NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Quality Account 2022 / 2023

“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 for 2022/23.

This report provides an important opportunity for us to look back over the last 12 months and take stock of how we have performed but also to take a look ahead at our priorities for the next year and how we will meet the challenges we face.

There is no denying it's been a difficult year for the NHS nationally and locally, and Blackpool Teaching Hospitals has not been immune to this. We continue to see immense pressures particularly across our urgent and emergency pathways. Despite easing many of our COVID-related restrictions, we are faced with a different set of challenges around financial responsibilities, the health and wellbeing of our teams, reducing our waiting lists and a changing healthcare landscape in Lancashire and South Cumbria.

I'd like to start by thanking every single colleague for their continuing hard work and commitment to providing caring, safe and respectful treatment – this goes for our hospital and community colleagues and our support teams, as well as our partners in the wider community.

I'm so proud of the work being done under such immense pressure. We truly have some tremendous people and I'm never prouder to lead this organisation than when I see how we come together in difficult times to support each other as well as patients and their families.

Last year, following an important period of engagement with colleagues, partners and stakeholders, we were excited to launch our new five-year strategy for 2022-2027 which set out the critical themes and objectives we will achieve. From this, we developed our quality objectives for 2023/24 which continue the important work outline agreed and progressed the previous year.

Quality improvement continues to be a driving force for the Trust and I'm delighted to report that we have made important progress with our three key improvement programmes:

- Establishing our Clinical Quality Academy
- Improving the identification and management of the deteriorating patient
- Reducing fractured neck of femurs (working with local care homes).

In addition, we continue implementing all actions aligned to:

- Better Births, the Ockenden review into maternity services
- The continuity of carer model for maternity services

Our quality priorities for 2023/24 will focus on:

- Building on our sepsis pathways
- Working with system partners to launch a second phase of the 'last 1,000 days' collaborative which aims to provide improved end of life care for everyone
- Working to further build quality improvement capability at all levels of the organisation

In the Trust, there are now around 1,000 people who have participated in collaborative programmes or improvement training and we've built a 12-month programme for clinically led teams known as the Clinical Quality Academy (CQA).

The CQA aspires to create a culture for improvement across the Trust, developing colleagues with skills to improve care while developing advanced improvement science and knowledge. This programme was recognised nationally after being shortlisted for the 'Changing Culture' HSJ Patient Safety Award in October 2022.

Meanwhile, important work has taken place to improve our clinical pathways and in turn the safety of our patients – a prime example is our commitment to the clinical and screening guidelines of the UK Sepsis Trust, including use of the Sepsis Six treatment and testing bundle aimed at delivering resuscitative treatment within the first hour of identifying sepsis.

Finally, I must report on the immense amount of work which has gone on to improve our facilities which include the opening of state-of-the-art Same Day Emergency Care (SDEC) and Critical Care units as part of our ongoing Emergency Village project.

Both these schemes have made an incredible difference to the way we work and ultimately to the care our patients receive. SