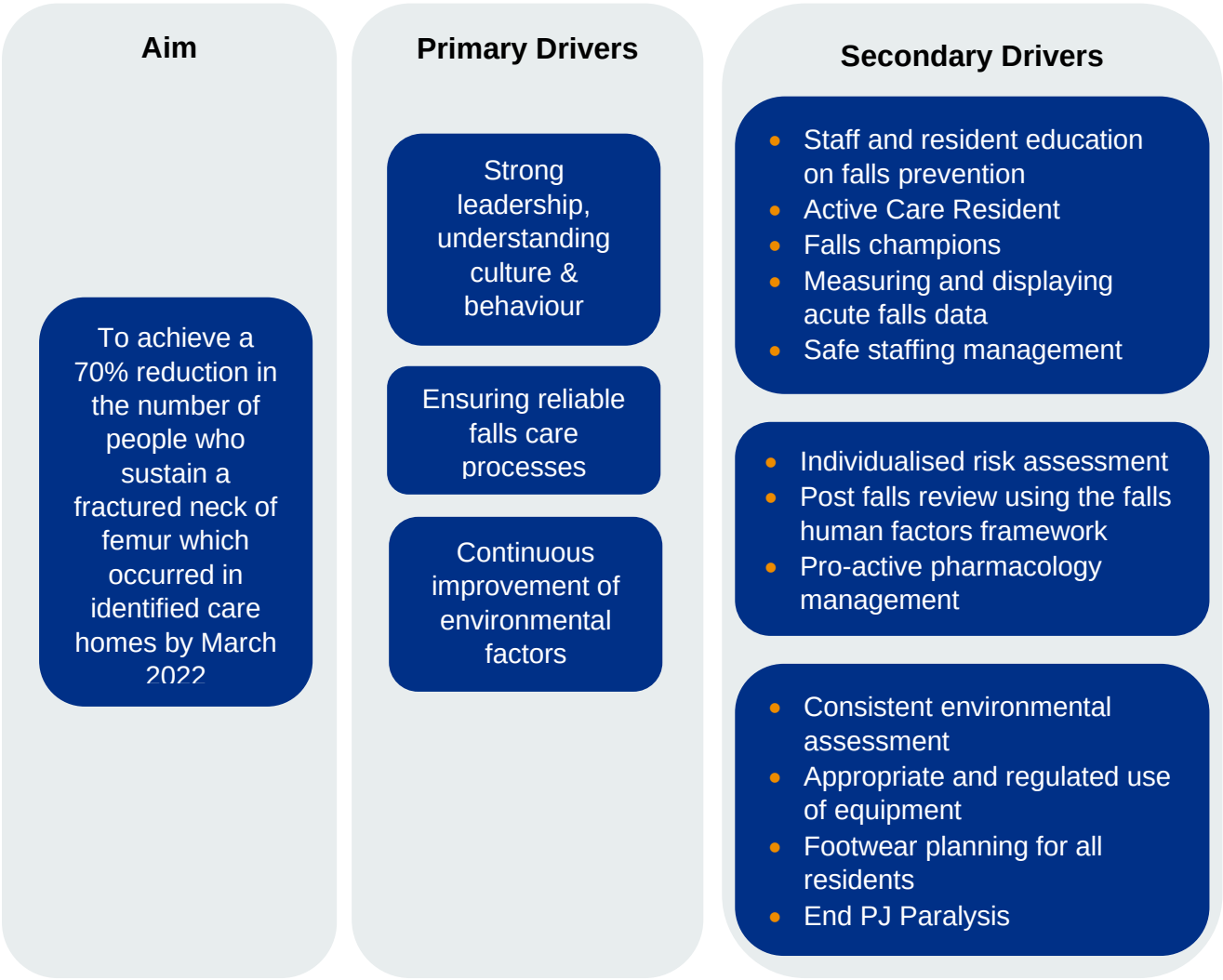
2.2.3 Improving the Last 1000 days of Life: Preventing Fracture Neck of Femur (#NOF)

What?	To reduce the number of residents who sustain a #NOF within collaborative care homes.
How Much?	To achieve a 70% reduction by March 2022

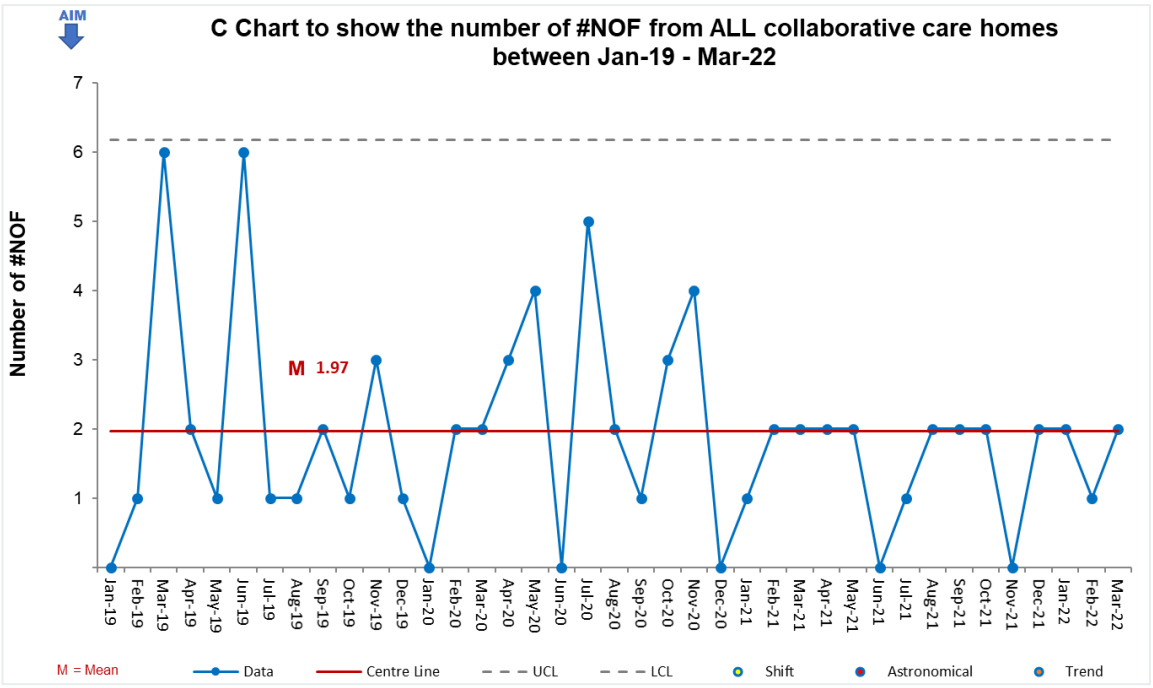
A fracture neck of femur (#NOF) is defined as a fracture from the head of the femur (fracture of the hip). The “Preventing #NOF” collaborative was launched in September 2021 and is in line with the Trust’s aim to “Improve the last 1,000 days of life” for patients. This refers to how the local population can live as well as possible until they are dying, and how they can then be enabled to die with dignity, ideally in the place of their choosing. This aim is in line with the desire to give the patients and their families back the “gift of time”. The gift of time refers to how people can be supported to spend their precious time as they wish. To achieve this, Fylde Coast system partners came together to improve services, and the Trust has worked with local care homes.

While none of us know when our last 1000 days of life begins, there are certain groups who are more likely to be in this period, for example, older people. There are also certain harms which these groups are more likely to experience. These harms have significant impact on quality of life and health outcomes, but many are preventable, such as fracture #NOF. On average 47 people per month attend Blackpool’s Emergency Department (ED) with a #NOF. The 2010 National Institute for Health and Care Excellence (NICE) guidelines indicated that for those who sustain a #NOF, approximately 10% die within a month and 33% die within three months of sustaining this injury. To help to reduce the number of older people who sustain a #NOF, it is important to look at the main mode of injury, which is a fall. Even if residents do not sustain a #NOF post-fall, they can still be significantly impacted and may lose independence.

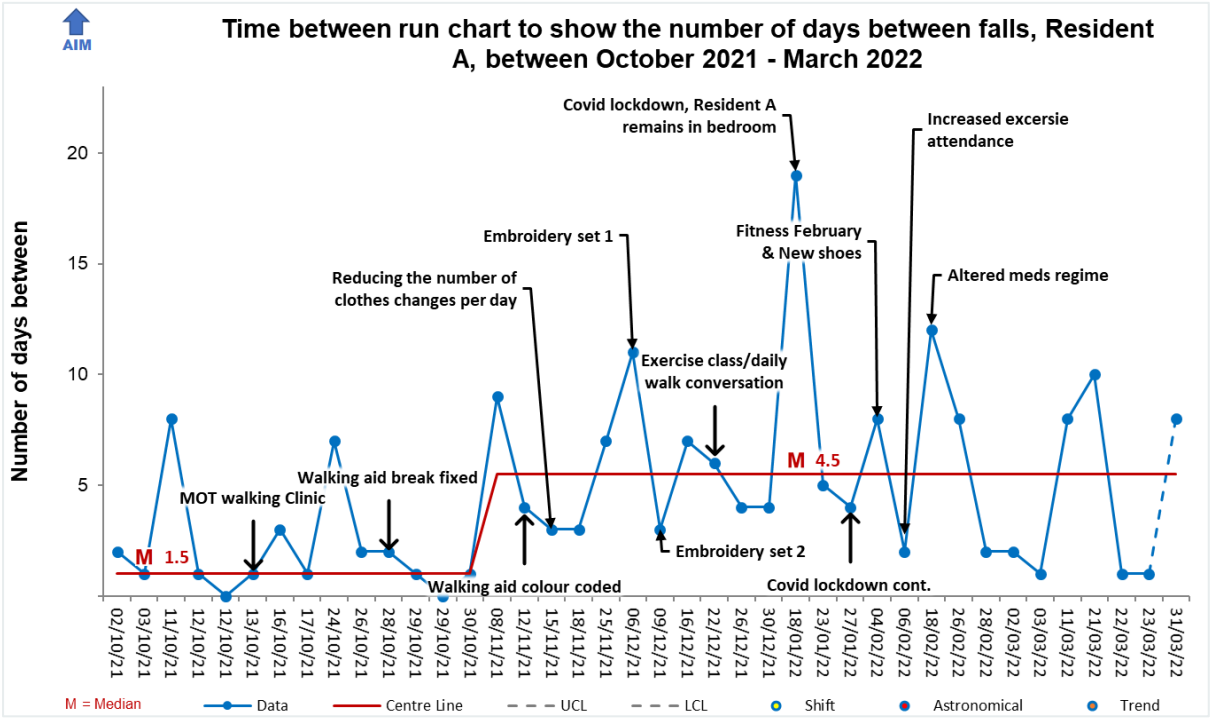
Therefore, this programme has focussed on reducing the number of care home residents who have falls, as there is a strong evidence base highlighting that falls can often be prevented. The driver diagram below highlights the programmes aim in detail.



To help to achieve the aim, improvement coaching and support has been offered to the care home teams. The Covid-19 pandemic continues to have an impact on face-to-face coaching, and four teams have been unable to fully participate in the collaborative, however, they have still been offered coaching support. The chart below shows the number of #NOF that the collaborative care homes have experienced.



As well as supporting care home staff, the Trust has supported individual care home residents to prevent falls. In particular, for individual residents who were identified as "frequent fallers", empowering the residents themselves to understand their own falls data, and testing small changes to help to prevent falls. The chart below presents one example of a resident's data over time. The data has helped to understand challenges, reasons for the resident falling and plan future tests. Examples of changes made have been annotated on the chart.



Participant feedback has suggested that the programme has already helped with the aspiration of improving the last 1000 days of life and that changes made have helped to prevent residents spending unnecessary time waiting in the Emergency Department of the hospital in their last 1,000 days.

Outcome	Aim not met, however, reduced variation in #NOF. Updated aim under development and Trust continues to work on this programme
Progress	This programme continues, and work is underway to learn from the positive resident stories further. As #NOF are relatively rare events, the days between falls have been monitored and statistically significant improvements have been seen in the participating care homes

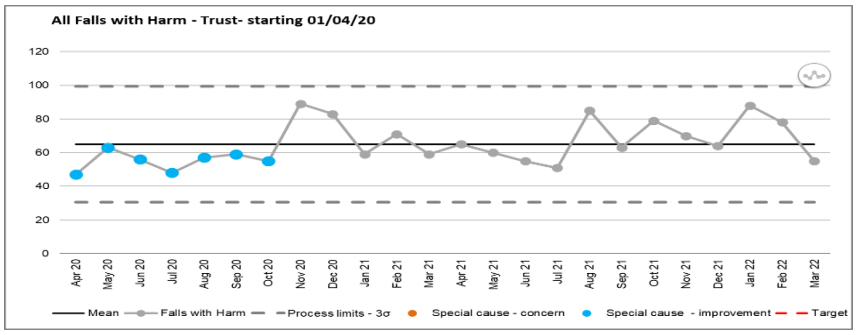
2.2.4 Reducing Patient Falls

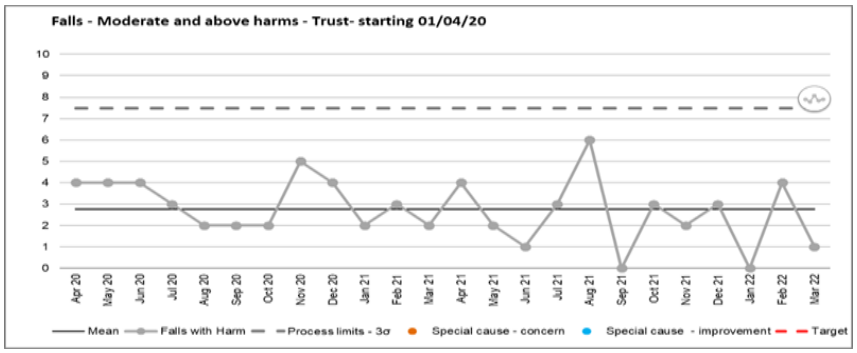
What?	Reduce the number of patients experiencing harm as the result of a fall.
How Much?	To achieve a 10% reduction by March 2022.

The use of the 'falling leaf' symbol continues to be used throughout in clinical areas to alert staff of patients who have been identified as being at risk of falls. The process of using visual identification of a risk has been considered and relaunched as part of the new "what matters most to me" back of bed boards. The falling leaf symbol will be one of several which will enable staff to easily understand the risk each patient has.

"Leaves are supposed to fall, people are not"

Following the implementation of the new bed frames during 2019, with a low height setting, the Trust was able to see a reduction in patient falls within the Hospital setting. During 2021/2022 however, because of the continuing COVID-19 pandemic, the increase in acuity of patients, cessation of hospital visiting, and increased challenges in communication, there was an increase in the number of falls across the primary care (community) and secondary care (hospital) settings. Whilst the number of falls remained within normal variation the average number of falls during 2021/2022 was 67 each month compared to 62 per month for 2020/2021.





Whilst there was an overall increase in the number of falls.

The numbers resulting in a moderate harm or above decreased with a total of 29 during 2021/2022 compared to 37 the previous year.

These remain within normal variation.

The identification of patients at risk of falls and the implementation of the appropriate plan of care to reduce the opportunity to fall is an important response in reducing falls. The redevelopment of the falls risk assessment and supporting falls policy as part of the admission process is due to be completed following successful pilots within the acute hospital.

The risk assessment will assist in identifying the level of risk that a patient is at of potentially having a fall. This will enable preventative measures to be introduced to reduce the risk and ensure a safe environment is maintained. The new Falls policy and post falls questionnaire will help with this and is due to be implemented on completion of this pilot.

The trial of a new product to support falls reduction through a non-contact patient monitoring system, which alerts staff to unexpected patient movement is being overseen by the Tissue Viability team. It is anticipated that if successful this will replace the current falls prevention system.

The development of the enhanced care policy and improved levels of staff across the organisation has supported the use of bay tagging being introduced across wards at BTH. This is where a Nurse or Health Care Assistant (HCA) is assigned to a bay of patients. Initially launched during June 2021 further education around the use of this policy is being rolled out. The benefits of this are:

- Call bells are answered promptly
- Patients who attempt to mobilise unsupervised are given the necessary supervision
- Patients/relatives feel safe and confident when there is a constant presence

- More personalised care
- Patient can be visually observed
- Overnight patients who are getting out of bed can be heard and given assistance promptly

Outcome	Target not met - during 2021/22, the number of patients who had acquired an injury because of a fall increased by 8.84% from 747 in 2020/21 to 813. However, this figure represents 0.28% of all inpatients involved in a fall sustaining harm for the year 2021/22, which is a decrease on the previous year of 0.02%.
Progress	Whilst the overall number of falls increased during 2021/22 due to the number of acutely ill patients, the number of falls resulting in a moderate or above harm decreased by 21.62%.

2.2.5 Reduction in Pressure Ulcers – Trust wide - Acute / Community

What?	Reduce the number of patients experiencing a harm as a result of a pressure ulcer
How Much?	• A 50% reduction category 2 hospital acquired pressure ulcers • A 50% reduction in community acquired pressure ulcers • An 80% reduction in Category 3 and 4 hospital acquired pressure ulcers

Pressure ulcers cause pain and distress to patients, they also increase length of hospital stay and dependence on health care providers. Pressure ulcers are largely avoidable, and the Trust considers hospital acquired category 3 and 4 ulcers to be internal never events due to their severity. The Trust is committed to eradicating category 3 and 4 ulcers and sets challenging targets for a significant reduction of category 2 pressure ulcers and community acquired pressure ulcers.

In the 12 months between 2021-2022 the Trust recorded 951 Category 2 pressure ulcers; 34 people sustained Category 3 pressure ulcers, and 25 people sustained Category 4 pressure ulcers.

The Tissue Viability service continues to validate reported pressure ulcers face to face within the in-patient services and remotely via wound photography within community services (except for community patients with category 3 and 4 pressure ulcers who are seen face to face). Validation helps to ensure the accuracy of our reported pressure ulcer data, with category 2 pressure ulcers often reported incorrectly; these are corrected by the Tissue Viability Nurse. To support greater accuracy in reported category 2 data, a rolling programme of

training on pressure ulcer identification and prevention along with moisture associated skin damage prevention and management was developed, with monthly sessions available to all staff and good attendance noted.

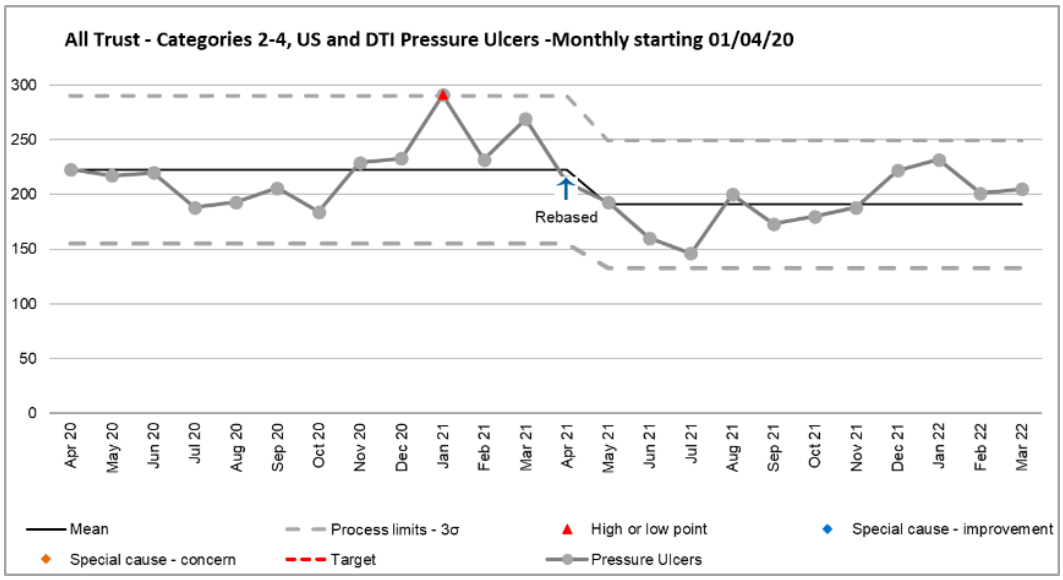
The Pressure Ulcer Collaborative which commenced in July 2020 has continued, with the third phase due to complete in May 2022. All 20 teams who have participated continue to receive support from the Tissue Viability Team and Quality Improvement team and are provided with their weekly pressure ulcer data so they can monitor their performance.

The Tissue Viability Team has identified a need to ensure that validation of reported data does not reduce their ability to provide targeted pressure ulcer prevention support to areas that require it. This will be a focus of their attention in 2022.

The chart below shows all Trust pressure ulcers over the previous 12 months.

When the collaborative teams are separated from the Trust data, they demonstrate a 62% reduction in hospital acquired category 2 and a 47% reduction in category 3 and 4 pressure ulcers.

There has also been a 43% reduction in community acquired pressure ulcers at category 2 to 4 within the collaborative teams.



Outcome	Target not met
Progress	Across the Trust (acute and community), in 2022, category 2 pressure ulcers decreased by 21.34%, category 3 pressure ulcers increased by 70% and category 4 increased by 19.05%. The overall position for all categories together was a decrease of 19.2% in year.

2.2.6 Clinical Pathways

What?	Improve the safety of our patients through delivery of care within defined evidence-based pathways
How Much?	The Trust now participates in Advancing Quality Alliance (AQuA) Audit data collection

The Trust is committed to adherence to the clinical and screening guidelines of the UK Sepsis Trust. This includes use of the 'Sepsis Six' treatment and testing bundle, aimed at delivering resuscitative treatment within the first hour of identifying sepsis with red flag symptoms.

The Trust has maintained adherence to the bundle, with an average of 78% compliance in 2020/2021, with 93% compliance to the vital task of administration of antibiotics in the first hour of care, an increase from 82% for the preceding year.

Linking into the Fylde Coast Clinical Pathway Group, the Trust has taken a QI approach to improving sepsis care on the Fylde Coast. This has involved empowering our staff to explore solutions and ensuring continuous measurement and review of progress. A Pathways Improvement Group has been assembled and is focusing on a number of pathways in line with AQuA reporting, including Sepsis.

Improvement works have built upon the introduction of specialised sepsis trolleys being introduced into the Emergency Department (ED) and the Surgical Assessment Unit (SAU) with the introduction of sepsis 'grab bags' on the wards containing the necessary equipment to assist in initiating the treatment bundle. Sepsis 'boxes' with additional equipment are also being introduced into our Care of the Older Person wards, recognising them as a particularly vulnerable group of patients. ED is further strengthened by the presence of a department 'Sepsis Nurse/Practitioner' supporting the work embedded within the department.

The Trust has appointed an Associate Director of Mortality Governance and Clinical Audit who is providing medical leadership, regarding Sepsis, in conjunction with the Associate Director of Nursing for Harm Free care. They will be addressing the issues of timely treatment in conjunction with best practice in antibiotic stewardship. This review, supported by Critical Care Outreach, will produce a fresh treatment pathway which, in addition to treating red flag Sepsis within the hour, will prompt an early senior review for less severe presentations in order to establish the best treatment goals for the patients involved.

Our NEWS2 chart carries prompts to aid recognition of likely sepsis, and these are incorporated into the current training programmes of 'Recognise and Act', 'Forward to Basics' and Acute Kidney Injury (AKI)/Sepsis sessions which support the practice of nursing staff and Allied Health Professionals (AHPs), junior medical staff, and

preceptors respectively. Our Simulation and Skills team have developed a ‘Sepsis in Sim’ programme which, when aligned with renewed guidelines will support medical undergraduates with the skills to recognise and treat sepsis in a timely manner. Sepsis continues to be highlighted and explored at a ward level, including at our Clifton site where it hoped early intervention will reduce the rate of readmission to the acute Hospital site.

Outcome	• AQuA Sepsis NEWS Audit Composite Process Score (CPS) 57.4% (April 21 – Dec 21). • Sepsis Antibiotics administered within an hour 49.2% (April 21 – Dec21). • Rolling 12 months for Sepsis SHMI maintained below 100 (92 in December 2021 – rolling 12 month figure)

2.2.7 Patient Safety

Lessons Learned

As a large healthcare organisation, which provides both acute and community care services, BTH continues to demonstrate a very positive and proactive culture of patient safety incident reporting and being open with patients, visitors, and staff when things go wrong.

In the past year around 25,500 patient safety incidents were reported by staff, ranging from harm impacts of near misses, no harm, minor harm, moderate harm, severe harm, and death. Incidents are also reported and managed which involve staff, visitors, contractors, and other partnership organisations.

All incidents are investigated proportionately, with moderate, severe harm and unexpected death incidents requiring a higher level of investigation using recognised investigation tools. These root cause investigation tools help to establish and identify whether there have been gaps or omissions in care or treatment, or process and system errors, whilst also identifying best practice and shared learning. SMART action plans, with definitive timeframes and identified responsible leads are produced for each of these incidents, which are monitored for compliance and effectiveness in reducing harms. However, it is also recognised by the Trust the importance of investigating low harm and near miss incidents, to prevent future more serious harm occurring. This is evidenced through our local investigation processes for category 2 pressure ulcers, where through our QI Collaborative programme, we have seen a 60% reduction in category 2 hospital acquired pressure ulcers and a subsequent 13.5% reduction in category 3 & 4 hospital acquired pressure ulcers.

In the event of an unexpected patient death, these incidents are also reviewed through the Trust’s mortality and morbidity review process, which in turn help to inform our investigation processes. Details of our internal investigations are also shared with our regulators, Clinical Commissioning Groups (CCGs) and with the coroner, in the event of an inquest.

The Trust ensures that its harm investigation findings, conclusions, and learning are shared widely across the organisation and in 2021 the Trust produced its first issue of the new 'Safety Focus' newsletter. This newsletter focuses on learning from safety events, including Learning from Excellence, positive patient feedback, clinical incidents, serious incidents and complaints. The Trust's Safety Movement is part of a Safety Culture Programme, which has been developed based on the NHS's Patient Safety Strategy. In addition to this newsletter, shared organisational learning visibility is captured through the creation of videos, simulation exercises, podcasts and through multidisciplinary educational forums and safety huddles.

Video still of a simulation exercise created following a Never Event incident involving an NG (nasogastric) tube.

The Trust also triangulates learning from formal complaints, informal patient concerns, litigation and inquests, as well as from incidents, to capture where improvements and innovative change needs to happen. Some of the ways in which we share learning from incidents, complaints, patient feedback and litigation are through the following processes:

The review of patient harm incidents, their outcomes and trends and themes across all levels of the organisation from the Board reporting Committees, Divisional Governance and Departmental meetings to departmental and ward level team meetings, handovers, and patient safety huddles.

- A bi-monthly dedicated forum - Learning from Incidents and Risk Committee (LIRC), where divisional quality leads report on and share their learning outcomes and improvement projects following patient safety incidents, risks, complaints, inquests and litigation claims.
- The Trust's new Safety Focus newsletter.
- Learning from Serious Incidents (SIs) and Never Events is shared routinely with the QI team to inform the QI Strategy and Improvement Programme.

- Sharing with Clinical Divisions weekly and monthly data reports on incidents, complaints, and litigation, including trends and themes and new initiatives established to improve patient safety.
- The submission of a monthly Risk Management report to the Board's Quality and Clinical Effectiveness Committee, which provides assurance on the management of incidents, SIs, risk, health and safety, duty of candour compliance and shared learning.
- Videos, podcasts, simulation exercises and presentations arranged through multidisciplinary forums, to share thematic reviews and trends and themes from incidents, SIs, and Never Events.

2.2.8 Being Open and Duty of Candour

The Trust promotes and encourages openness, transparency and candour between staff and patients/service users throughout the organisation. This is an integral part of the Trust's safety culture which supports organisational and personal learning.

The intention of the duty of candour legislation is to ensure that health providers are open and transparent with people who use their services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

In March 2022, the Trust updated its Being Open and Duty of Candour Policy to further raise awareness to staff of their obligations to keep patients informed when patient safety incidents occur, to offer apologies and to inform the patient or Next of Kin (NOK) of what we are doing to resolve the issue.

This policy outlines the expectations of the Trust in relation to open and transparent communication with patients, (or where appropriate their families and carers) following a patient safety incident. In particular the policy focuses on providing guidance for Duty of Candour Leads to support the statutory Duty of Candour process.

Adherence to this policy will ensure that staff communication with patients and their families is open and transparent when an incident has occurred and that the organisation meets its statutory Duty of Candour requirements in relation to "notifiable" incidents, as detailed in Regulation 20 of the Health and Social Care Act (2; 3). In addition, the Trust makes every effort to keep patients, or their NOK/family informed of the progress of investigations and offers to share the outcome of investigations and our learning, preferably through face-to-face meetings, or if this is not possible, by sharing the investigation report with a covering letter and providing contact details of a Trust representative.

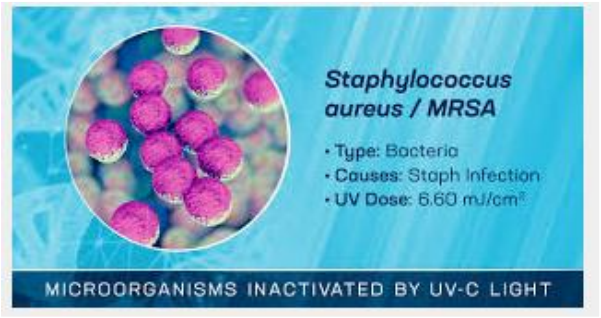
Duty of Candour is undertaken by senior officers of the Trust to ensure that these communications with patients and their families are of the highest standard and quality, providing both meaningful information and ongoing support.

The Trust's compliance against the Duty of Candour Regulation, is monitored by the Incident and Risk Team and reported through various forums, including the Learning from Incidents and Risk Committee (LIRC) and the Board's Quality and Clinical Effectiveness Committee.

2.2.9 Infection Prevention

2.2.9.1 Reduce cases of Methicillin Resistant *Staphylococcus aureus* (MRSA) – Acute

What?	Reduce cases of Methicillin Resistant Staphylococcus aureus (MRSA) Blood Stream Infections within the Trust
How Much?	Zero cases of MRSA Blood Stream Infections



Staphylococcus aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure.

If the bacteria enter the body, illnesses which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves (endocarditis), pneumonia and bacteraemia (blood stream infection).

Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin resistant Staphylococcus aureus (MRSA) and often require different types of antibiotics to treat them.

The NHS Standard Contract 2021/22 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of MRSA, *Clostridioides difficile* and of Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement.

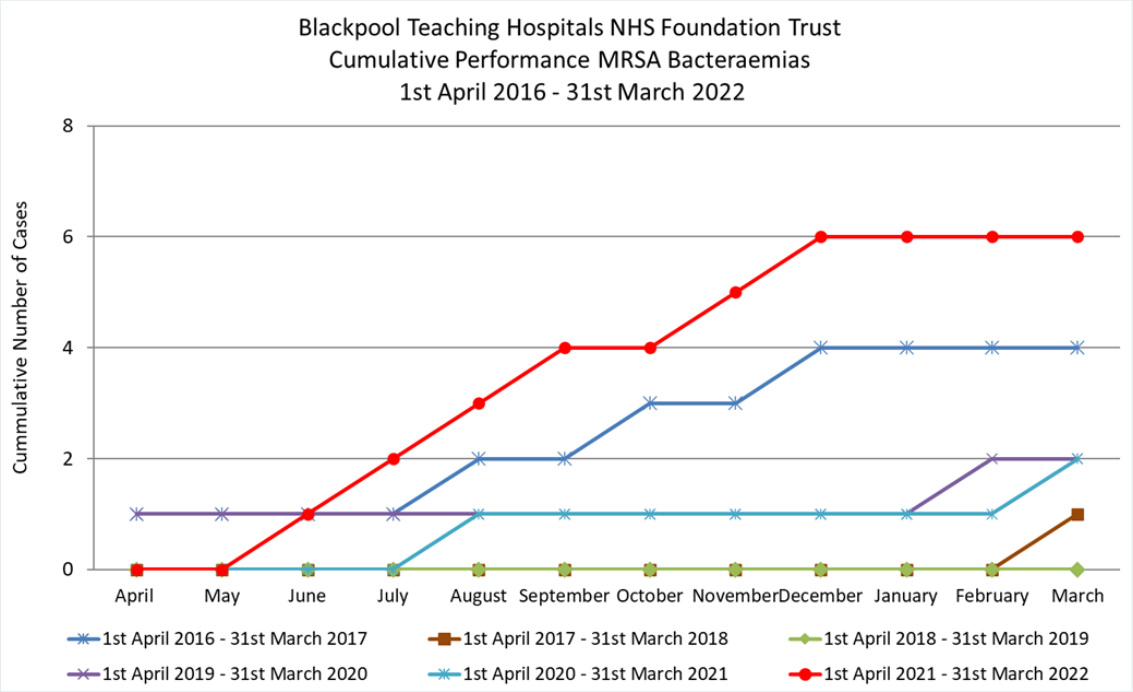
The graph below shows that six cases of MRSA blood stream infection were attributed to the Trust during 2021/2022.

Two cases were defined as ‘Hospital-Onset Healthcare Associated’ (HOHA) – where days from admission to specimen date is equal to or greater than 3 days (where day of admission is day 1).

Four cases were defined as ‘Community-Onset Healthcare Associated’ (COHA) – where days from admission to specimen date is equal to or less than 2 days (where day of admission is day 1), and patient has been discharged from the reporting trust within the last 28 days of this specimen date (where day 1 is day of discharge).

Both HOHA cases and one COHA case relate to the same patient who has a deep-seated infection that is being managed by a multi-disciplinary team. No lapses in care were attributed to these cases.

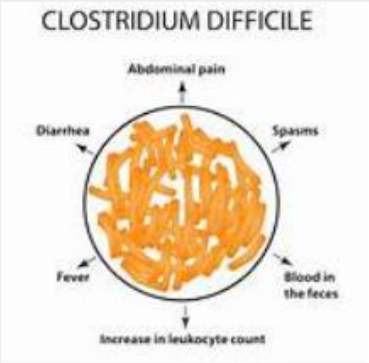
Of the remaining three COHA cases, only one lapse in care was reported which relates to the management of IV devices. This issue is being addressed through Quality Improvement work.



Outcome	Six cases of MRSA Blood Stream infection
Progress	Target not met

2.2.9.2 Reduce cases of *Clostridioides difficile*

What?	Reduce cases of Clostridioides difficile infections (CDI) within the Trust.
How Much?	No target set



Clostridioides difficile (C. difficile) is a bacterium that's found in people's intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies).

C. difficile causes disease when the normal bacteria in the gut are disadvantaged, usually by someone taking antibiotics. This allows C. difficile to grow to unusually high levels. It also allows the toxin that some strains of C. difficile produce to reach levels where it attacks the intestines and causes mild to severe diarrhoea. C. difficile can lead to more serious infections of the intestines with severe inflammation of the bowel (pseudomembranous colitis).

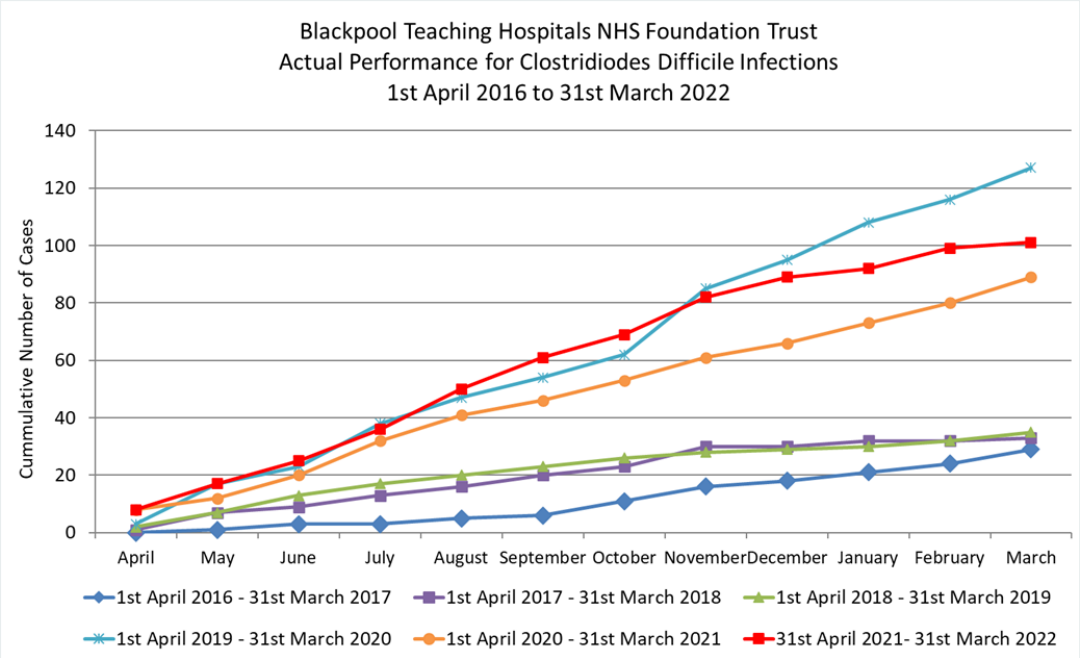
C. difficile is the biggest cause of infectious diarrhoea in hospitalised patients. You can become infected with C. difficile if you ingest the bacterium (through contact with a contaminated environment or person). People who become infected with C. difficile are usually those who've taken antibiotics, particularly the elderly and people whose immune systems are compromised.

A total of 101 cases were attributed to the Trust.

76 cases were defined as 'Hospital-Onset Healthcare Associated' (HOHA) – where days from admission to specimen date is equal to or greater than 3 days (where day of admission is day 1)

25 cases were defined as 'Community-Onset Healthcare Associated' (COHA) – where days from admission to specimen date is equal to or less than 2 days (where day of admission is day 1), and patient has been discharged from the reporting trust within the last 28 days of this specimen date (where day 1 is day of discharge).

Of note, 11 of these cases are duplicate samples taken more than 28 days after the first positive test result. The implementation of the latest NICE guidance which recommends more effective first line treatments should prevent relapses or reinfections from occurring.



Outcome	101 cases of Clostridioides difficile (76 HOHA / 25 COHA).
Progress	Target achieved

2.2.9.3 Covid-19

The ongoing COVID-19 pandemic continued to impact on services during 2021-2022 due to both the Delta variant, which was known to cause severe disease and Omicron variant which caused less severe disease but was far more transmissible.

New National guidance was published in November 2021 after the Delta wave had peaked which aimed to remove the need for Low, Medium, and High-Risk COVID-19 pathways and to instead focus on patients with seasonal respiratory infections including COVID-19. This in effect would have created two pathways for unplanned admissions. One for patients with respiratory infections and one for patients without.

Further guidance was also issued to assist with the Elective Recovery Programme that removed the need for pre-operative PCR testing and self-isolation 72 hours prior to surgery in fully vaccinated patients. Instead, such patients were to provide evidence of a negative lateral flow test instead.

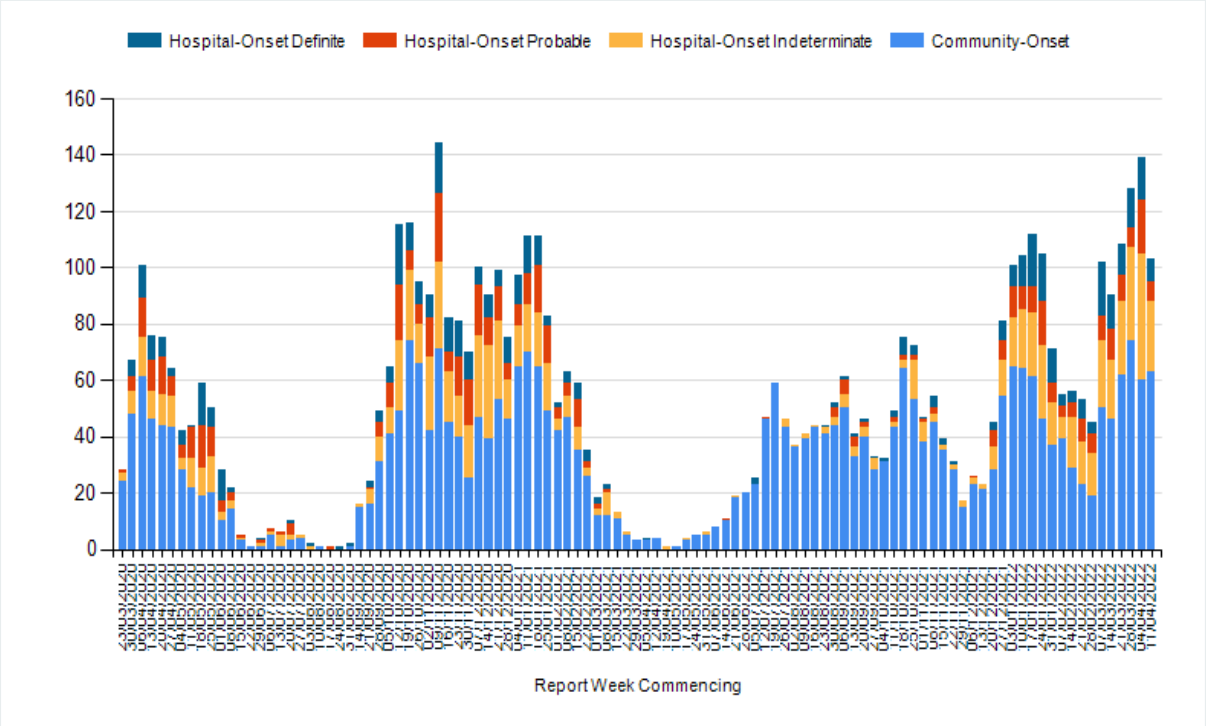
However, the publication of these documents corresponded with the start of a new wave of COVID-19 caused by the Omicron variant. At that time, it was unclear as to the severity of the new variant therefore most Trusts, including BTH opted to continue using the Low, Medium, and High-Risk pathways which although were designed for patient safety, impacted upon patient flow.

National 'Plan B' restrictions were lifted as planned on January 27th, 2022. This combined with the end of compulsory self-isolation periods from March 24th, 2022, resulted in an exponential increase in cases in the community. This would further impact on patient flow due to the number of patients testing positive on admission to

the organisation. The ease at which Omicron is spread also led to nosocomial cases and outbreaks which have been a feature in all NHS Trusts.

Fortunately, most patients with Omicron have been asymptomatic with very few experiencing severe disease. In light of this, incremental changes are being made to National guidance for healthcare settings which will ultimately result in a return to pre-pandemic IPC practices.

The chart below clearly demonstrates the various peaks that have resulted in patient admissions or nosocomial infections



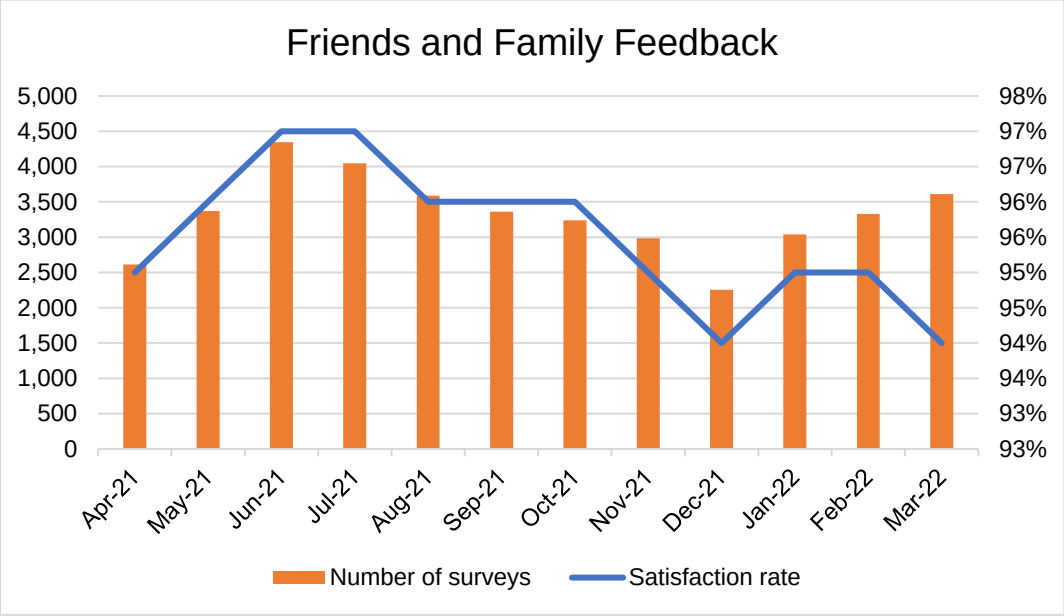
2.2.10 Patient, Family and Carer Experience

2.2.10.1 NHS Friends and Family Test

What?	To improve the Friends and Family Test (FFT) satisfaction rate
How Much?	The organisational objective by 2021 was that 98% of patients would rate our services as good or very good in the NHS Friends and Family Test survey (FFT).

The NHS Friends and Family Test survey (FFT) resumed in December 2020, following a temporary pause due to the pandemic. The Patient Engagement Team have been working hard in 2021-22 to promote the importance of the survey with Trust staff and increase the number of survey responses from patients and their families. The survey feedback is collected using a variety of methods, such as paper (A5/A4/ Large Print/ Easy Read), SMS or online surveys accessed through QR codes. Paper surveys continue to be the preferred method of giving feedback amongst patients, with 78% of surveys completed by paper in 2021-22.

The proportion of patients and their families stating that their experience of our services has been good or very good remained broadly static in 2021-22, as evidenced in the chart below:



The Trust employ CIVICA Solutions to manage all patient and family satisfaction data. The 'Experience' system enables our staff to compare their FFT survey data with other patient experience feedback, so they know how their service is performing in the eyes of patients and the public. They use both the positive and negative feedback to influence the care and treatment they provide, detailing any actions they have taken if required.

From April 2021 – March 22, there were 913 closed actions recorded by our clinical staff on the Experience system, a 136% increase compared to the previous year. Some of these actions are listed below.

Area	Concern raised via the FFT survey	Action taken via the FFT survey
Ward 37	*"Noise from the machine is annoying at night-time and it is hard to sleep."*	The 'Sleeping Helps Healing' campaign was launched in the Trust in November. Earplugs are now offered to patients on admission.
Outpatients, Blackpool Victoria Hospital	*"It's very warm in lilac clinic. Do something about the aircon."*	The Outpatient manager attended a ventilation safety group meeting to address the concerns.
Ward D Maternity	*"It's difficult to sleep, the blinds aren't very good".*	Blinds and curtains have now been added to the ward which are opened at the start of every morning.
Primary Intermediate Mental Health service	*"It's frustrating to keep re-telling my story".*	Processes were introduced to streamline the assessment process to reduce the number of times patients were having to re-live their experiences.

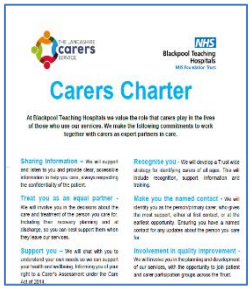
Outcome	In 2021/22 BTH surveyed 39,784 patients using the FFT survey. 96% of patients rated their care as good from April 2021 – March 2022, an increase of 1% from 2020-21. FFT satisfaction rates have been affected on a national level in 2021-22 by the pressures of the Covid-19 pandemic, especially in emergency and urgent care. The national FFT satisfaction rate for A&E is below 80% currently, it was 85% pre-pandemic.
Progress	There has been an increase of 29,215 in surveys when compared to 2020-21. 8817 (22%) of the FFT surveys in 2021-22 were collected via online and SMS text, compared to 3436 in 2020-21. The FFT survey is now available in easy read and the 6 languages most spoken in Trust services, Urdu, Bengali, Romanian, Polish, Arabic, and Kurdish Sorani.
Actions for 2022/23	• Provide visible evidence in public places throughout the Trust to demonstrate what actions have taken place because of FFT feedback. • Maintain the percentage of patients who would recommend our services to friends and family to 96% or above. • Continue to increase the number of actions recorded on the Experience platform, and the number of surveys completed by seldom heard groups.

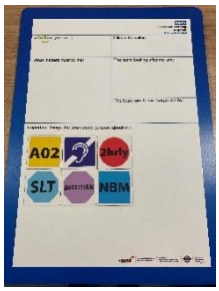
2.2.10.2 Co-production with patients and the public

What?	Ensure the model for co-production is followed by staff across the organisation
How Much?	Trust staff engage groups of people with 'lived experience' at the earliest stages of service design, development and evaluation as they are best placed to advise on what support and services will make a positive difference to their lives.

Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.

Co-production is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches.



Key Priorities	Our targets	Outcome
Develop comprehensive Carer's information, to enhance their experiences at the Trust.	• Involve patients and Carers in the development of a Carer's Charter. • Produce a dedicated section to Carers on the Trust website, with information on carer's assessments external support and network groups.	Met
Produce a *What Matters to Me* Board to be displayed behind all hospital beds.	• Consult staff, patients and the public on what key information they would like displayed on a bedside board. • Trial the *What Matters to Me* Board on the wards to ensure it will make a noticeable difference to patient care. • Secure funding from the Blue Skies Hospital Charity to purchase 1000 boards in the co-produced design.	Met
Provide staff with tools on how to take a co-production approach.	• Produce a Patient and Public Involvement Guideline, showing the different levels of engagement staff can have with patients and the public. • Work with the Quality Improvement Team to develop the principles of co-production in the Clinical Quality Academy. • Increase the number of people on the Trusts Influence Panel ensuring	Met

	membership is representative of the Fylde Coast population.	
Advertise the Hidden Disabilities Scheme widely around the Trust, ensuring all patients and carers have access to a Sunflower Lanyard.	• Secure funding from the Blue Skies Hospital Charity to purchase 6000 sunflower lanyards, badges, wristbands and pin badges. • Design and install two Hidden Disabilities banners in the main entrance of Blackpool Victoria and Clifton Hospital. • Continue to promote the campaign and staff guideline via Trust communications. • Provide guidance to regional Trusts on how to roll out the scheme in their organisation.	Met
Continue to promote the #Hellomynameis badge campaign.	• Advertise the badge scheme to all new starters on the Trust induction programme. • Purchase and distribute all badges to staff.	Met

Outcome	Achieved
Progress	• Over 8200 #hellomynameis badges have been requested by staff since the scheme commenced in 2019-20. • 4000 Hidden Disabilities Sunflower lanyards have been requested by patients and the public. Requests for lanyards have been nationwide, NHS Trusts from the Preston, Manchester and Oxford have contacted the Patient Engagement Team for guidance on how to successfully introduce the scheme into their organisation. • Task and Finish groups are in place with the Trusts Quality Improvement Team and the Lancashire Carers Service to raise staff awareness about the importance of patient and carer involvement.
Actions for 2022/23	• Produce mandatory training on carer awareness, training Trust staff in carer engagement strategies. • Create a Sensory Needs Patient Panel. To produce sensory needs training for staff and ensure our wayfinding and patient information is accessible to all. • Ensure there is a continuous annual programme of co-production work, to make consistent improvements around any issues identified in patient and carer feedback.

2.2.11 Workforce Experience

Percentage of staff not experiencing harassment, bullying or abuse from staff in last 12 months (historical comparison):

2017	2018	2019	2020	2021
81%	79%	77%	79%	82%

Percentage of staff believing that the Trust provides equal opportunities for career progression (historical comparison):

2017	2018	2019	2020	2021
86%	83%	86%	87.4%	86%

Summary of Performance

The staff survey response rate for 2021/2022 improved significantly last year with a response rate of 59%. National benchmarking of Acute and Acute and Community Trusts placed BTH in the top 20% of Trusts for seven of the nine themes surveyed. The survey highlighted some areas for the Trust to focus on improving, however this is to be expected given the challenges that the pandemic has brought. There are no areas of significant concern to report.

Future Priorities and Targets

Divisional leaders are preparing to host the annual Big Conversation ‘listening into action’ events. Feedback from these sessions is used to develop meaningful divisional improvement action plans.

An updated corporate improvement plan is currently in development. Progress in meeting both the corporate and divisional action plans will continue to be regularly reviewed at the quarterly Employee Engagement Sponsor Group which is chaired by the Chief Executive.

2.2.12 Freedom to Speak Up

The Trust always takes concerns by staff very seriously and the Trust responds to concerns where possible and where appropriate to do so; and provides support to staff who raise concerns. The Trust promotes an open and honest culture and encourages staff to raise concerns to help the Trust keep improving services for all patients and the working environment for staff. The Trust’s ‘Freedom to speak up: raising concerns (whistleblowing)’ policy guides staff in how to raise a concern and it details a number of ways how they can do this, for example via their line manager or via the Freedom to Speak Up (FTSU) Guardian.

The Trust proactively encourages staff to raise concerns if they have any and outlines a number of steps staff can indeed take to raise those concerns. Although the Trust encourages staff to raise concerns internally, the policy also guides staff to which external organisations they can raise a concern with, if they feel that is indeed the most appropriate channel to take.

The FTSU service has continued to grow over the last 12 months and an increase can be seen in staff's awareness about how to raise concerns from both the staff survey and the increase in colleagues coming through the FTSU Service to raise concerns.

Blackpool Teaching Hospitals	2017	2018	2019	2020	2021
Would feel secure raising concerns about unsafe clinical practice	72%	71.3%	71.6%	74.3%	76.5%
Would feel confident that organisation would address concerns about unsafe practice	58.4%	58.5%	59.6%	62.2%	62.9%

2.2.13 Improving Care for Patients Living with Dementia

2021 – 2026 Dementia Delivery Plan – Remember me in Dementia

Blackpool Teaching Hospitals NHS Foundation Trust is committed to improving patient experience and delivering improvements in clinical outcomes. During 2021 our workforce responded to the COVID- 19 pandemic by caring for patients in and out of hospital. In 2022 we will restore our services back to pre-pandemic levels and reset by learning, innovating, and maintaining improvement. This is no less important for the people living with dementia who experience the care we provide. This Quality Strategy sets out our ambitions to provide the best care without waits, without harm and effectively use the resources available. Improvement will be made in conjunction with our Quality Improvement team and be shown through our COAST programme as well as through the development of the key performance indicators.

Our aim is to be recognised as a paragon of Dementia care and treatment by continuously building upon the progress already made and listening to those experts through experience and key stakeholders. Following the consultation event which took place in June 2021 seven key commitments were identified to take forward to These commitments, the passion our staff give, and the measurable performance indicators are at the centre of this new strategy and fundamental to ensuring that we continue to 'Remember the Me in Dementia'.

Those 7 commitments are:

1. Dementia Friendly Environments
2. Person-centred approach to dementia care

3. Improve the hospital experience
4. Educated and informed workforce
5. Living Well at Home
6. Partnership working
7. End of Life care

Each of the 7 Key commitments has an identified lead to take forward the associated work stream. Since the consultation event in June 2021 each workstreams group have met and engaged with colleagues from across the health economy as well as experts by experience to take each commitment forward. The progress of each workstream as well as monitoring of the key performance indicators will be presented by each lead at the quarterly Trust Dementia Advisory Board (DAB). The DAB reports on a biannual basis to the Quality and Clinical effectiveness committee.

Each key commitment will be delivered by continuing to work alongside our patients, carers, staff, community groups and partner organisations to deliver services that support the wellbeing of all involved, create integrated care and maximising the impact of resources available. The success will be monitored through consistently achieving the following key performance indicators:

The Remember the Me in Dementia' 2021 -2026 delivery plan will ensure that the foundations of good, high-quality care, treatment, operational delivery and governance are embedded in our commitment to patients with a diagnosis of dementia.

Clear and robust indicators show our progress and regular listening events driven by patient sand engagement will provide the narrative to our journey so that we can continue to demonstrate, influence, and innovate across the Fylde Coast, and amongst our system partners.

Key QI areas:

The Demetria Advisory Board - The Dementia Advisory Board continues meet and reviews and drives key areas of improvements. The Trust has recognised that the pandemic has restricted certain areas of patient, volunteer and third sector involvement

Dementia Champions

Dementia champions meet on a monthly basis and we 152 champions across and all areas/departments and the community who are the "go to person" for dementia resources in their area.

Butterfly Scheme

Butterfly scheme is used to as an alert on tracker and on the back of the bed boards, this is used to inform staff that patients have either a diagnosis of dementia or a mild confusion. Training and awareness of this scheme has been delivered to Champions and ward staff.

Paint me a Picture

This is a person-centred tool that is used widely in the Trust, it gives vital information about the individual needs, wants, and wishes of a person and allowing staff supporting that individual to deliver a more holistic and individualised approach to their care as well as applying any reasonable adjustments.

Tier Two Training

This package is delivered monthly in collaboration with the memory assessment team, rapid intervention team, safeguarding, dieticians and experts by experience. This training is available to all staff who have direct contact with people who have a dementia and is now available to book via ESR.

John's Campaign

Blackpool Teaching Hospitals has pledged to John's Campaign, which promotes partnerships in care with families & carers, improving patient experience & quality of care.

Enhanced care and enhanced care workers

The enhanced care policy was launched in 2021 and this policy aims to improve the quality and patient experience of 1:1 Care. It aims improve the quality of care for patients by ensuring their individual needs are met and improve their experience by building a partnership approach to care delivery. The increase interaction and engagement will have therapeutic advantages and moves away from a culture from providing 1:1 care through a medical model approach to a Partnership in care approach, a holistic model.

The Trust has recruited seven enhanced care workers who will support provide support to individuals/wards/departments who have identified the need for enhanced care through the risk assessment tool.

Dementia Action week

Dementia Action week event programme 2021 was scaled down. The focus during this week was to promote the Champions, the Butterfly Scheme, and Johns

Campaign. Wards and departments participated in afternoon teas, cake sales with funds going to blue skies.


COAST assessments

COAST assessments as led to an increased understanding and awareness of a dementia friendly hospital, and areas of good practice and areas for improvement have been identified.

Some actions have been suspended or delayed or scaled down due to Covid restrictions, however, plans to resume activities once restrictions are lifted are in place:

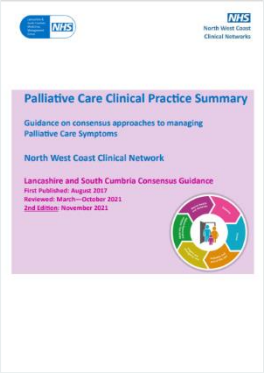
- National dementia audit – is still suspended, however the Trust participated in a voluntary case notes audit. The findings of this audit will inform the themes and actions of local audits that are planned to be introduced in 2022.
- Dementia friendly day room upgrades for Care of Elderly wards - suspended
- Facilitation of dementia HUB and carer's café at Clifton Hospital. – suspended.
- Support of use of memory corridor with a daily activity programme – restricted.

2.2.14 Palliative, End of Life and Bereavement Care

For the last 12 months the Hospital Palliative Care team, End of Life Care and Swan and Bereavement teams have been working as one directorate under the Clinical Support Services Division. The team are led by Dr Harriet Preston, Consultant for Palliative Medicine, as Head of Department and Jackie Brunton in a newly established role as Lead Nurse for End of Life & Bereavement Care.

We were proud to see our teams recognised in the Trust's Celebrating Success awards as finalists and runner up in the Clinical Team of the Year and the Swan Team in Champions of Care category. Our Lead Nurse, Jackie Brunton was awarded Nurse of the Year in the National Sun & NHS Charities "Who Cares Wins

Awards" her nomination was made by a family she supported during the early days of the pandemic.



The teams have continued to support patients, those important to them, and staff across the acute trust and community in line with the Swan Model of Care and the National Ambitions for Palliative and End of Life Care (2021-26) and also the Lancashire and South Cumbria Palliative Care Clinical Practice Palliative Care Summary (2nd Edition) which have been reviewed and updated in 2021.

The Swan model of care is about providing excellent, individualised end of life and bereavement care for every patient and every family, every time.

It is patient and family focussed and centres on meeting the unique needs of each individual and their loved ones.

The team continues to meet regularly with our Fylde Coast partners to oversee the development and delivery of services. Our Fylde Coast End of Life Strategy Group is well established, and we will be reviewing our end-of-life care strategy during 2022 with key stake holders.

Hospital End of Life & Bereavement Care Group

Our End of Life and Bereavement Care Group continues to meet monthly and leads on the Trust agenda for end-of-life care and bereavement support services. The Group is chaired by the Head of Department and Lead Nurse.

Swan End of Life Care Champions

Our Champions meetings were relaunched in 2021 utilising Microsoft teams and support the teams across acute and community care and care homes and nursing homes. The Champion's feedback has informed development of the twelve-month education programmes to support and develop them in their role.

Specialist Palliative Care Services

The Trust and Trinity Hospice have made significant investment to enable the expansion of our specialist palliative care team. The seven-day service commenced in May 2021. We have introduced new roles into the team such as health care assistants and advance care practitioners and we have recently benefitted from a dedicated pharmacist who we hope to secure funding for permanently in the future.

Consultant cover has been strengthened despite the retirement and return of Dr Andrea Whitfield, as we welcome Dr Martin Davidson, who joins us from Trinity

Hospice in a combined hospital/community post. We are also delighted to now have full time secretarial support.

We continue to see an increase in specialist palliative care referrals year-on-year between 1st April 2021 - 31st March 2022:

- 1,463 referrals were seen
- 5,286 face to face visits were undertaken.
- An impressive 96% of patients were seen within 24 hours of referral. This increase (from 88% in 2020/21) can mainly be attributed to seven day working.
- 19% of new referrals (277) seen were at weekends as well as 904 reviews (Saturday/Sundays only from 8/5/2021 - 24/4/22).

The impact of seven-day working has also been seen through emergency department presence with 69 patients having been supported in the department with hospital admission being avoided for 19 of those (28%) saving 78 acute bed days (figures from February 2021 to January 2022).

Close working with our partners at Trinity and the introduction of daily huddles have enabled us to transfer more patients to the Hospice at weekends and hospital patients accounted for 58% of the patients admitted to the inpatient unit last year.

We continue to work closely with the trust in the Emergency Village project to identify appropriate pathways for those patients that are admitted and hope to trial a pilot of the advice and guidance portal to widen primary care access to specialist palliative care advice. Work also continues at a locality and network level, to widen access to specialist palliative care advice and enhance advance care planning & end of life training across all health care professionals to reduce unwanted and avoidable hospital admissions.

Swan End of Life & Bereavement Care Team

Thanks to the Blue Skies Hospital Charity, NHS Charities and the Trust, the team have been able to secure a permanent Swan Suite and a permanent End of Life and Bereavement care team.

The Team commenced in June 2021 and consists of three specialist nurses and a support worker.

Referrals to the team for bereavement support continue to increase with overall referrals of 549.

The team will continue to work alongside ward teams and champions to embed the Swan Model and end of life care support. All end-of-life patients' care is reviewed and support offered at this point.

National Audit Care End of Life

The team continues to participate in local and national audit programmes. They have recently received the results of the 3rd round of the National Quality Survey (NACEL) audit looking at deaths in the acute Trust and will undertake the 4th round due to commence in June 2022. The results from these and the recent Nursing Care Plan audit will continue to inform their education programme, which is also currently under review in line with the Network review.

Education and Training

The education programme continues but is currently under review, with expected competencies for staff groups being mapped to appropriate training to fulfil them. A training needs analysis has been completed and will inform the ongoing development of training.

Education has been delivered across all settings – acute, community and care homes, in both formal and ad-hoc sessions. For the more formal sessions training was delivered to the following numbers of staff:

- End of Life Study Day - 66
- Verification of Death – 133
- Mayfly (Advance Care Planning and Difficult Conversations) – 97
- T34 Syringe Driver training – 51
- DNACPR Training 33

Support for staff in care homes has been delivered through the End-of-Life Educator/Facilitator. A Fylde Coast wide audit was undertaken of care homes with regard to the End-of-Life care provided and their training needs. As a result of this a dedicated training package is in production to meet their specific needs.

Our End-of-Life Care team continue to be engaged with quality and service improvement initiatives both locally and regionally e.g., Verification of Death by Nurses, Last 1000 days/Fractured Neck of Femur Collaborative and EPaCCS workstreams.

Engaging and supporting our communities:

We continue to support national, regional and local campaigns to raise awareness of the support and services available to our Fylde Coast Community, these include a National Grief Week Campaign during December 2021 which coincided with our annual remembrance services - “Tree of Lights”” and Baby Remembrance Service” and Dying Matters Week in May 2021.

2.2.15 Mortuary

The Mortuary at BTH has a body store which can accommodate 120 deceased patients. Two additional separated refrigerated units have recently been purchased

to increase capacity to 180 in response to the COVID pandemic. The Mortuary also has two rooms available for bereaved families to visit their loved one, a large post-mortem room and separate forensic/infectious post-mortem suite. The Mortuary is licensed with the Human Tissue Authority (HTA) and has United Kingdom Accreditation Service (UKAS) ISO 15189:2012 accreditation with the most recent HTA inspection having taken place in January 2022.

Over the past 12 months, there has been a reduction in the number of deaths and a slight decrease in the number of post-mortems performed.

The mortuary, bereavement and ME team work closely with the End of Life Care teams and Chaplaincy and as a result, a new IT system has been purchased to ensure data is stored securely and can be accessed by relevant personnel whilst in contact with the patient and bereaved families.

Our mortality statistics for the past five years are as follows:

Deaths	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**
Number Hospital Deaths	2083	1887	1847	2105	1855
Number Community Deaths	629	643	642	661	724
Total Number Deaths	**2712**	**2530**	**2489**	**2766**	**2579**

Post Mortems (PMs)	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**
Number Coroner PMs	562	467	458	245	528
Number Hospital PMs	4	1	2	0	0
Number Infectious PMs	105	81	80	241	61
Number Home Office PMs	15	30	15	14	27
Number Independent PMs	9	9	0	21	0
Number of CT PMs		94	93	101	120
Total PMs Combined	**695**	**682**	**648**	**622**	**616***

**invasive does not include Computed Tomography Post Mortems*

2.2.16 Medical Examiner System

Blackpool Teaching Hospitals has recently introduced a Medical Examiner system, which has been operational since March 2021. The purpose of the medical examiner system is to scrutinise non-coronial deaths both here at BTH and Clifton Hospital, to improve the quality of death certification, provide a better service for the bereaved and provide an opportunity to raise concerns as well as improving the quality of mortality data and subsequent learning.

During the initial roll-out, there was an expectation that all non-coronial acute deaths were scrutinised by the Medical Examiner (ME), however from April 2022 there is a requirement to scrutinise all community deaths. Throughout 2021-22 the Trust has employed a number of MEs and Medical Examiner Officers, with the team gradually expanding to accommodate the scrutiny of community deaths.

The service currently runs Monday to Friday and will have a Medical Examiner in situ during these days by mid-April 2022. Once the new ME's are in post and trained,

the team will start to review community deaths starting with Trinity Hospice and 2 GP practices (Highfield Surgery & Bloomfield Medical Centre) before gradually rolling this out to the rest of the GP practices / integrated care services within the area.

The Medical Examiner's service continues to work closely with the SWAN Bereavement Nurses, the Coroner's team, and governance and mortality teams in order to support the improvement of patient care and provide greater safeguards for the public by identifying matters for clinical governance and improving how we can learn from deaths.

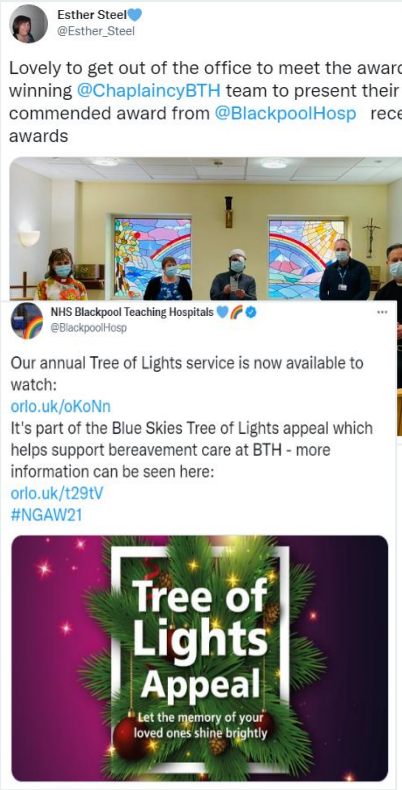
2.2.17 Spiritual and Pastoral Care

The Chaplaincy and Spiritual Care Department consists of seven members of staff: three full time Chaplains, and four part time Chaplains covering a variety of faiths. There are 20 Chaplaincy Volunteers, and an online directory of Local Faith Communities is maintained by the team to ensure all spiritual requests are met.

The Trust Chaplains provide a 24/7 on-call service to help meet specific spiritual and religious needs, often in an end-of-life context. In 2021-22 they had 475 emergency calls to attend the hospital, 287 (60%) of which were out of hours. A new Service Level Agreement with Lancashire and South Cumbria began in 2021 to facilitate Chaplaincy support to patients at The Harbour. The Chaplaincy Service Level Agreement with Trinity

Hospice also continued, helping to facilitate a continuity of spiritual care for patients, carers, and family members across the Fylde Coast Healthcare community.

The Chaplains have remained on the front line throughout the Covid-19 pandemic, always working in all areas and available. This dedicated team received the Non-Clinical Team of Year and Chairman's Commendation at the Trusts annual Celebrating Success Awards, for their outstanding provision of spiritual and religious care, supporting staff, patients, and relatives



The annual Bereavement Services were held in December 2021. All services were done virtually, with the restrictions still in place around mass gatherings.

The Tree of Lights service

The Tree of Lights service (Trusts annual bereavement ceremony) has been accessed almost 400 times on You Tube. The Light up a Life (Trinity Hospice annual bereavement service) service was also well engaged, with festive lights switched on and 600 people participating in the event.

The Hospital Chapel Garden in Victoria Hospital continues to be developed for staff wellbeing. In 2021-22 the Chaplains worked closely with the Staff Wellbeing Team on the new Trust Health and Wellbeing Strategy. The Chaplaincy and Spiritual Care Department continue to deliver an education programme to staff that highlights good spiritual care, religious needs, spiritual assessment, and staff wellbeing. In 2021-22 they provided Spiritual Care Awareness and Refresher training as part of the wider End of Life and Bereavement Care Programme and on the Trust staff induction.

2.2.18 Learning Disability Service

“Getting it Right" For People with a Learning Disability and or Autism Delivery Plan

Blackpool Teaching Hospitals NHS Foundation Trust is committed to improving patient experience and delivering improvements in clinical outcomes. This ambitious delivery plan sets out our how we will drive improvements for patients with a learning disability and or autism and for whom care is often complex and admissions to hospital challenging. The delivery plan also takes up the key actions developed following an index case where concerns were raised.

It sets out our ambitions to provide people with a learning disability and or autism safe effective care, for everyone, every day. To achieve this will require strategic planning, commitment, and leadership at all levels within our organisation, coproduction with those with the lived experience, self-advocates, and the contribution of our entire workforce. Improvement will be made in conjunction with our Quality Improvement team and be shown through our COAST programme as well as through the development of the key performance indicators.

The commitment is to be recognised as a paragon in the care and treatment of people with a learning disability and or autism, by a delivery plan that reflects the needs of people with a learning disability and or autism and listening to those experts through consultation and engagement. Following the consultation event which took place in July 2021, seven key actions were identified to take forward to improve further the quality of care and treatment for people with a learning disability and or autism. These key actions along with the commitment of our staff team and the measurable performance indicators are at the centre of this new delivery plan and fundamental to ensuring that we are “Getting it Right” for people with a learning disability and or autism. Those seven key actions are:

1. Person centred care
2. Reasonable Adjustments
3. Workforce
4. Decision making
5. Training
6. Service user engagement
7. Transition

Each key action has an identified lead to take forward the associated work stream. Since the consultation event in July 2021 each workstream group have met and engaged with colleagues from across the health economy as well as experts by experience to take each action forward. The progress of each workstream as well as monitoring of the key performance indicators will be presented by each lead at the

quarterly Learning Disability and Autism Planning Group. This reports on a biannual basis to the Quality and Clinical Effectiveness Committee.

Each key action will be delivered by continuing to work alongside our patients, carers, staff, community groups and partner organisations to deliver services that support the wellbeing of all involved, create integrated care and by maximising the impact of resources available. The success will be monitored through consistently achieving the following key performance indicators:

The “Getting it Right” for people with a learning disability and or autism delivery plan will ensure that the foundations of high-quality person-centred care, treatment, operational delivery, and governance are embedded in our commitment to patients with a learning disability and or autism. It has clear and robust indicators that show our progress against the key actions within this. This will be further demonstrated through regular engagement events supported by the Patient Experience and Engagement team and driven by our experts by experience. This will provide the narrative to our journey so that we can continue to demonstrate, influence, and innovate across the Fylde Coast, and amongst our system partners.

Key QI areas:

National Benchmarking Exercise

The Trust participated in round three (2020/2021) of the learning disability improvement standards project. The findings of this exercise have been incorporated in the delivery plan.

Learning Disability Awareness Week

This event was scaled down due to covid restrictions, however during this week champions promoted person centred care through an “odd sock day”, this was to symbolise our own uniqueness and individualism. The week was also used to promote the role of the Champions, the hospital passport, and the learning disability folder.

Champions

The learning disability champions meet on a monthly basis and we 136 champions across and all areas/departments and the community who are the “go to person” for learning disability and autism resources in their area. They are responsible for updating the Learning Disability folder that all wards and departments have, which provides information on reasonable adjustments, easy read information, and pictorial supports.

DNCAPR

There is now an easy read resource pack available on the Trust intranet that gives accessible information on DNACPRs.

Training

Learning disability and autism awareness training is now delivered on new HCA and RN staff inductions as well as ad-hoc/bespoke training to areas or teams that request support.

Alert and symbol

A new learning disability symbols has been agreed and launched. This symbol is used as an alert on tracker and on the back of the bed boards and is used to inform staff that patients have either a learning disability and or autism so consider reasonable adjustments and read the hospital passport. It was important to incorporate the colour blue in this symbol as reminder of some of the lesson learnt from the index case where a much loved and treasured blue blanket was lost, resulting in great upset and distress.

Enhanced care and enhanced care workers

The enhanced care policy was launched in 2021 and this policy aims to improve the quality and patient experience of 1:1 Care. It aims improve the quality of care for patients by ensuring their individual needs are met and improve their experience by building a partnership approach to care delivery. The increase interaction and engagement will have therapeutic advantages and moves away from a culture from providing 1:1 care through a medical model approach to a Partnership in care approach, a holistic model.

Hospital Passports

Hospital passports are widely used throughout the hospital now, and through education and promotion of these person-centred documents, clinical areas are using these tools to support individuals and staff appreciate the value of them. The hospital passport can be accessed via the Trust intranet and a copy of this template is kept in the learning disability folder for staff to complete with those individuals who do not come with their own passport.

2.2.19 LeDeR Process

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to support improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce health inequalities and premature mortality, sometimes faced by people with learning disabilities. The Trust actively participates in these reviews and has a process in place for recording when a person with learning disabilities dies whilst in our care.

The Trust offers ongoing support to the LeDeR program through the following:

- Trust guidelines for the management of patients with known learning difficulties.
- Mandatory notification of deceased patients with learning difficulties to the Trust LeDeR coordinators (medical and/or nursing),
- Details of all deceased patients with learning disabilities are registered with the LeDeR central organisation in Bristol.
- All LeDeR deaths are recorded on the Trust's Learning from Deaths recording system, the LfD App and monthly figures are reported to the Mortality Improvement Group and the bi-monthly Mortality Governance Committee.
- Deaths of patients with Autism as well as Learning Difficulties are now reported through the LeDeR process.
- Maintenance of a local database to monitor acute unit case record reviews and external LeDeR reviews.
- Hospital case records are made available to external LeDeR reviewers on site under the supervision of the Trust's medical LeDeR coordinator.
- Action points for implementation and learning points for dissemination are generated by individual case record reviews and are distributed Trust-wide to all departments.

2.3 Our Plans for the Future

The Trust's QI Strategy (2019-2022) is current, and a subsequent updated QI strategy is due in November 2022. The current focus for all programmes is to ensure sustainability and spread of improvements. The Trust will continue to focus on current improvements, to help ensure they become part of everyday practice and "business as usual", and is currently developing and launching further improvement programmes, which are under review and receiving feedback from colleagues and patients. Another key focus for the Trust is to continue building Improvement capability which has been described in more detail in Section 2.4.

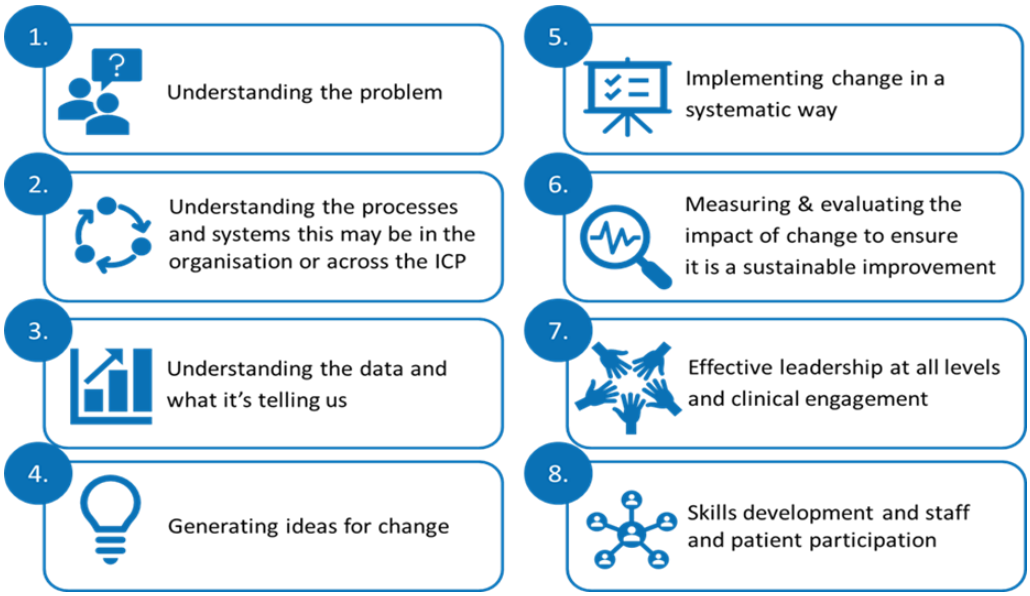
2.4 Our Quality Priorities 2021/2022

As well as facilitating the large-scale improvement programmes, the Trust aimed to increase improvement capability and therefore knowledge in all staff groups and grades to achieve service improvement at every level.

The Trust continues to build on existing initiatives and to create opportunities to accelerate trust-wide learning. A "dosing strategy" was developed in 2020 to help the Trust ensure colleagues get the support that they require depending on their current QI capability and what they are aiming to achieve, so that everyone is able to contribute to continuous improvement with the right skills and opportunities. Colleagues involved in the Trust-wide collaboratives have been learning the science of improvement and practicing the art of improvement in their jobs. Additionally, all staff are provided with opportunities to attend a range of training programmes. In 2022, the training programmes were opened up to patients wishing to become involved in improvement work.

In the last 12 months, around 500 people have participated in collaborative programmes or improvement training, and have developed quality improvement key skills, including the quality improvement principles, adapted from the NHS England NHS Improvement Quality, Service Improvement and Redesign (QSIR) programme, which is one form of quality improvement training offered by the Trust.

Quality Improvement Principles:



Clinical Quality Academy (CQA)

The Trust's efforts to build capability have included a 12-month training programme for clinically led teams, known as the Clinical Quality Academy (CQA), Cohort 1 of which launched in October 2021 and is currently in progress. The CQA aspires to maximise potential to move at pace and scale, creating a critical mass of "improvers" and create a culture for improvement across the Trust.

By the end of 2022, ten clinically led teams which have formed Cohort 1, will deliver projects to improve care, whilst developing advanced improvement science, knowledge and skills.

The CQA was designed using learning from similar programmes, such as Salford NHS Trust Improvement Science for Leaders (IS4L) programme. The academy is delivering an intensive programme of teaching, action learning and coaching in the science of improvement. The programme has been delivered by eminent teachers from around the world, and leaders in the improvement science field. Teaching has been both virtual and where possible, in person.

2.4.1 Statements of Assurance from the Board of Directors

Review of Services

During 2021/2022, BTH provided and/or subcontracted over 150 acute and community services including the following:

- Urgent and Emergency Services
- Medical care (including Care of the Older Person)
- Surgery
- Tertiary Cardiac
- Haematology
- Critical Care
- Maternity
- Services for Children and Young People
- End of Life Care
- Outpatients
- Diagnostic Imaging
- Gynaecology
- Community Services
- CAMHS
- Neonatal Care
- Cancer Services
- Dementia Services
- Pain Management

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

The income generated by the relevant health services reviewed in 2021/22 represents 100 per cent of the total income generated from the provision of relevant health services by BTH for 2021/22.

2.4.2 Participation in Clinical Audits and National Confidential Enquiries

During 2021/2022, 44 national clinical audits and three national confidential enquiries covered relevant Health services that BTH provides.

During that period BTH participated in 88% of national clinical audits and 100% of 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 BTH were eligible to and/or did participate in during 2021/2022 are as outlined below.

2.4.3 National Clinical Audits

The national clinical audits and national confidential enquiries that BTH participated in, and for which data collection was completed during 2021/2022, are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage or the number of registered cases, as required by the terms of that audit or enquiry. The table also outlines audits the Trust did not participate in, or which were not applicable to the Trust:

	National Clinical Audit / Project Title	Eligible	Participated	Number or Percentage submitted
1	Case Mix Programme	✓	✓	746
2	Child Health Clinical Outcome Review Programme (NCEPOD)	✓	✓	Ongoing
3	Chronic Kidney Disease registry	✓	✓	
4	Cleft Registry and Audit NEtwork (CRANE)	No	Not applicable to Blackpool Teaching Hospitals	------
5	Elective Surgery (National PROMs Programme)	✓	✓	
6	**Emergency Medicine QIPs**			
	Pain in children	✓	✓	Ongoing
	Infection prevention and Control	✓	✓	Ongoing
7	**Falls and Fragility Fracture Audit Programme (FFFAP)**			
	Fracture Liaison Service Database			Ongoing
	National Audit of Inpatient Falls	✓	✓	100%
	National Hip Fracture Database	✓	✓	65%
8	Inflammatory Bowel Disease (IBD) Audit	✓	Not participated due to Covid	------
9	Learning Disabilities Mortality Review Programme (LeDeR)	✓	✓	
10	Maternal and New-born Infant Clinical Outcome Review Programme	✓	✓	
11	Medical and Surgical Clinical Outcome Review Programme	✓	✓	Ongoing

12	Mental Health Clinical Outcome Review Programme	No	Not applicable to Blackpool Teaching Hospitals	------
13	**National Adult Diabetes Audit**			
	National Diabetes Core Audit	✓	✓	
	National Pregnancy in Diabetes Audit	✓	✓	
	National Diabetes Footcare Audit	✓	✓	61
	National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	No	Audit did not take place due to Covid	------
14	**National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)**			
	Paediatric Asthma Secondary Care	✓	✓	
	Adult Asthma Secondary Care	✓	✓	
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	
	Pulmonary Rehabilitation-Organisational and Clinical Audit			
15	National Audit of Breast Cancer in Older Patients (NABCOP)	✓	✓	
16	National Audit of Cardiac Rehabilitation	✓	✓	
17	National Audit of Cardiovascular Disease Prevention			
18	National Audit of Care at the End of Life (NACEL)	✓	✓	100%
19	National Audit of Dementia (NAD)	Audit withdrawn		
20	National Audit of Pulmonary Hypertension	No	Not applicable to Blackpool Teaching	------
21	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	✓	✓	
22	National Cardiac Arrest Audit (NCAA)	✓	✓	
23	**National Cardiac Audit Programme (NCAP)**			
	National Audit of Cardiac Rhythm Management	✓	✓	100%
	Myocardial Ischaemia National Audit Project	✓	✓	Ongoing
	National Adult Cardiac Surgery Audit	✓	✓	1001
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)			
	National Heart Failure Audit	✓	✓	Ongoing
	National Congenital Heart Disease	No	Not applicable to Blackpool Teaching	-------
24	National Child Mortality Database			

25	National Clinical Audit of Psychosis (NCAP)	No	Not applicable to Blackpool Teaching Hospitals	------
26	National Comparative Audit of Blood Transfusion	✓	✓	40
	2021 Audit of the management of Patient blood Transfusion	✓	Not participated due to Covid	------
	2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	✓	Not participated	------
27	National Early Inflammatory Arthritis Audit (NEIAA	✓	✓	
28	National Emergency Laparotomy Audit (NELA)	✓	✓	
29	**National Gastro-intestinal Cancer Programme**			
	National Oesophago-gastric Cancer	✓	✓	
	National Bowel Cancer Audit	✓	✓	
30	National Joint Registry	✓	✓	
31	National Lung Cancer Audit (NLCA)	✓	✓	
32	National Maternity and Perinatal Audit	No	Not applicable to Blackpool Teaching Hospitals	------
33	National Neonatal Audit Programme (NNAP)	✓	✓	
34	National Paediatric Diabetes Audit (NPDA)	✓	✓	
35	National Perinatal Mortality Review Tool (MBRRACE-UK)	✓	✓	
36	National Prostate Cancer Audit (NPCA)	✓	✓	
37	National Vascular Registry	No	Not applicable to Blackpool Teaching Hospitals	
38	Neurosurgical National Audit Programme	No	Not applicable to Blackpool Teaching Hospitals	
39	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	No	Not applicable to Blackpool Teaching Hospitals	
40	Paediatric Intensive Care Audit (PICANet)	No	Not applicable to Blackpool Teaching Hospitals	
41	Prescribing Observatory for Mental Health UK	No	Not applicable to Blackpool Teaching Hospitals	
42	National Outpatient Management of Pulmonary Embolism	✓	Not participated	
43	Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	1198
44	Serious Hazards of Transfusion Scheme (SHOT)	✓	✓	
45	Society for Acute Medicine Benchmarking Audit	✓		

46	Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment			
47	The Trauma Audit & Research Network (TARN)	✓	✓	268
48	UK Cystic Fibrosis Registry	✓	✓	Required
49	**Urology Audits**			
	Cytoreductive Radical Nephrectomy Audit			
	Post Colonoscopy colorectal Cancer Audit	✓	✓	
	Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	✓	✓	
	UK Renal Registry National Acute Kidney Injury programme	✓		
	National Mortality Case Record Review Programme	✓	✓	
	National evaluation of accuracy of stillbirth certificates (NESTT) study	✓	✓	
	National Comparative 2019 re-audit of the medical use of red cells	✓	✓	40
	NatSSIPs / LocSSIPs	✓	✓	Ongoing
	Potential Donor audit	✓	✓	
	British & Irish Orthoptic Society Vision Screening Audit	✓	✓	
	Cardiovascular outcome4s after major abdominal surgery (CASCADE)	✓	✓	Ongoing

** Note: - Some National Audits require a total number of patients entered into the data base, rather than a percentage*

The reports of four national clinical audits were reviewed by the provider in 2021/2022 and BTH intends to take the following actions to improve the quality of healthcare provided (see Appendix A).

The reports of 106 local clinical audits were reviewed by the provider in 2021/2022 and BTH intends to take the following actions to improve the quality of healthcare provided (see Appendix B).

2.4.4 NCEPOD National Confidential Enquiries into Patient Outcome and Death 2021/22

One study was postponed due to the COVID-19 pandemic in 2021/2022 and 3 are ongoing:

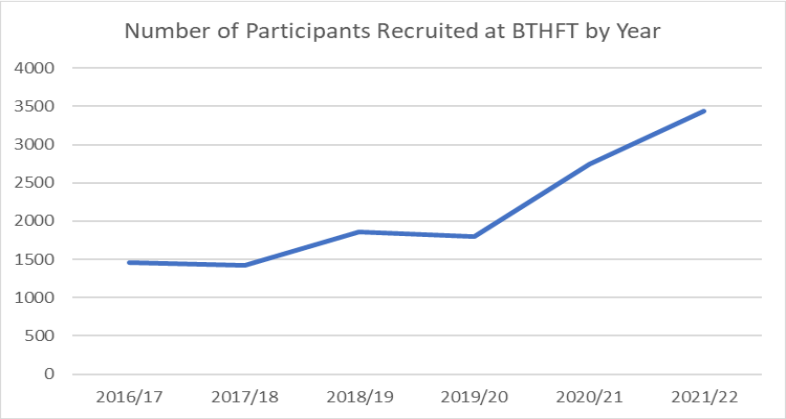
Study Title	Eligible	Participated	Position
Transition	✓	✓	Postponed
Epilepsy	✓	✓	Ongoing
Crohn's disease	✓	✓	Ongoing
Children with chronic Neurodisability	✓	✓	Ongoing

2.4.5 Participation in Clinical Research in 2021/2022

Clinical research is a vital part of the NHS enabling the offer of innovative treatments and therapies to our patients leading to an overall improvement in people's health. This has been clearly demonstrated by the pandemic. BTH has been at the forefront of the delivery of urgent public health research and in 2021/22, a new C-19 vaccine (Novavax) which recruited its first trial patient within Blackpool, was successfully approved by the regulators within the UK and across the world.

BTH has made significant strides forward across all of our research programmes throughout the year. BTH hosts one of only 5 National Institute of Health Research (NIHR) Patient Recruitment Centres (PRC) which has now completed its second year of operations and is the leading PRC in participant recruitment nationally. A state-of-the-art research facility located within the centre of the hospital, which has significantly increased our capacity to deliver late-phase commercial clinical research across a range of health priority areas including cardiovascular disease, oncology, haematology and infection. Cutting edge treatments are now being offered to these patient groups and rapid study set up has enabled our BTH patients the opportunity to be some of the first to receive these nationally.

The R&D team are committed to supporting the development of our BTH staff and their capability to participate within the delivery of research. Over the past 12 months, we have contributed to the Trust Induction programme, offered research training opportunities across all staff groups. We have also supported the delivery of the Service Evaluation programme at BTH with 32 projects initiated. Over 65 journal articles have been published with affiliation to BTH.



In 2021/22, 3,432 participants were recruited to NIHR portfolio research across 19 clinical specialties. We have offered more research to our BTH community this year than ever before. A total of 62 projects were active and all of these projects were approved by the relevant regulators including the Health Regulatory Agency (HRA), Medicines and Healthcare Products Regulatory Agency (MHRA) and the NHS Research Ethics Committee.

Research is a partnership between the people who volunteer to take part, our participants, and the researchers. The Participant in Research Experience Survey (PRES) is an annual nationally standardised survey used to collect adults and children's views and experiences of participating in NIHR supported research. It is the largest survey of its kind and each year PRES findings are shared back with research teams to enable us to learn what we are doing well and identify immediate opportunities to make improvements in specific research studies and local research settings.

In 2021-22, 262 of our research participants completed the survey which represents 15% of the regional response. The PRES demonstrated that we are offering research to a wide range of adults aged between 20 and 80. 94% of people taking part in research at BTH agreed or strongly agreed that they would be happy to take part in research again at BTH. Some participant comments are below.

"I think that all the staff that have been doing the research are a credit to this hospital. And I would be willing to the part in any other trials if needed"

"The staff were all brilliant, very friendly and competent. the made the whole experience enjoyable and explained everything clearly so I knew what would happen and what was expected of me"

The CQUIN scheme was designed to pay providers for achieving quality improvement and innovation goals. However due to the COVID-19 Pandemic, NHS England and NHS Improvement suspended the 2012/22 contracting process and contracts between NHS Trusts and NHS Commissioners were no longer required. This meant that the CQUIN scheme, covering general and specialist services, for Trusts was suspended for the period April 2021 to March 2022. Providers were therefore not required to take action to implement CQUIN requirements, carry out CQUIN audits or submit CQUIN performance data.

NHS England and NHS Improvement revised the financial guidance for the period April 2021 to March 2022. This stated that on a monthly basis NHS commissioners were required to pay providers nationally set block payments from April 2021 to March 2022 and these block payments included monies to cover the CQUIN scheme.

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

BTH is required to register with the Care Quality Commission (CQC). Within the time period 2021/22 there were no conditions on the Trust's registration.

Statements from the Care Quality Commission

September 2021, Inspection:

The CQC carried out an unannounced inspection, from the 14 September to the 20 October 2021, of Blackpool Teaching Hospitals NHS Trust. They inspected core services at the Blackpool Victoria Hospital site including urgent and emergency care, medical care, critical care and surgical care services because of continuing concerns about the quality and safety of these services. The CQC also inspected the well-led key question for the Trust overall. We rated urgent and emergency services as inadequate and surgery, medical care and critical care as requires improvement. We rated well-led for the Trust overall as requires improvement. Following this inspection, due to the concerns the CQC had identified at Blackpool Victoria Hospital, they wrote to the Trust asking for urgent action to be taken to ensure safe care and treatment. The letter from the CQC was in the form of a section 29a warning notice focusing on three key areas:

1. The management of risks to service users who are waiting to receive care and treatment, and the systems to identify and reprioritise service users based on changes to their presenting risks.
2. Safety concerns within the Emergency Department.
3. The systems and processes to ensure incidents are reported, reviewed, and investigated appropriately to ensure lessons are identified and shared with teams.

Since receipt of the warning notice in October 2021, the Trust has commenced programmes of work to address the concerns raised by the CQC and has submitted evidence of the improvements made, we await the outcome of the CQC's review. An ED improvement plan has been developed to work with system partners to make the required improvements for patients.

2.4.8 Special Reviews / Investigations

As outlined above, the Trust received a section 29a warning notice in October 2021.

2.4.9 Information on the Quality of Data

High quality information leads to improved decision making that in turn results in better patient care, wellbeing, and patient safety. Data should always be accurate, up to date and clear.

In order to respond to our ambitions, over the last year we have continued to deliver the Integrated Performance Report (IPR) and rolled this out at the committee level to support both day-to-day operations and executive oversight. A new Operational Exception Report has been developed and is provided weekly to the Executive Team to provide further oversight and assurance.

In recognition of our system working being in the developmental stages and the release of a new Standard Operating Framework (SOF) in 2020/2021, any updates and improvements to the reporting mechanism have become business as usual, led by the Head of Performance and the Board updated accordingly.

Data quality policies and procedures are reflected in the Data Security and Protection Toolkit (DSPT) and all evidence is audited via the Information Governance Team and Internal Audit. Data quality reports are developed and submitted through the Health Informatics Committee, Divisional Performance Review Meetings, Divisional Better Information Meetings, and through to the Board of Directors.

The Board of Directors ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency, and economy as well as the quality of its healthcare delivery. The Board regularly reviews the performance of the Trust through its Board Committees who monitor performance against regulatory requirements as well as the Board Assurance Framework. The Committee structure being temporarily amended in year to reflect the Covid pressures within the Trust.

All data that supports the performance dashboards, Integrated Performance Report, and national returns, are checked and have Executive oversight prior to submission, to ensure that compliance with the reporting standards criteria is met and activity conforms to the standard definitions.

The Trust is provided with external assurance on a selection of the quality data identified within the Quality Accounts which was taken from National Data Submissions, HED, National Patient Survey results, Local Inpatient Survey results and Data Security and Protection Toolkit (DSPT) results. Local internal assurance is also provided via:

- Provision of external assurance on a selection of the quality data identified within the Quality Report
- Analysis of data following local internally led audits in relation to nursing care indicators, analysis of data following incidents, analysis of complaints and claims data and safe nurse staffing

- Quality and safety metrics performance data reporting for scrutiny to the Board on a monthly basis through the Integrated Performance Report, and committees of the Board
- Controlled processes for the provision of external information with control checks throughout the process with formal sign off procedures
- Data reporting validation by internal and external control systems involving Clinical Audit, the Audit Commission, Senior Manager and Executive Director Reviews
- Random check processes on pathways by the Trusts internal performance team
- Quarterly formal Divisional Reviews held with Executive Directors to overall monitor financial, operational, governance and quality key performance indicators
- Scrutiny of data provision to commissioners monitored at the Quality and Performance contract meetings
- Peer review processes as part of the National Quality Surveillance Programme
- Data Quality assurance reports through Specialist Commissioner Quality Dashboard quarterly submission and routine meetings

The Trust has a fully controlled process for the provision of external information with control checks throughout the process. Formal sign off processes of key performance indicators on data are submitted through the Information Management Department and then signed off within the Performance department's processes.

The assurance on the performance of operational data that impacts on quality of care, such as elective waiting times, is monitored through the process of 'patient target list' meetings, where all divisions hold internal meetings and then report up to an Assurance and Escalation meeting weekly. All data regarding operational performance included within the commissioning performance contract is monitored with commissioners at the Commissioning Contract Board, the frequency of this reduced due to Covid. Random audits across the patient pathways at sub-speciality level are carried out throughout the year. Results of these audits are used to generate any improvement plans required.

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

2.4.10 NHS Number and General Medical Practice Code Validity

BTH submitted records during 2021/2022 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:

- 99.8% for admitted patient care
- 100% for outpatient care
- 99.2**%** for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 99.9% for accident and emergency care.

**Data from April 2021 – February 2022*

2.4.11 Information Governance Assessment Report 2021 / 2022

Information Governance (IG) relates to the way organisations 'process' or handle information. It covers personal information, for example that relating to patients' / service users and employees, and corporate information, for example financial and accounting records.

The Data Security and Protection Toolkit is an online system, which allows the Trust to undertake a self-assessment by providing evidence and judging whether the organisation is able to meet assertions that demonstrate that the organisation is working towards or meeting the National Data Guardians (NDG) standards.

The purpose of the assessment is to assist the Trust in measuring our compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

2.4.12 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.

2.4.13 Learning from Deaths

In March 2017, the National Quality Board published guidance to introduce a standardised approach to the way NHS trusts review, report, investigate and learn from deaths. Therefore, NHS trusts are required to collect and publish information on deaths through a paper and an agenda item to a public board meeting on a quarterly basis as a minimum. Following the published guidance, the Trust reviewed internal processes, embedded a new way of working and updated the *Responding to Deaths Policy (BTH NHSFT CORP/POL/189)*.

During the period April 2021 to March 2022, 1,579 BTH patients died. This comprised of the following number of deaths, which occurred in each quarter of that reporting period:

- 332 in the first quarter
- 367 in the second quarter
- 473 in the third quarter
- 407 in the fourth quarter

The three conditions with the highest number of excess deaths are as follows (from the most recent HED data –12 month rolling SHMI average to November 2021):

- Pneumonia
- Heart Failure
- Cancer of the Colon

Following recommendations from a number of key enquiries a new National Service, the Medical Examiner Service has been rolled-out across England and Wales to provide greater scrutiny of deaths. The system also offers a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one. BTH hosts and line manages the service, but the Medical Examiners (MEs) and Medical Examiner Officers (MEOs) are independent of the Trust and have a separate professional line of accountability to both regional and national teams.

Learning from Deaths App

In May 2021, the Trust launched the Learning from Deaths App (LfD App). The App is a digital tool used for retrospective review of the case records of deceased patients. The purpose is to ensure all phases of care are evaluated in order to identify actions for implementation and learning points for dissemination as a means of continuous quality improvement.

All deaths require an initial screening, and where the screening triggers the need for a more in-depth analysis of the patient journey, a Structured Judgment Review is then enabled through the application. The input from the LfD App then informs Directorate and Divisional Mortality & Morbidity meetings, and Quality meetings, to

enable specialities to put the learning into practice. The information provided then populates the mortality dashboards and supports the on-going monitoring of quality of care.

However, the Trust's current mortality reporting does not meet the Trust Key Performance Indicators or national standards. The compliance rate is inconsistent, with long delays in some cases.

Following the launch of the LfD App, use of the tool has been at times inconsistent, due to doctors' limited capacity, due to Covid and the pressures experienced by the Trust in the last 12 months.

Actions have been identified and implemented to resolve the challenges for staff to consistently use this tool for improved reporting of learning from deaths, including:

- Trust wide training and awareness of the Learning from Deaths App, including a training video.
- The appointment of an Associate Medical Director for Mortality Governance & Clinical Audit.
- The establishment of a Trust wide Mortality Improvement Group.
- The development of the LeDeR programme, with support from the Swan and Quality teams.
- Revised process for communication with doctors failing to complete relevant paperwork within required timescales.
- Establishment of a Mortality Community Roll Out Task & Finish Group.
- New Medical Examiner Officer appointments made, and funding allocated for additional Medical Examiners.
- A revised Learning from Deaths Policy.
- New formal process adopted for complaints from bereaved families to be routed via the PALS team.

Further improvement recommendations have also been identified for implementation, including:

- Implementation of the action plan for review of Community Deaths by April 2022.
- Development of a clear Mortality Improvement Strategy.
- Initiate Phase 2 of the Learning from Deaths App.
- Build further case record review capacity through cascading Structured Judgement Review (SJR) training to enable detailed review completion for outliers as identified through monthly HED data.

- Full implementation of the Medical Examiner's Office and the Learning from Deaths Application are both anticipated to continue to contribute substantially to sustained improvements.
- Engagement with the processes of mortality governance, such as Morbidity and Mortality Meetings at Departmental and Divisional level and completion of SJRs, still shows room for improvement. There will be continued emphasis on these aspects of mortality governance, overseen by the Mortality Governance Committee, with the completion of the SJR learning on the LfD App.
- An electronic Bereavement and Chaplaincy package from Ulysses has been commissioned and this will join up seamlessly with the Trust's Ulysses Risk Management system.

2.4.14 Consolidated Annual Report on rotas for NHS doctors and dentists

The trust guardian of safe working hours has oversight of the issues relating to junior doctors in training. A key part of the role is overseeing the exception reporting process if rotas as stipulated in the 2016 junior doctors' contract.

Exception Reports (ER) 2021/2022	
Total number of exception reports received	87
Number relating to immediate patient safety issues	7
Number relating to hours of working	51
Number relating to pattern of work	3
Number relating to educational opportunities	13
Number relating to service support available to the doctor	20

The majority of the exception reports relate to additional hours worked. A key factor driving this pattern of exception reporting is pockets of rota gaps on the medical rotas due to vacancies.

Huge efforts have been made to reduce the gaps and reliance on additional hours and internal/external locum cover. Recruitment into vacant posts with locally employed doctors (non-training grade) and international medical graduate (IMG) doctors has increased significantly in the last 12 months across all areas.

Minimising post vacancies and rota gaps are vital to ensure safe staffing levels especially out of hours ensuring patient safety. Those key areas of the hospital which have encountered sustained clinical pressure have to prioritise fully staffed rotas, which will create a sustainable workforce and workload.

Together with the medical education team, efforts are made to regularly monitor all additional shifts being worked by junior doctors via the internal bank/ locum system. It is a useful surrogate measure of existing rota gaps/ sickness levels. From a trends'

perspective, the trust has seen a dramatic reduction in the additional shifts worked over the last 6 months. This is in part due to better recruitment to vacancies and scale back of escalated Covid rotas.

2.4.15 The NHS Outcome Framework Indicators

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

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

Domain	**Preventing people from dying prematurely –**						
Indicator	**SHMI - The value and banding of the summary hospital level mortality indicator (SHMI) (January – December 2021 107 (Within the expected range)**						
National Average	**100**						
Where applicable – Best Performer	**75**						
Where applicable – Worst Performer	**121**						
Trust Statement							
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:					• This is the most up to date data available.		
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:					• Mortality Governance Committee and Mortality Improvement Group in operation. • All deaths in hospital reviewed, Medical Examiner Process and team embedded into Trust process.		
2018/19	113	**2019/20**	109	**2020/21**	107	**2021/22**	107 (Jan-Dec 2021)

Domain	**Enhancing quality of life for people with long-term conditions**						
Indicator	**% of patient deaths with palliative care coded at either diagnosis or speciality level for March 2021 to February 2022, taken from Latest HED information.**						
National Average	36.74%						
Where applicable – Best Performer	82.2%						
Where applicable – Worst Performer	5.2%						
Trust Statement							
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:						• Data taken from National HED System as governed by standard national definitions.	
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:						• Education of staff regarding documentation of palliative care input	
2018/19	22.80%	**2019/20**	23.16%	**2020/21**	28.05%	**2021/22**	32.12%

Domain	**Helping people to recover from episodes of ill health or following injury**	
Indicator	Patient outcome scores for hip replacement surgery April 2020 to March 2021 (most recent full year of data)	
National Average	**Adjusted National Average**	**0.465**
Where applicable – Best Performer	**Adjusted average health gain – best performer**	**0.575**
Where applicable – Worst Performer	**Adjusted average health gain – worst performer**	**0.391**

Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	Patient reported outcome measures (PROMS data taken from NHS Digital as governed by standard national definitions) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following hip replacement surgery.
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Promotion continues throughout the Trust, on the importance of completing the questionnaire and enhancing patient awareness. There has been a significant increase in the number of surveys collected by the Patient Engagement Team over the past year with 117 model records for hip replacement surgery completed in 2021-22. It is hoped this will lead to an increase in the Trust's average health gain for 2021-22 figures. • Participation rate information is published within quarterly reports for reporting and monitoring purposes. Monthly bulletins are circulated to the Medical Director and Director of Operations, as Trust leads for PROMs and shared with Theatre teams. • In 2022-23 work we must integrate the PROMs data into existing outcomes measurement systems and evaluate the effectiveness of surgical interventions taken, comparing our data to other providers and surgical sites.

2018/19	0.386	**2019/20**	0.396	**2020/2021**	0.424	**2021/22**	data not yet available

Domain	**Helping people to recover from episodes of ill health or following injury**		
Indicator	**Patient outcome scores for knee replacement surgery April 2020 – March 2021 (most recent full year of data)**		
National Average	**Adjusted National Average**	0.315	
Where applicable – Best Performer	**Adjusted average health gain – NHS Trusts best performer**	0.400	
Where applicable – Worst Performer	**Adjusted average health gain – NHS Trusts worst performer**	0.176	

Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• Patient reported outcome measures (PROMS) data taken from NHS Digital as governed by standard national definitions) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following knee replacement surgery.
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Promotion continues throughout the Trust, on the importance of completing the questionnaire and enhancing patient awareness. There has been a significant increase in the number of surveys collected by the Patient Engagement Team over the past year with 138 model records for knee replacement surgery completed in 2021-22. It is hoped this will lead to an increase in the Trust's average health gain for 2021-22 figures. • Participation rate information is published within quarterly reports for reporting and monitoring purposes. Monthly bulletins are circulated to the Medical Director and the Director of Operations, as the Trust leads for PROMs, and shared with the Theatre teams. • In 2022-23 work we must integrate the PROMs data into existing outcomes measurement systems and evaluate the effectiveness of surgical interventions taken, comparing our data to other providers and surgical sites.

2018/19	0.335	**2019/20**	0.308	**2021/2022**	0.315	**2021/22**	data not yet available

Domain	**Helping people to recover from episodes of ill health or following injury**						
Indicator	**28-day readmission rate for patients 16 or over**						
National Average	No national benchmarking data available						
Where applicable – Best Performer	No national benchmarking data available						
Where applicable – Worst Performer	No national benchmarking data available						
Trust Statement							
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• The number of patients readmitted to hospital within 28 days of being discharged from hospital expressed as a percentage of all discharges in the period (data taken from local source and as governed by NHSI standard national definition).						
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Clinically led reviews of readmissions to identify and implement actions to reduce avoidable admissions. • Inclusion of commissioners on joint working group to identify and implement health economy wide readmission avoidance schemes. • Monitoring at Trust Board a quality improvement programme for the year. • Monitoring of relevant performance indicators and plans at Commissioning Quality Review Board and contract meetings.						
2018/19	5.24%	**2019/20**	7.66%	**2020/21**	9.15%	**2021/22**	7.14%

Domain	**Helping people to recover from episodes of ill health or following injury**						
Indicator	**28-day readmission rate for patients 0-15**						
National Average	No national benchmarking data available						
Where applicable – Best Performer	No national benchmarking data available						
Where applicable – Worst Performer	No national benchmarking data available						
Trust Statement							
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• The number of patients readmitted to hospital within 28 days of being discharged from hospital expressed as a percentage of all discharges in the period (data taken from local source and as governed by NHSI standard national definition).						
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Clinically led reviews of readmissions to identify and implement actions to reduce avoidable admissions. • Inclusion of commissioners on joint working group to identify and implement health economy wide readmission avoidance schemes. • Monitoring at Trust Board a quality improvement programme for the year. • Monitoring of relevant performance indicators and plans at Commissioning Quality Review Board and contract meetings.						
2018/19	13.05%	**2019/20**	13.43%	**2020/21**	14.14%	**2021/22**	13.95%

Domain	**Ensuring that people have a positive experience of care**
Indicator	**Responsiveness to inpatients personal needs: - NHS Outcomes Framework Indicators**
National Average – 2020/21	74.5
Where applicable – Best Performer 2020/21	85.4
Where applicable – Worst Performer 2020/21	67.3

Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• The NHS Outcomes Framework Indicator 4.2 – is scored from a selection of questions within the National Inpatient Survey that focus on the responsiveness to personal needs. The score indicates how NHS Trusts are personalising care to suit their patients' individual needs.
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• The Patient Engagement Team shared the Trusts 2020-21 National Inpatient survey results with staff across the Trust, sitting on both Board and ward manager discussion forums. The importance of communicating to patients on discharge how to take their medication and reducing staff noise levels at night was the campaign focus last year. • The Patient Engagement Team monitored the Trust's local patient feedback survey data to see if the improvements identified in the national survey, were consistent themes throughout the year. • Trust staff worked collaboratively with our patients and carers to plan and co-design new ideas for service improvement, such as the Carer's Charter and 'What Matters to Me' boards across all wards to ensure staff are personalising the care experience. The Patient Engagement Team and COAST Team designed new 'Knowing how we are doing' boards ensuring that up to date ward information is available to patients and carers in all ward entrances.

2018/19	64.6	**2019/20**	65.7	**2020/21**	72.8	**2021/22**	Data not yet available

Domain	**Ensuring that people have a positive experience of care**
Indicator	**Percentage of <u>patients</u> who would recommend the provider to friends or family needing care. Inpatients**
National Average	94% - February 2022 – latest figure on NHS England website
Where applicable – Best Performer	100% - February 2022 – highest figure on NHS England website
Where applicable – Worst Performer	77% - February 2022 – lowest figure on NHS England website

Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	• We remain above the national average for our FFT inpatient survey score. The COAST ward accreditation system has ensured that high standards are maintained across both our hospitals. With the COAST inspection team reviewing how ward staff engage with their patient and carer feedback on their visits. The Patient Engagement Team also drop into the wards on a weekly basis to ensure they are collecting FFT surveys and provide training to the ward managers on the Experience platform, ensuring they action feedback.

2019/20	96% - figure from March 2020	**2020/21**	98% - figure from March 2021	**2021/22**	97%- figure from March 2022

Domain	**Ensuring that people have a positive experience of care**				
Indicator	**Percentage of <u>patients</u> who would recommend the provider to friends or family needing care. Patients discharged from Maternity Services as per question asked at birth.**				
National Average	94% - February 2022 – latest figures on NHS England website				
Where applicable – Best Performer	100% - February 2022 – highest figure on NHS England website				
Where applicable – Worst Performer	67% - February 2022 – lowest figure on NHS England website				
Trust Statement					
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	We remain above the national average for our FFT maternity survey score. The Patient Engagement Team has worked with the new managers on Ward D and Delivery Suite providing them with tips and advice on how they can improve their FFT performance. Adaptions have been made to the environment based on patient feedback, with QR code posters now placed in central areas. The SMS text FFT survey has also been reviewed to ensure women can feedback about the whole of their birth journey.				
2019/20	86%	**2020/21**	85% figure from March 2021	**2021/22**	100% figure from March 2022

Domain	**Ensuring that people have a positive experience of care**				
Indicator	**Percentage of patients who would recommend the provider to friends or family needing care. Patients discharged from Accident and Emergency.**				
National Average	77% - February 2022 – latest figure on NHS England website				
Where applicable – Best Performer	100% - February 2022 – highest figure on NHS England website				
Where applicable – Worst Performer	29%- February 2022 – lowest figure on NHS England website				
Trust Statement					
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	We remain below the national average for our FFT A&E score. Urgent and emergency care has been seriously impacted by the COVID-19 pandemic with patients reporting delays in receiving timely and accessible care across the country. Our Emergency Department has been under considerable pressure in the last 12 months, with often over 100 patients in the department waiting for review or treatment. Patients have reported long waits to access a bed on a ward, or delays in receiving their diagnosis or information about their condition or treatment from our A&E staff.				
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	Escalation areas and new wards have been built to try and ease patient flow from the Emergency Department. Customer Service training was provided to staff in the department in 2021-22 to ensure they displayed positive attitudes at all times, after there was a surge in comments about staff behaviour. The Patient Engagement Team meet regularly with the department manager to discuss their feedback and highlight any significant concerns.				
2019/20	88%	**2020/21**	85% figure from March 2021	**2021/22**	67% - figure from March 2022

Domain	**Ensuring that people have a positive experience of care**				
Indicator	**Percentage of <u>staff</u> who would recommend the Trust as a provider of care to their Friends or family. Staff Survey.**				
National Average	66.9%				
Where applicable – Best Performer	89.5%				
Where applicable – Worst Performer	43.6%				
Trust Statement					
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	Data extracted from the National Staff Survey management and key findings report for 2021.				
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Further exploration of staff sentiment is taking place through divisional Big Conversations. Trust wide and local action plans will then be developed to address issues of concern including that of advocacy. • Significant programmes of work are being led by the QI hub including COAST inspections and the development of a digital QI platform. Strategic programmes of work contained within the local delivery plan and the Integrated Care Partnership aim to improve patient pathways.				
2019/20	63%	**2020/21**	69%	**2021/22**	65.3%

Domain	**Ensuring that people have a positive experience of care**				
Indicator	**The number of Mixed Sex Accommodation Breaches**				
National Average	Average Breach rate in Trusts is 1.7 taken in February 2022				
Where applicable – Best Performer	0 breaches recorded by another NHS Trust in February 2022				
Where applicable – Worst Performer	323 breaches recorded by another NHS Trust in February 2022				
Trust Statement					
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	Under the revised DSSA guidance (2019), the Trust records a breach when: ▪ A patient is not stepped down from level 2 or 3 care in Critical Care Units within 4 hours of the clinical decision being made that they are safe to transfer. ▪ Patients have not been moved from an assessment / observation unit within four hours of a decision to admit. We had a higher amount of MSA breaches in 2021/22. The Trust has been escalated to OPEL level 4. There have been extremely high levels of bed occupancy making it difficult to step down patients from critical care areas as no medical or surgical beds were available. This is reflective across the country and the DSSA guidelines are being updated by NHS England and Improvement to better support the operational pressures from COVID-19.				
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Produced a new Delivering Same Sex Accommodation policy • Used a new reporting template for communicating the breaches with staff and local Commissioners The Associate Director of Nursing and Head of Patient Experience conducted regular inspections of areas where MSA breaches have occurred or where there are planned building changes, to ensure they meet the DSSA Guidelines.				
2019/20	0	**2020/21**	4	**2021/22**	14

Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm –**						
Indicator	**Percentage of admitted patients' risk-assessed for Venous Thromboembolism (VTE)**						
National Average	This has been put on hold due to COVID						
Where applicable – Best Performer	See above						
Where applicable – Worst Performer	See above						
Trust Statement							
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:					• Nationally published via NHS Digital and is governed by standard national definition for VTE. National data not available at time of publishing data provided from local source.		
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:					• Ongoing monitoring and Audit. • VTE Committee with a Medical Chair in place. • VTE Assessment completion incorporated into IT ward tracker.		
2018/19	65%	**2019/20**	72.25%	**2020/21**	The audit was put on hold due to COVID	**2021/22**	85.51%

Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm**
Indicator	**Rate of *Clostridioides difficile* (C Diff) per 100,000 bed days of cases reported amongst patients aged 2 or over (2021/2022)**
National Average	2019-2020 = 21.28 (Data for 2021/2022 is not available as yet)
Where applicable – Best Performer	2019-2020 = 3.38 (Data for 2021/2022 is not available as yet)
Where applicable – Worst Performer	2019-2020 = 84.96 (Data for 2021/2022 is not available as yet)
Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	NHS England and NHS Improvement set the NHS Standard Contract Thresholds for acute trusts. The threshold was 104 cases and the Trust reported 101 cases. Data regarding the 101 cases reported were extracted from the United Kingdom Health Security Agency (UKHSA) Healthcare Associated Infection Data Capture System (HCAIDCS) and are governed by standard national definition. Rates per 100,000 overnight bed days and day admissions have been included in this report for the first time. *This denominator is used to determine the rate for 'Healthcare Associated' infections which includes hospital and community onset cases. This rate does not however take into consideration local risk factors such as deprivation, older NHS Estates which do meet modern IPC standards or differences in geographical location such as rural versus urban areas.
The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportions/score/rate/number) and so the quality of its services, by undertaking the following action:	The Trust recently implemented the latest NICE guidance which aims to prevent recurrence of infections by recommending more effective first line treatments. The Trust has also implemented a new two stage testing platform that includes PCR testing. It is hoped that this will help identify cases more accurately and lead to earlier treatment.

					The Divisions continue to undertake a root cause analysis of all cases. The outcome of these investigations determines which actions are required and forms the basis of a divisional action plan. The Infection Prevention team undertake commode cleanliness audits and the results also factor in to the Divisional action plans. Each Division then reports their progress against their CDI action plans at the Whole Health Infection Prevention Committee meeting.		
2018/19	35 cases 13.53	**2019/20**	127 cases 45.61	**2020-21**	89 cases 33.60	**2021/22**	101 cases *2428.12 (33.20 HOHA)

Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm –**
Indicator	**The number of and percentage of patient safety incidents within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death (April 2021– March 2022)**
National Average	**No national averages for this indicator**
Where applicable – Best Performer	**No national averages for this indicator**
Where applicable – Worst Performer	**No national averages for this indicator**
Trust Statement	
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:	The Trust continues to promote and exhibit a culture of open and honest reporting. Incident data is recorded through the Trust's Risk Management Incident Reporting system, governed by national standards and definitions for levels of harm and timescales for incident reporting.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:	• Encouraging a culture of voluntary reporting by staff by continuous improvement of Trust risk management systems. • Implementing a monitoring system for the management of timely reporting and management of incidents to capture early learning. • The implementation of easily accessible training for staff on incident reporting and management of incidents and investigations. • Promoting Duty of Candour and supporting staff to ensure initial contact is made with the patient/family within 10 days of the incident being identified. • The continued review and development of the 'Management of Incidents, Incorporating Serious Incidents' Policy and the streamlining of new processes for reporting and managing incidents. • The implementation of further training for staff in undertaking an effective investigation, to ensure quality learning and effective SMART action plans. • Continued engagement with the Quality Improvement Team to ensure that the Quality Improvement Strategy and Programme is informed through learning identified from incident trends and themes.

2018/19	0.009% (12 months data)	**2019/20**	0.05% (12 months data)	**2020/21**	0.02% (12 months data)	**2021/22**	0.02% (12 months data)

Domain: Preventing people from dying prematurely

The standardised Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with our predicted number of deaths. The Trust has continued to implement its mortality governance programme concentrating on pathways of care. The latest nationally published SHMI rate for the Trust is 107 for the period January - December 2021.

The 12-month rolling SHMI indicator for the Trust remains within the expected range.

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

Patient reported outcome scores

A patient reported outcome measure (PROM) is a series of questions that patients are asked in order to gauge their views on their own health. Using data gathered in relation to knee replacement and hip replacements, patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery.

The patient is invited to complete two questionnaires; the data provided then gives the average difference between their first score (pre-surgery) and second score (post-surgery).

Blackpool Teaching Hospitals works closely with Quality Health to continuously look at different ways to increase responses to PROMs, to gain a comprehensive overview of our service in these areas.

Domain: Ensuring that people have a positive experience of care

Responsiveness to Inpatients' personal needs

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

The Trust is proud of its 'Tell Us' campaign which is part of the patient experience delivery plan, this provides the structure to increase the feedback we obtain from patients and relatives which we use to influence and evolve service developments.

Domain: The number of and percentage of patient safety incidents that resulted in severe harm or death (April 2021 to March 2022)

Patient safety incidents are reported to NHS England, via the NRLS. The number of patient safety incidents reported by BTH for the year 2021/22 was 25,497. The number of severe harm or death incidents reported and closed within this period was five, which equates to 0.02%. This low figure of severe harm or death incidents, in comparison with the high number of patient safety incidents reported, indicates that the Trust's safety record continues to improve. Organisations that report more incidents usually have a better and more effective safety culture and the organisation continues to perform within the top 25% of Trusts nationally.

3. Review of Quality Performance

3.1 An Overview of Quality of Care

The measures in the table below provide performance in 2021/2022 against indicators selected by the Board, which reflects the list of priorities that the Board deemed necessary to continue to monitor throughout the year. Previous years priority indicators have remained the same and these continue to be measured as the metrics within the quality strategy. The below are areas that feature in the Trust's strategy for quality improvement, feature within the Trust's Quality Strategy and which the Trust wishes to highlight within the quality accounts.

Indicators*		**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**
Patient safety Outcomes	Hospital Standardised Mortality Rate (Summary Hospital Mortality Indicator)	Data not yet available	107 (Dec 20 to Nov 21)	111 (Dec 18 to Nov 19)	115	111	113
	Stroke Mortality Rate *Data Source HED:*	107 (Jan-Dec 2021)	114 (Mar 20 to Feb 21)	107 (Dec 18 to Nov 19)	132	132	120
	Pressure Ulcer harm reduction	Category 2 21.34% decrease, category 3 70% increase, category 4 19.05% increase	Category 2 4.85% decrease, category 3 20% decrease, category 4 81.82% increase	Category 2 18.7% decrease, category 3 5.2% increase, category 4 75.2% decrease	Stage 2 29.62% increase, stage 3 9.4% increase, stage 4 20.83% increase.	Stage 2 10.96% increase, stage 3 183.33% increase and stage 4 56.25% increase.	Stage 2, 1.94% increase, stage 3, 32.26% decrease and stage 4 16.67% decrease.

	Reduction in harm as a result of a fall	8.84% increase	32.04% increase	59.7% reduction	16.9% reduction	2.47% increase overall	7.23% increase overall
Clinical Effectiveness	Compliance with implementation of NICE guidance	79%	88 %	90%	97%	98%	89%
	Opportunities to care within clinical pathways - sepsis	94.93% (Apr21-July 21) Audit ceased WEF 1.8.21	95.04% (Apr20-Feb21)	93%	89%	86%	84%
	Opportunities to care within clinical pathways – AKI	92.25% (Apr 21 – Feb 22)	92.37% (Apr20-Feb21)	91%	84%	79%	75%
	Opportunities to care within clinical pathways – pneumonia	Audit ceased WEF 1.4.21	98.70% (Apr20-Feb21)	98%	98%	97%	95%
	Opportunities to care within clinical pathways - Stroke	94.14% (Apr21 - Aug 21) Audit ceased WEF 1.9.21	91.33% (Apr20-Feb21)	92%	95%	96%	93%

	Indicators	***2021/22***	***2020/21***	***2019/20***	***2018/19***	***2017/18***	***2016/17***
	Opportunities to care within clinical pathways – Fractured Neck of Femur (#NOF)	Not audited from April 2018	Not audited from April 2018	Not audited from April 2018	Not audited from 01.04.2018	75%	75%
	Opportunities to care within clinical pathways – Cardiac Chest Pain	No longer Audited	No longer audited	No longer audited	97%	98%	97%
	Opportunities to care within clinical pathways – Chronic Obstructive Pulmonary Disease (COPD)	94.64% (audited quarterly Apr21 –Feb22)	96.32% (audited quarterly Apr20 – Feb21)	99.33%	95%	95%	94%
	Opportunities to care within clinical pathways – Abdo Chest Pain	No Longer Audited	No longer audited	No longer audited	91%	86%	88%
	Opportunities to care within clinical pathways – Heart Failure	71.88% Apr21 – Jan 22)	67.60% (Apr20 - Feb21)	68.53%	61%	56%	72%

Patient Experience	Percentage of Adult Inpatient who rate care as excellent/very good/good	2021 data not yet available	(2020 data) 83%	(2019 data) 81%	(2018 data) 81%	(2017 data) 79%	(2016 data) 81%
	Percentage of Adult Inpatients who have been treated with Respect & Dignity	2021 data not yet available	(2020 data) 91%	(2019 data) 89%	(2018 data) 88%	(2017 data) 85%	(2016 data) 89%
	Percentage of Adult Inpatients who felt involved in their care and/or treatment	2021 data not yet available	(2020 data) 70%	(2019 data) 71%	(2018 data) 68%	(2017 data) 67%	(2016 data) 71%

3.2 The Risk Assessment Framework

The Trust aims to meet all national targets and priorities and we have provided an overview of the national targets and minimum standards including those set out within the NHSI Single Oversight Framework.

National Targets and Minimum Standards*	Target	Operational Standard	2021/22	2020/21	2019/20	2018/19	2017/18
Maximum two weeks from:	GP Urgent Referral for suspected cancer to First Consultant Appointment	93%	Under Achieved: Q1 91.3% Q2 92.4% Q3 79.7% Q4 Not yet available	Achieved: Q1 94.1% Q2 96.9% Q3 97.0% Q4 95.7%	Under Achieved: Q1 81.7% Q2 87.6% Achieved: Q3 93.7% Q4 94.6%	Under Achieved: Q1 84.2% Q2 82.9% Q3 88.8% Q4 84.1%	Achieved: Q1 93.5% Q2 93.2% Q3 94.6% Q4 95.6%
	GP Urgent Referral for breast symptoms (where cancer not initially suspected) to First Consultant Appointment	93%	Under Achieved: Q1 62.0% Achieved: Q2 96.8% Under Achieved: Q3 75.3% Q4 Not yet available	Under Achieved: Q1 74.0% Achieved: Q2 95.9% Q3 95.8% Under Achieved: Q4 85.1%	Under Achieved: Q1 3.2% Q2 58% Q3 89.6% Q4 98%	Under Achieved: Q1 22.2%, Q2 20.4% Q3 52.2% Q4 – 30.5%	Achieved: Q1 98.4% Q3 99.6% Under achieved: Q2 91.3% Achieved: Q4 99.1%
Maximum 28 days:	Faster Diagnosis Standard	75%	Under Achieved Q3 66.2% Q4 Not yet available	Not Applicable			

Maximum one month (31 days) from:	Decision to Treat to First Treatment	96%	Achieved: Q1 99.0% Q2 98.5% Q3 96.1% Q4 Not yet available	Achieved: Q1 95.9% Q2 96.9% Q3 97.9% Q4 97.4%	Achieved: Q1 98.1% Q2 97.7% Q3 99% Q4 99%	Achieved: Q1 98.1% Q2 99.8% Q3 98.9% Q4 98.4%	Achieved: Q1 97.7% Q2 96.7% Q3 99.4% Q4 99.6%
	Decision to Treat to Subsequent Treatment – Drugs	98%	Achieved: Q1 100% Q2 100% Q3 100% Q4 Not yet available	Achieved: Q1 100% Q2 100% Q3 100% Q4 100%	Achieved: Q1 100% Q2 100% Q3 100% Q4 100%	Achieved: Q1 100% Q2 100% Q3 100% Q4 –100%	Achieved Q1 100% Q2 100% Q3 100% Q4 100%
	Decision to Treat to Subsequent Treatment – Surgery	94%	Achieved: Q1 94.1% Under Achieved: Q2 92.9% Q3 93.5% Q4 Not yet available	Under Achieved: Q1 75.7% Q2 81% Achieved: Q3 100% Under Achieved: Q4 93.5%	Achieved: Q1 100% Q2 100% Q3 100% Q4 100%	Achieved: Q1 100% Q2 100% Q3 100% Q4 100%	Achieved: Q1 94% Q2 98.4% Q3 100% Q4 97.7%
Maximum two months (62 days) from:	GP Urgent Referral for suspected cancer to First Treatment	85%	Under Achieved: Q1 80.9% Q2 73.5% Q3 67.4% Q4 Not yet available	Under Achieved: Q1 71.1% Q2 82.3% Q3 74.8% Q4 72.0%	Change in Allocation Rules. Under Achieved: Q1 76.9% Q2 80.0% Q3 78.9% Q4 78.9%	Achieved: Q1 86.0% Under Achieved: Q2 81.0% Q3 82.7% Q4 79.0%	Under Achieved: Q1 82.7% Q2 80.5% Q3 82.8% Q4 84.7%

	A National Screening Service to First Treatment	90%	Under Achieved: Q1 31.3% Q2 25.9% Q3 25.7% Q4 Not yet available	Under Achieved: Q1 29.4% Q2 29.6% Q3 73.3% Q4 63.0%	Under Achieved: Q1 73.7% Q2 89.2% Q3 48.8% Q4 38.8%	Under achieved Q1 75.9%: Q2 82.3% Q3 83.6% Q4 – 64.7%	Under Achieved: Q1 80.8% Q2 74.5% Q3 76.7% Q4 77.8%
	A Consultant Upgrade to First Treatment	No separate operational standard set	Q1 89.1% Q2 87.4% Q3 72.0% Q4 Not yet available	Q1 83.3% Q2 87.5% Q3 90.0% Q4 87.7%	Q1 89.9% Q2 88.1% Q3 88.9% Q4 92.3%	Q1 91.1% Q2 89.8% Q3 96.6% Q4 91.2%	Q1 92.3% Q2 91.6% Q3 90.6% Q4 90.3%
Maximum 6 weeks for:	Patients waiting for a diagnostic test	99%	Under Achieved: Q1 76.9% Q2 72.6% Q3 82.3% Q4 Not yet available	Under achieved: Q1 61.5% Q2 67.0% Q3 75.4% Q4 78.7%	Under achieved: Q1 98.9% Q2 97.0% Q3 95.8% Q4 91.3%	Achieved: Q1 99.58% Q2 99.54% Q3 99.52% Q4 99.05%	Achieved: Q1 99.71% Q2 99.86% Q3 99.73% Q4 99.75%
Cancelled Operations	Percentage of Operations Cancelled	0.8%	Data Collection reinstated from Q3 21/22 Q3 1.26% Q4 Not yet available	Not collected due to Pandemic	Under achieved Q1 1.67% Q2 1.42% Q3 1.82% Q4 1.88%	Under achieved Q1 1.67% Q2 1.17% Q3 1.26% Q4 1.55%	Under Achieved 2.1%
	Percentage of Operations not treated within 28 days	0%	Data Collection reinstated	Not collected due to Pandemic	Q1 11% Q2 5% Q3 4.3% Q4 4.68%	Q1 3.5% Q2 0% Q3 0% Q4 7.14%	Achieved 0%

			from Q3 21/22 Q3 17.24% Q4 Not yet available				
Maximum 18 weeks for:	Patients on an incomplete pathway awaiting consultant-led treatment	92%	Under Achieved: Q1 73.4% Q2 71.5% Q3 71.4% Q4 Not yet available	Under Achieved: Q1 52.9% Q2 60.2% Q3 64.7% Q4 67.6%	Under achieved Q1 80.98% Q2 81.56% Q3 81.62% Q4 79.87%	Under achieved Q1 81.04% Q2 79.99% Q3 81.24% Q4 81.06%	Under Achieved 87.2%
Infection Control	Incidence of MRSA	6 (Apr 21 to Mar 22)	Under achieved	Under achieved	Under achieved	0 Achieved	
	Incidence of *Clostridioides difficile*	101 (April 21 to Mar 22) Threshold = 104 Achieved	Achieved	Under achieved	Under achieved	31 Achieved	33 Achieved
Maximum four hour wait from:	Arrival to Admission, Discharge, or Transfer	95%	Under Achieved: Q1 85.0% Q2 81.1% Q3 79.5% Q4 77.8%	Under Achieved: Q1 92.0% Q2 88.4% Q3 80.2% Q4 80.7%	Under Achieved: Q1 84.57% Q2 86.82% Q3 83.85% Q4 85.79%	Under Achieved: Q1 – 85% Q2 – 83% Q3 – 86% Q4 – 85%	Under Achieved: 84.4%
VTE Risk Assessment	Venous thrombo-embolism risk assessment	95%	No Audits undertaken due to COVID	No Audits undertaken due to COVID	Under achieved Q1 69.76% Q2 71.72% Q3 74.07%		65% (data capture failure for 1 quarter data not included)

					Q4 73.96% Q4 Data collection suspended 17th March due to COVID19		
**Where needed the criteria for the above indicators has been included in the Glossary of Terms*							

NB. For all indicator figures where the Trust are providing limited assurance, they are clearly referenced with Ⓐ
The reported indicator performance for A&E has been calculated on the number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge as per the national guidance.

The reported indicator 62-day cancer has been calculated based on the accountable number of first definitive treatments for patients diagnosed with a new primary cancer (the numerator) and the number of accountable breaches (the denominator). The definition of a breach as per Cancer Waiting Time Guidance, is any patient treated more than 62 days after receipt of a GP suspected Cancer referral.

All quality performance targets form part of the quality contract between the Trust and Commissioners. These targets are reported monthly within the Trust integrated performance report which is monitored through the sub committees of the Trust Board and the quality contract targets are discussed at the monthly Quality Contract Review Group. Under performing indicators are captured within relevant work programmes and quality improvement projects which inform future service developments, for example: the proposed development of an emergency village, has been influenced by the A&E Boards programme of work to improve 4- and 12-hour targets.

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

3.3.1 Commentary from Fylde Coast CCGs

The Blackpool CCG and the Fylde and Wyre CCG thank the trust for producing this Quality Account which is reporting on 2021-2022, acknowledging that it represents and was collated during an unprecedented period of challenge due to the Covid pandemic.

The report evidences that the trust has continued to embed the quality and patient safety improvements identified within its Quality Improvement Strategy (2019-2022), reported in previous Quality Accounts. In particular, we recognise the efforts to ensure that there are clear objectives and measures being applied for all improvements being undertaken. We look forward to receiving the new Five-Year Strategy later this month. Sustainability of improvements being achieved, as well as the spread of the good care which underpins these improvements is what the CCGs are particularly keen to see come through both the Strategy and the data coming from the trust in 2022/23 and beyond.

It is encouraging to see that a measurable impact has been made on the number of pressure ulcers at their early stage of development (category 2), in itself this will reduce the number which go on to be grade 3 and 4 and therefore the target percentage reduction for those will be difficult to achieve. Further work on community acquired pressure ulcers and ensuring all teams benefit from the learning within the collaborative will be necessary to maintain this improvement but we are more confident that the trust now has the infrastructure and processes to deliver this.

In relation to falls which result in a fractured neck of femur, the report is not clear why care homes were targeted for this improvement work and how the learning will spread to non-care home residents. However, the approach to supporting not just the staff to understand and prevent falls, but where possible the residents themselves, is interesting and potentially very empowering for people. It is unclear whether the same approach is being adopted within the in-hospital falls prevention programme described.

The report section regarding sepsis may have been clearer about how AQuA pathways data and the use of Standardised Hospital Mortality Indicator (SHMI) informs the trust about its current and changing management of sepsis. Sepsis must remain an area of focus within the trust and with a commitment to work across all providers and agencies which support or respond to patients who may be presenting with sepsis, prior to hospital admission. The creative approaches described to enable staff to learn from safety incidents they or their colleagues experience are essential to keeping interest and commitment to a vibrant improvement culture.

Whilst the report outlines the Duty of Candour commitment, it does not outline the level of compliance within the reporting year, which would be a useful baseline against which to judge the March 2022 revised trust policy.

It is pleasing to see that despite the difficult year, patients who chose to take up the opportunity to provide feedback through the Friends and Family survey, have sustained a high level of satisfaction with the care they received and experienced. It is equally helpful to see the trust has taken very real and practical action on the feedback it has received. This aligns with evident greater engagement and co-production with patients of the trust, providing a good springboard to take this further.

The significant efforts to improve end of life and palliative care provision; to support and educate staff in these important aspects of personalised care are very reassuring to see in this Quality Account. Similarly, the report is clearer about its offer and obligations to people with learning disabilities and autism but has not confirmed the number of deaths the trust reported onto the national LeDeR platform, or the learning points from LeDeR reviews and mortality reviews.

The CCGs have seen a sustained approach in the trust's response to the CQC inspection and we look forward to working with the trust to test out and assure ourselves and the public that the findings and commensurate actions are having a real benefit for patients and patient safety generally.

We are sure that to the public, the value of staff to the organisation; their individual impact for patients and their wellbeing is becoming of greater importance both in strategy and in day-to-day ways of working and culture. We expect his to come through strongly in subsequent Quality Accounts.

Claire Lewis

Head of Quality - Fylde Coast CCGs

15 June 2022

3.3.2 Statement from Lancashire Healthwatch

1. What do you like about the 2021/2022?

We would highlight:
Table of Contents: Really helped navigation around the Report.
Openness: acknowledging targets not met but prioritizing actions to meet them
The involvement of patients helping the improvement of the 'last 1,000 days of life' work.
The continuous high satisfaction rate as evidenced by the NHS Friends and Family Test
Co-production with patients and the public to meet key priorities; including the Carers' Charter and the 'What Matters to Me Board'.
The Freedom to Speak Up shows a year-on-year increase in numbers feeling secure about raising concerns and confidence that these would be addressed.
Improving Care for patients living with Dementia, particularly the recruitment of Dementia Champions.
The work of the Hospital Palliative Care team and their achievements.
The Getting it Right Delivery Plan for people with learning disabilities or autism – and again the number of Champions in wards and departments.
We liked the comprehensive Glossary of Abbreviations and Terms, very useful.

2. What suggestions do you have for alternative additional content for 2022/23?

Data to evidence the number of times the Freedom to Speak Up has been used would be interesting.

3. What other comments or suggestions for improvements would you like to propose?

We have no additional suggestions.

4. What would you suggest are the Trust's priorities for quality improvements for 2022/2023?

We would support the described priority of increased improvement capability as this will impact on all aspects of the Trust's work.

5. Do you consider that the draft document contains accurate information in relation to NHS services provided by the provider?

We believe that the Trust has met the NHS England Requirements and in the view of Healthwatch Lancashire the information in the Report is consistent with our experiences.

6. Do you consider that any other information should be included relevant to the quality of NHS services provided by the provider?

No, we found the Report very detailed but well presented.

Kerry Prescott - Manager, Healthwatch Lancashire

16 June 2022

3.3.3 Statement from Lancashire Health Scrutiny Committee

“Although we are unable to comment on this year’s Quality Account, we are keen to engage and maintain an ongoing dialogue throughout 2022/23.”

Gary Halsall
Senior Democratic Services Officer (Overview and Scrutiny)
Democratic Services
Lancashire County Council
10 June 2022

3.3.4 Statement from Blackpool Heath Scrutiny Committee

“This document was shared with Members of the Blackpool Health Scrutiny Committee; however, no comments have been forthcoming.”

Sharon Davis - Scrutiny Manager

Blackpool Health Scrutiny Committee

13 June 2022

3.4 Statement of Directors' Responsibilities in Respect of the Quality Account

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

NHS Improvement 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 updated March 2022* and supporting guidance:
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes for the period
    - Papers relating to quality reported to the Board over the period
    - Feedback from Fylde Coast Clinical Commissioning Groups dated 15/05/2022
    - Feedback from Healthwatch Lancashire dated 16/06/2022
    - Feedback from the Blackpool Council's Health Scrutiny Committee dated 13/06/2022
    - Feedback from Lancashire Council's Health & Scrutiny Committee dated 10/06/2022
    - The Trust's annual complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, has not yet been completed, however quarterly reports have been completed for each quarter within 2021/22.
    - The 2020 national patient survey published in 2021. The 2021 survey results have not yet been published by the CQC.
    - The national staff survey published in 2021.
    - Care Quality Commission inspection report, published in January 2022.
    - 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
- The Quality Report has been prepared in accordance with NHS England and NHS Improvement reporting guidance (which incorporates the Quality Accounts regulations) published at: NHS England » Financial accounting and reporting updates as well as the NHS England and NHS Improvement Quality Accounts Requirements 2021/22 available at NHS England » Quality Accounts requirements 2021/22

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

By order of the Board:

Chairman:	Chief Executive:
Steve Fogg	Trish Armstrong-Child
June 2022	June 2022

4. Appendices

Appendix A: Actions taken following issue of National Report

Report	Action Taken
Feverish Children (care in emergency departments) Audit	Staff to perform appropriate observations at triage using an age-appropriate observation chart. Initial observations to be recorded within 15 minutes of booking into the department. Appropriate sepsis screen tool to be used.
National Emergency Laparotomy audit (NELA)	New pathway developed and rolled out with clear guidance for risk documentation on listing for surgery. Emergency laparotomy to meet BPT (Best Practice Tariff).
Getting it Right First Time (GIRFT) Thrombosis Audit	Informatics now produce a monthly list of potential HAT (hospital acquired thrombosis). This is based on patients identified with VTE admission and previous admission within 90 days. The case notes are retrieved by the clinical audit team and reviewed by the Clinical Improvement & Effectiveness Manager and members of the VTE committee. Currently there are between 25-30 patients per month. Coding will be informed where any patients are identified as HAT. The admitting team will be notified and instructed to undertake a serious incident investigation. A comprehensive VTE assessment tool is used within the Trust. This is to be reviewed and standardised across all Divisions. GIRFT have been informed that the assessment tool used locally builds on the National Tool and includes NICE guidance. The Trust uses weight-based dosing for anticoagulant prophylaxis.
National Maternity and Perinatal Audit	No new actions required from recommendations – appropriate procedures & processes are already in place.
Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (Saving Babies' Lives Care Bundle Version 2)	Staff to carry out the new triage system and proforma to facilitate better referral for ultrasound at appropriate gestation.

National Paediatric Diabetes Audit	Team to sign up to Quality Improvement programme ‘Weekly Youth Therapy’ clinics. Review of sub-optimum glycaemic control pathway, to include monthly upload to NPDA and clinical review through virtual clinics and extra clinic appointments.
Maternal, infant and new-born programme (MBRRACE-UK) Saving lives - improving mothers’ care	Additional field to be provided on Euroking to ensure midwives document history at booking appointment. Process in place for women to receive an Echo.
National Bowel Cancer Audit Programme (NBOCAP)	There is no action plan required. Measured parameters (90 days mortality, 30 days unplanned readmission rate, 30 days unplanned return to theatre, 18 months closed ileostomy rates) are all within National limits.

Appendix B: Actions Taken as a Result of Local Audit

Audit Title	Actions taken as a result of local clinical audit
Integrated Medicine & Patient Flow	
Assessment of the use of cardiac chest pain pathways	Trust Chest Pain Pathway designed and implemented.
Management of Bronchial asthma re-audit	Ongoing monitoring and updating of A&E staff with the current practice.
Consultants sign off	The need to complete the consultant sign off during the shifts highlighted - ongoing education.
Management of Intracranial Haemorrhage	Discussion with the Neurosurgeon on day of admission so delay in the management of the patient will be avoided. Close observation to prompt medical review if necessary, on admission and through hospital stay.
Documentation of DNACPR	Teaching for all doctors on consultant review and discussion before signing the DNACPR form. Education has taken place to ensure that appropriate Rockwood Score is updated during clerking and post take frailty is considered as main diagnosis.
Compliance of Trust Antimicrobial Formulary in AMU against Trust guidelines	Training at Junior doctors' induction to ensure that they are aware of Trust guidelines.
Stroke department performance on Carotid stenosis investigation for clinically indicated stroke patients	Ward rounds benefiting from work-up checklist including assessment of whether patients require carotid imaging. Checklist also includes a tick box for surgical vascular referral to ensure early discussion and decision around CEA (Carotid endarterectomy).
Oxygen prescription Wards 23,25,26 audit	Posters distributed to wards to raise awareness. Teaching for nurses undertaken to provide awareness and encouragement for oxygen prescribing.
Audit of urinary catheterisation	Catheters reviewed every 3 days for weaning off the urinary catheter by the medical team. Alpha one blocker will be considered in males. Patient to be referred to Urology in cases of complications or TWOC (Trial without Catheter).
Investigating the management of hypocalcaemia	Teaching session for doctors in Medicine and A&E detailing the appropriate investigations and management of hypocalcaemia according to the guidelines.
Management of Hyponatraemia in Care of the older persons ward	Departmental education undertaken in documentation of diagnosis and fluid status in patients' case notes and completing Hyponatremia investigations.
Drug allergy and prescribing details documentation	Management team supplied stamps for all AMU/ AEC prescribers. Develop quality improvement programme (QIP) to improve compliance with this information

	gathering. Regular reminders in closed group meetings and through email.
Quality of oxygen prescription practice on wards 3 and 8	Improved awareness about oxygen prescribing and respiratory failure among doctors on the wards through teaching, presentations and posters.
Sepsis bundle timeframe adherence on Wards 3 and 8	Sepsis pathway document will be placed in the patients' notes for the guidance of clinicians and nursing teams.
Management of Acute Kidney Injury - are we following the guidelines?	Ongoing education for doctors and nurses working in AMU/AEC to remind them that daily body weight measures can be considered as a suitable alternative to input-output chart. Proper documentation of volume status and monitoring is essential.
Monitoring of HbA1C and assessing diabetes control for admitted patients	Results presented, poster to be created and sent to hospital staff and GPs to increase compliance with guidelines. Discussion on starting more T1DM clinics.
Driving advice after acute stroke and TIA	Education of doctors undertaken on adding needs to be documented clearly in the appropriate section of the proforma on admission and on discharge.
Interim therapeutic anticoagulation of suspected DVT or PE	Assess pre-test probability with well's score. Aim to get imaging within 24hrs of patients with suspected DVT. All patients with confirmed VTE should be prescribed Direct-Acting Oral Anticoagulants (DOAC) unless contraindicated.
Clinical Documentation in AMU Clerking Proforma	To increase physician awareness through teaching. Remind doctors at morning handover around documentation of clinician clerking details.
Record Keeping Audit - Clifton Hospital	All ward managers to complete spot checks weekly on patient held records. Admin staff on ward to ensure notes are secure and if notes have come from another hospital with loose records, then to complete an incident form. Ward managers to check compliance figures and ensure all staff complete within 1 month and if staff fail to comply with record keeping standards to consider performance management.
Clifton Hospital review of one-to-one nursing re-audit	12-month cycle of audit completed, improvements noted, ongoing monitoring through ward managers and matron in place. To continue to do spot checks of the documentation of patients requiring one-ones.
Feverish Children (care in emergency departments)	Emergency Department (ED) staff to perform appropriate observations at triage using an age-appropriate observation chart. Initial observations should be recorded within 15 minutes of booking into the department. Appropriate sepsis screen tool used.
Surgery, Anaesthetics, Critical Care & Theatres	
Intra-op management of temperature and post-op temperature monitoring	Every patient will have their temperature monitored every 30 minutes.

Documentation of Anaesthetic Consent	Patients will be directed to leaflet or website.
New elective caesarean section lists operational standards	Surgeons to review the list one day before to set the plan. Midwives: IV access to be inserted and all required samples to be sent immediately on admission. Anaesthetists: To help midwives in cases of difficult venous access. Logbook customised to document causes of overruns to monitor the reflection of our actions on timing accuracy. Minimize overbooking.
Compliance with NICE CG 100 Alcohol Disorders and CORP/PROC/487 (was GM1917)	GAS1917 - Ongoing training on the assessment and management of patients with alcohol use disorders. Use of link nurses on all wards to promote identification and assessment referrals and effective care.
Acutely ill patients in hospital recognition of and response to acute illness in adults in hospital. Incorporating recording, monitoring & assessment of fluid balance & recognition of risk factors for AKI	Ongoing training delivered to nursing and medical staff and re-enforce the use of NEWS 2. Ensure all new junior doctors have safe oxygen prescribing embedded in 'Forward to Basics' – delivered in their induction programme. Trust-wide comms on fluid balance improvements with a link to the ESR training package. This will be linked to those wards engaged in fluid balance projects as part of the Deteriorating Patient Collaborative. Strengthen the embedding of clinical pathways documentation in the Forward to Basics (F2B) course.
Assessing management of gallstones in acute emergency admissions with acute cholecystitis and acute pancreatitis	Refinement of the surgical rapid access clinic undertaken. Patient information leaflets and materials developed.
Trans-urethral resection of prostate audit	Compliance with standards met - no actions required.
Calcium monitoring post-total thyroidectomy	Guideline poster hung in Surgical High Care unit (SHCU) treatment room; Guidelines included in induction. Continue electronic handover process, ensure ward round templates that have prompts to check blood results continue to be used.
Self-management follow up for breast cancer	Eligibility criteria extended to include male patients and patients following a bilateral mastectomy.
Nutritional screening on emergency surgical admission	Spreading awareness posters on surgical staff's communicative platform. (Checked and updated poster).
Transperineal precision point prostate biopsy audit	Standards met - no actions required.
Urethral catheterisation audit	Urology clinical skills session during Foundation Year 1 (FY1) doctors' induction to take place and further teaching sessions provided in order to give experience and confidence to Junior doctors.

Renal Colic admission in SAU	Joint discussion with ED and Radiology- develop a clear pathway. To develop the Renal Colic pathway and for dissemination via Grand Rounds.
Re-audit VTE prophylaxis in Urology patients in comparison with the trust guidelines	Teaching session for the new set of FY1 doctors and other junior doctors in the department to be undertaken. Dalteparin to be prescribed in the pre-op clinics.
How are we prescribing VTE prophylaxis following colorectal cancer surgery?	Senior team members to inform incoming juniors (on team) about 28 days of low molecular weight heparin (LMWH). Senior team members to document length of LMWH when patient is deemed fit for discharge. Teaching sessions for junior doctors about the importance of LMWH in colorectal cancer patients.
Intravesical Botulinum Toxin A injection efficacy	Criteria met - no actions required.
A prospective review of medical documentation of surgical patients	Inform junior doctors at induction which parameters should be documented in patients' notes. Senior reviewer to read out observations during review. Circle the role of reviewing clinician. Print out additional ID stickers.
Visual outcomes and complication rates of the treatment of macular oedema	Further injection clinics have been introduced.
Pre-operative assessment and biometry for cataract surgery in adults	Teaching sessions have been undertaken for all surgeons about the NICE guidelines and recommendations for biometry for cataract surgery in adults.
Common Orthopaedic practice Consent form audit	Ongoing education. Consent forms for common procedures to be made readily available.
Malnutrition Universal Screening Tool (MUST) Regional Audit	All patients to have MUST score performed on day of admission - awareness raised within department.
Re-audit Compare timing of ankle fracture surgery with NICE Guidelines	Awareness raised in re-enforcing available ankle fracture management pathway. Staff reminded about variable resources such as weight bearing x-rays.
Families & Integrated Community Services	
Audit of Emergency Readmissions within 30 days of Surgery (hysterectomy)	Review of service undertaken – additional doctor provided for gynaecology.
Re-audit LLETZ procedure	Colposcopy capacity has been increased to meet the backlog of patients due to the COVID-19 Pandemic. Colposcopy restoration data has been submitted fortnightly to SAQS since June 2020, this has shown that targets have been met with non-screening related referrals. Audit findings were communicated to

	colposcopists in the Colposcopy operational meeting in Sept 2021.
Routine questioning around domestic abuse at booking	Reminder issued in the Families Division Newsletter January 2022 to ensure that at every safe opportunity, enquiries are made at booking as to whether the woman is experiencing domestic abuse and to record a plan of action if there was not an opportunity to do so. Topic covered at Safeguarding study days.
Induction of Labour	Spot check review of 10 case notes completed to ensure use of Maternity Early Obstetric Warning Scoring (MEOWS) chart for daily recording during process of induction of labour (IOL). Reminder issued in weekly newsletter to avoid delay in insertion of PG and to discuss with on call (ST3+) doctor if any concerns.
Outpatient hysteroscopy and management of endometrial hyperplasia	All hysteroscopists advised of the requirement to undertake written consent for outpatient hysteroscopy and for the consent form to be filed in the patients' notes. Spot checks of Post-Menopausal Bleeding (PMB) waiting times undertaken by PMB lead.
Surgical management of Stress Urinary Incontinence	Multi-disciplinary Team (MDT) proforma updated to include physio review, QOL questionnaire, NICE PDA and British Society of Urogynaecology (BSUG) consent. Surgical listing forms changed to prompt referral to MDT. Waiting list team advised of the requirement to ensure urogynae patients have been through MDT prior to giving a date for surgery. Direct GP referral into physiotherapy or triage of referrals to physiotherapy explored.
Gynaecological cancer pathway breaches	To continue to review patients within the 2-week referral window, ideally aiming for 7 days. Fast track booking and co-ordination team reminded that clear documentation of required diagnostic test should be documented on booking form. Direct referral is in use between oncology MDT and other teams e.g. lung sarcoma.
Management of women with Hyperemesis in pregnancy	Laminated copy of 'Appendix ll' Flow chart from Local Guideline on management of Hyperemesis put on wall for reference in Ward D. Teaching session for CMW/ GP/ED doctors on hyperemesis in particular PUQE scoring & need for inpatient management completed. A sample 'Hyperemesis Pack' containing all necessary paperwork and a checklist for management has been made up and is available on Ward D.
Termination of pregnancy	All women undergoing termination of pregnancy (TOP) are to be given Azithromycin - staff members involved in TOP were advised regarding the need for a prescription for all patients.
Re audit of 3rd and 4th degree tears	Due to COVID-19, many perineal clinic appointments were undertaken via telephone consultation, and several were outside of the normal 8–12-week time frame. Re-audit proposed for 2022 when audit results are not showing pandemic effect.

Reduced Fetal Management	A mandatory field to the maternity data system has been added. All women who present with reduced foetal from 26+0 weeks will have a computerised CTG.
Paediatric High Dependency Review	Training provided to staff in nursing patients requiring HDU care. HDU documentation bundle production produced to remind staff of proper documentation & nursing care requirements. Care plans pre-printed to reflect HDU care.
Clinical Handover - Transfer Audit	All staff are up to date and on a rolling programme for paediatric life support (PLS) and advanced paediatric life support (APLS) training. Feedback given at the ward/unit meetings reminding staff to complete transfer documentation, medical transfer notes and North West & North Wales Paediatric Transport Service (NWTS) transfer documentation appropriately.
(LISA) Less invasive sufacant administration in level 2 neonatal unit	Proforma now used on every case of surfactant administration on the unit to identify all babies satisfying criteria for LISA. Training of LISA included as part of Induction and simulation.
Compliance with recognising and treating early onset neonatal sepsis	Retrospective Neonatal Sepsis audit proforma updated. Practice Development Midwife disseminated key points of Neonatal sepsis guideline to Midwifery staff. Neonatal Sepsis included in departmental teaching programme.
Paediatric and NeonataL X-ray result and documentation	Changes made to x-ray sticker. Changes and use of x-ray sticker discussed with radiographers and radiology department.
Compliance with Trust guidelines for Neonates of mothers with Thyroid Disease	Thyroid guideline reviewed including the monitoring algorithm to include a checkpoint prompting the clinician to double check if the mother has TRAB -ive Thyroid status. Changes approved.
Single centre experience of outcomes of surveillance for neonatal development dysplasia of hips	Hospital new-born hip screening policy has been updated to be in line with national standards and submitted to Child Health Directorate. Changes fed back at audit meeting with paediatric consultants and radiologists.
Neuro-developmental follow-up and special needs identified in children	Teaching sessions ongoing. Neonatal team and Paediatric consultants to inform parents about the need for follow ups in NNU. Every effort is to be taken to liaise with families regarding non-attendances.
Adherence to guidelines in managing Neonates with a cardiac murmur	Clinical guideline updated. Checklist sticker templates have been created and included in the new guideline.
Did not attend (DNA) for Paediatric dental patients	WNB-CYP Pathway for missed appointments introduced. Audit findings & WNB training delivered during clinicians meeting.
Dental radiography quality assurance audit	The calibration exercise became void due to new dental guidance published in June 2020, which revised image quality rating and analysis grading. A re-audit will take place against new guidance.

Compliance with SDCEP and IACSD guidelines for the use of Flumazenil for over sedation	The service has met the standards of the audit and there was no need to implement changes, however educational sessions are ongoing to increase awareness on national guidelines.
Use of the Non-compliance to Treatment Policy	A new process for managing non-compliance has been approved and published by the Trust. This is documented within the 'Difficult to Engage Escalation Policy' CORP/PROC/584. This new process allows increased scope for negotiation and joint working with patients to agree a management plan before escalation through a UIR. This process is supported by use of the patient management plan to assist in negotiating and agreeing a plan of care with the patient, using a coaching approach. This audit will now be discontinued, and a new audit registered in line with the new Difficult to engage escalation policy CORP/PROC/584. Feedback was given to the team who completed an incident form for a patient who lacked capacity, to aid learning and to identify any training needs.
Clinical Supervision Audit	The Clinical Improvement Team (CIT) reviewed the provision of the Clinical Supervision training, and this will be provided over MS Teams by the Trust Clinical supervision lead not CIT. The Clinical Supervision contract was sent out to all team leaders and managers. The CIT developed and shared a proforma template for Supervisors to use when providing clinical supervision and offered support to embed clinical supervision within community teams.
Record keeping audit at the Assessment and rehabilitation Centre (ARC)	Development support for the newly appointed Band 6 has been delivered by the Team Leader. The Team Leader, with support from the Locality Manager monitors staff record keeping and reviews incidents. Where staff are non-compliant supportive conversations have been held with individuals outlining the standards required. Where staff fail to meet the Trust requirements the performance improvement policy is triggered and followed.
Audit of safety huddles in Adult Community Teams	Audit results were disseminated through team leader meetings, all team leaders reviewed the huddle template to ensure minimum essential areas are covered. A new Standard Operating Procedure (SOP) was approved on 06/08/2021.
Implementation of the mental capacity act in adult community teams	Safeguarding team attended safety huddles for all community teams and are providing twice weekly 'drop in' sessions on MS Teams. Evidence was gathered through harms huddles throughout November and December

	2021 with the Associate Director of Nursing. EMIS template changed to prompt accurate recording of consent and decision making related to capacity / best interests in care contact template and MCA template.
Use of the difficult to engage escalation policy within adult community teams	The audit report was disseminated at team leader meetings to facilitate learning, specifically noting good practice points and identifying the need for senior review and escalation to senior management if the non-compliance remains unresolved. The new process for management and escalation of non-compliance in line with the new Difficult to Engage Escalation policy CORP/PROC/584 was presented to ensure all staff were made aware.
Clinical Support Services	
Reporting of Endometrial carcinomas on biopsy specimens	SNOMED coding to be done accurately and if necessary updated after external review. All endometrial malignancy cases to be internal peer reviewed before being sent for external / network review.
Audit of the cutaneous squamous cell carcinoma reporting	The need to provide accurate and essential clinical information was disseminated, with the focus on getting all the essential clinical information on the histology request card.
Compliance to the RCPATH dataset for colorectal cancer re-audit	No action required; overall standard is met for all criteria assessment.
Adherence of reporting of lung cancer resection against RCoPATH dataset	Dataset adjusted to make satellite nodule section clearer. Most recent lung resection reporting proforma copied to staff.
Adequacy of cervical biopsies and cervical loop excision biopsies	Recommendations were shared with the Colposcopy department and the National cervical screening QA team to maintain the compliance to provide a single piece loop biopsy for histological assessment in keeping with the National Standards. Maintain the compliance on depth of excision of loop biopsies for squamous epithelial abnormalities (≥7mm) to reach the 100% compliance target. Maintain the compliance on depth of excision of loop biopsies for glandular epithelial abnormalities (≥10 mm).
Cervical loop histopathology reports	Clinical team in colposcopy advised to include smear +/- biopsy results and colposcopy findings in the clinical information. Use of modified proforma to become mandatory for histopathology reporting of cervical loop biopsies.
Audit of Antibiotic Prescribing in Covid patients using the	Staff training ongoing to improve AMS compliance and documentation of start/stop dates of antibiotics and severity scores.

Trust's antimicrobial formulary as standard	
Quality of PA chest radiographs	Staff education as continuous process through online presentations and charts.
Head CT - lens exclusion	Audit findings were presented to radiographers, posters were created and placed in each CT control room reminding radiographers about the need to exclude the lens on CT head examinations.
Knowledge and understanding of revised RECIST guidelines	No actions required. Significant improvement in staff knowledge about RECIST guideline shown during the audit.
Compliance of the clinician and the radiology department with the case note sticker under the regulations of the Ionising Radiation (Medial Exposure) Regulations	All clinicians were emailed by the Head of Department to remind them of their IRMER responsibilities. The Radiology department were informed of high compliance and to keep up the great work.
Opacification of the renal collecting system during CT Urography (CTU)	Audit results shared with radiologists and radiographers. The re-audit showed some improvement compared to the primary audit.
To assess the correct recording of patient dose following imaging examination	Where the exposure factors need to be increased to outside the normal exposure range for a given examination, the exposure factors used dose and **reason** (i.e. obesity) must be recorded in the RIS observation box -staff asked to make themselves familiar with the policy and to carry out the guidance when required. All staff to follow the guidance as per “Pause and Check” methodology when recording patient dose - staff asked to make themselves familiar with best practice guidance and to comply with this at all times.
End of life nursing care plans	Audit findings disseminated at BTH EOLC training; Training slides were changed to incorporate recommendations from the audit. Nursing care assessment sheets were discussed at EOL project group. Changes made to the nursing care plans are to be re-audited once introduced.
Anticipatory prescribing case note review	Audit findings were presented to the Fylde Coast End of Life Strategy Group, A meeting was arranged with Coyle et al team to share learning, The EMIS template was amended to document review of dosage prior to commencement of CSCI. Policy updated. Support and mentoring is ongoing to non-medical prescribers across the Fylde Coast.
BAPEN National Care Audit	A ‘MUST’ training video has been produced to provide a brief overview of how to complete a ‘MUST’ evaluation.

	Meetings have been arranged with Clinical Improvement Leads to discuss ward-based training.
Tertiary Services	
Audit compliance on Antiplatelets in Coronary Syndromes	Greater risk stratification sheet created. Incorporate assessment tool and attach to ACS pathway.
Compliance of oral statins, b-blocker and antiplatelet therapy after CABG on discharge	Prescription format to be followed by SHO and ANP during discharge made available on e-mails/trust website/desk. Two common prescription formats to be agreed 1. statin, beta blocker and dual antiplatelet 2. Statin, betablocker and single antiplatelet. All prescriptions to have Aspirin and Clopidogrel/Prasugrel/Ticagrelor plus a statin like Atorvastatin/Rosuvastatin and a beta blocker like bisoprolol.
Use of DAPT with anticoagulation in patients presenting with Acute coronary syndrome and Atrial Fibrillation	All staff encouraged to actively check for and ensure relevant risk scoring documentation is in the notes and on discharge. TAT and DAT therapy recommendations to be used. DOAC to be used over Warfarin for non-valvular AF and ACS unless contraindicated, which will be documented.
To compare Heart Failure mortality in Cardiology and General Medicine patients against NICE guidance	Patients on general medical wards with a primary diagnosis of heart failure will be seen by the Heart Failure outreach team. Echo within 48 hrs of admission with acute heart failure to guide management. If the patient has a primary diagnosis of heart failure (HF), and no significant non-cardiac comorbidities requiring physician care, admit to cardiology ward as it is associated with better outcomes (lower mortality).
Adherence to recommended enhanced follow-up with annual echocardiogram for patients implanted with Trifecta Aortic valve bio prostheses	Patients implanted with a Trifecta valve need to be referred to dedicated prosthetic valve clinics, note on discharge letter informing GPs of this. Patients who are not compliant with their ECHO appointments need to be identified and educated about the need for surveillance ECHOs by telephone consultation or letter.
Effect of Dexamethasone and Clonidine to enhance the effect of Bupivacaine in intercostal nerve block	CAR2008 - Criteria met no actions required.
Primary prevention therapy in ischemic cardiomyopathy patients after surgical or percutaneous coronary resuscitation	Primary PCI booklet has been amended for follow up ECHOs after 90 days from re-vascularisation. ECHO Physiologists will arrange contrast ECHO if inconclusive. Cardiology/Cardiothoracic Consultants will request a follow up ECHO and provide clear instructions to local hospitals.

Complication rates associated with different TAVI vascular access points	Track fluid status more and appropriate fluid intervention. More training surrounding bleeding. Staff to look at using smaller sheaths sizes.
Orientation of Health Care Professionals regarding the appropriate use of surgical masks in inpatient Clinical areas re-audit	Presentation sent across different cardiac areas. Presentation created describing what the high-risk areas are.
Evaluate the use of Intra-aortic balloon pump (IABP) in cardiac patients	Need to complete the date with propensity matching of patients who do not have a balloon pump.
Re-audit Use of DAPT with anticoagulation in patients presenting with Acute coronary syndrome and Atrial Fibrillation	Promote awareness on the ESC guidelines to all parties. To conduct 'spot checks' to ensure adherence/good practice.
Audit on the effect of Covid on minimally invasive surgery	Standards met no actions required.
Corporate Services	
Sepsis pathway	No longer participating
Stroke pathway	No longer participating
Dementia Assessment / Quality Assurance	Closure of the DAR Return. The retirement of the DAR collection was approved at the June 2021 meeting of the Data Alliance Partnership Sub Board with effect from 30th June 2021. There is thus no requirement for trusts to submit any further data for this return. The last data published was for February 2020 on May 6th (see the 2019-20 DAR web page).
Dementia Compliance	Closure of the DAR Return. The retirement of the DAR collection was approved at the June 2021 meeting of the Data Alliance Partnership Sub Board with effect from 30th June 2021. There is thus no requirement for trusts to submit any further data for this return. The last data published was for February 2020 on May 6th (see the 2019-20 DAR web page).
Medical devices management and training	Reports devised to reflect medical devices related incidents. Managers to monitor Key Trainer certification and performance for standardised medical devices training.

Appendix C: Glossary of Abbreviations and Terms

Table i: Glossary of Abbreviations

Abbreviation	Meaning
SUTS	Sign up to Safety
NICE	National Institute Health and Care Excellence
CAUTI	Catheter Associated Urinary Tract Infection
NHS	National Health Service
AKI	Acute Kidney Injury
IV	Intravenous
CCG	Clinical Commissioning Group
CDI	*Clostridioides difficile* Infection
PROMS	Patient Reported Outcome Measures
HED	Healthcare Evaluation Data
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
GP	General Practitioners
MRSA	Methicillin Resistant *Staphylococcus aureus*
NCEPOD	National Confidential Enquiries into Perinatal Outcomes of Death
NICE	National Institute for Health and Care Excellence
PbR	Payment by Results
SHMI	Summary Hospital Level Mortality Indicator
VTE	Venous Thromboembolism
RCP	Royal College of Physicians
CTG	Cardiotocography
UV-C	Ultra Violet
AMU	Acute Medical Unit
AEC	Ambulatory Emergency Care Unit
NIHR	National Institute of Health Research
#NOF	Fractured Neck of Femur
COPD	Chronic Obstructive Pulmonary Disease
A&E	Accident & Emergency
SSNAP	Sentinel Stroke Audit Programme
RCEM	Royal College of Emergency Medicine
CADS	Complicated Acute Diverticulitis Audit
MINAP	Myocardial Ischaemia National Audit
NICOR	National Institute for Cardiovascular Outcomes Research
ICNARC	Intensive Care National Audit Research Centre
NPDA	National Paediatric Diabetes Audit
NCAA	National Cardiac Arrest Audit
NELA	National Emergency Laparotomy Audit
C-diff	*Clostridioides difficile*
LeDer	Learning Disabilities Mortality Review
HQIP	Healthcare Quality Improvement Partnership
SCR	Serious Case Review
SAR	Safeguarding Adult Review
DHR	Domestic Homicide Review
ACS	Accountable Care System
ICP	Integrated Care Partnership

MoU	Memorandum of Understanding
SUS	Secondary User Service
IG	Information Governance
VOICES	National Bereavement Survey
MSK	Musculoskeletal
MINAP	Myocardial Ischaemia National Audit Project
BAUS	British Association of urology Surgeons
NBOCAP	National Bowel Cancer Audit Programme
CRM	Cardiac Rhythm Management
CMP	Case Mix Programme
ICNARC	Intensive Care National Audit and Research Centre
CHD	Congenital Heart Disease
PCI	Percutaneous Coronary Interventions
NPDA	National Paediatric Diabetes Audit
FFFAP	Falls and Fragility Fractures Audit Programme
HANA	Head and Neck Cancer Audit
IBD	Inflammatory Bowel Disease
TARN	Trauma Audit & Research Network
MBRRACE-UK	Mothers and Babies; Reducing Risks through Audits and Confidential Enquiries
NABCOP	National Audit of Breast Cancer in Older Patients
NAIC	National Audit of Intermediate Care
NBSR	National Bariatric Surgery Registry
NCAA	National Cardiac Arrest Audit
RCP	Royal College of Physicians
NCSARI	National Clinical Audit of Specialist Rehabilitation for patient with Complex needs following Major Surgery
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme
RCOphto	National Ophthalmology audit Royal College of Ophthalmologists
PICANet	Paediatric Intensive Care
POMH	Prescribing Observatory for Mental Health
SHOT	Serious Hazards of Transfusion
GIRFT	Getting It Right First Time
BTS	British Thoracic Society
SUS	Secondary User Service
IG	Information Governance
BTH	Blackpool Teaching Hospital
EPaCCS	The Electronic palliative care co-ordination system

Table ii: Glossary of Terms	
Term	Meaning
Aseptic Non Touch Technique	A specific type of technique to protect key sites and key parts of a patient from microorganisms which may be transferred from a healthcare worker or the environment to a patient.
Catheter associated urinary tract infection	An infection which it is believed to have started by a urinary catheter.
Clinical	Relating to the care environment.
Commissioners	Group responsible for most healthcare services available within a specific geographical area
Clostridioides difficile	*Clostridioides difficile* (C.diff) is a bacterium that is present naturally in the gut. Some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C.diff bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. At this point, a person is said to be 'infected' with C.diff.
CQUIN	Commissioning for Quality and Improvement. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Emergency readmissions to hospital within 28 days of discharge	Location of the latest published data can be accessed from: http://www.ic.nhs.uk/pubs/hesemergency0910
Friends and Family Test	A test that provides us with a simple, easily understandable way to obtain patient feedback to pinpoint areas for improvement Further information can be located at the following link: http://transparency.dh.gov.uk/2012/11/28/nhs-friends-and-family-test
Methicillin Resistant *Staphylococcus aureus*	MRSA stands for Methicillin-Resistant *Staphylococcus aureus*. It is a common skin bacterium that is resistant to some antibiotics. MRSA Bacteraemia is when MRSA is found in the blood, which can lead to septicaemia, the clinical term for a severe illness caused by the bacteria in the blood stream. This is the kind of MRSA infection that has the highest death rate.
Mortality	Mortality relates to death. In health care mortality rates mean death rate.
Monitor	Monitor was established in 2004 and authorises and regulates NHS Foundation Trusts. Monitor works to ensure

	Foundation Trusts comply with the conditions they signed up to and that they are well led and financially robust.
National Johns Campaign	National campaign to promote the right of families and carers of people with dementia to be allowed to remain with them in hospital for as many hours as they are needed
National Patient Survey Results	The patient survey question to be monitored by the Trust is in relation to 'Responsiveness to inpatients' personal needs' http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_126972
National Staff Survey Results	The staff survey question to be monitored by the Trust is in relation to the 'Percentage of staff who would recommend the provider to friends or family needing care'. Location of the latest published data can be accessed from: http://www.nhsstaffsurveys.com/
NHS Outcomes Framework	The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on: • Domain 1 Preventing people from dying prematurely • Domain 2 Enhancing quality caring of life for people with long-term conditions • Domain 3 Helping people to recover from episodes of ill health or following injury • Domain 4 Ensuring that people have a positive experience of care; and • Domain 5 Treating and caring for people in a safe environment Available at:http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance
NICE	National Institute of Excellence. An independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health.
Organisational Strategic Framework	The organisations process of defining it strategy, or direction, and making decisions on allocating its resources and priorities to achieve the strategy.
Patient Reported Outcome Measures	The patient reported outcome scores are for i) groin hernia surgery, ii) varicose vein surgery, iii) hip replacement surgery, and iv) knee replacement surgery Patient Reported Outcome Measures (PROMs) - NHS Digital
Percentage of admitted patients risk-assessed for Venous Thrombo-Embolism	Location of the latest published data can be accessed from: Patient Reported Outcome Measures (PROMs) - NHS Digital
Quality Strategy	A document which outlines the aims and objectives of the Trust relating to patient safety and improving quality

Quality Improvement	A formal approach to the analysis of performance and systematic efforts to improve it resulting in better outcomes for patients, better systems performance and better staff development.
Root Cause Analysis	A method of problem solving that tries to identify the root causes of issues and why they are happening
Safety Thermometer	A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism)
Sign up to Safety Campaign	This is a national campaign and unified programme for patient safety across the NHS in England
Summary Hospital Level Mortality Index	The Summary Hospital-level Mortality Index (SHMI) is a system which compares expected mortality of patients to actual mortality. The Summary Hospital Level Mortality Indicator measures whether mortality associated with hospitalisation was in line with expectations. Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS Digital
Venous Thrombo embolism (VTE)	Venous Thromboembolism (VTE) is the term used for deep vein thrombosis (DVT) and Pulmonary Embolism (PE). A DVT is a blood clot that forms in a deep vein. Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE).
62 day cancer screening waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days referral from the screening programme as a percentage of the total number of patients receiving first definitive treatment for cancer following a referral from the screening programme.
Leading Change Adding Value	A National Framework for Nursing, Midwifery and Care Staff
Clostridioides difficile Target	Number of patients identified with positive culture for *Clostridioides difficile*
Rate of *Clostridioides difficile*	Location of the latest published data can be accessed from: clostridioides difficile - Search - GOV.UK (www.gov.uk) 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 *Clostridioides 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; 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.
Rate of MRSA	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review); • Reports of MRSA cases includes all patients who have an MRSA positive blood culture detected in the laboratory; whether clinically significant or not, whether treated or not; • The indicator excludes specimens taken on the day of admission or on the day following the day of admission; • Specimens from admitted patients where an admission date has not been recorded or where it cannot be determined if the patient was admitted, are attributed to the Trust; and Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where the specimens were taken.
Maximum 62 days from urgent GP referral to first treatment for all cancers	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • The indicator is expressed as a percentage of patients receiving their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer;

	• An urgent GP referral is one which has a two week wait from the date that the referral is received to first being seen by a consultation (see http://www.dh.gov.uk/prod-consum-dh/groups/dh-digitalassets/documents/digitalassset/dh-103431.pdf); • The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date the referral is received by the Trust; and The clock stop date is defined as the date of first definitive cancer treatment as defined in the NHS Dataset Change Notice (A copy of this can be accessed at: http://www.ish.nhs.u/documents/dscn/dscn2008/dataset/202008.pdf. In summary this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition**,** or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.
Rate of patient safety incidents and percentage resulting in severe harm or death	Location of the latest published data can be accessed from: http://www.nrls.npsa.nhs.uk/resources/?entryid45=132789
Waiting times and the 18 weeks referral to treatment (RTT) pledge	The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. Patients have the legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer, or it is clinically appropriate that the patient wait longer.
4-hour A&E waiting times	The maximum four-hour wait in A&E is a key NHS commitment and is a standard contractual requirement for all NHS hospitals. In addition, NHS England has an added contractual requirement covering NHS hospitals that no A&E patient should wait more than 12 hours on a trolley.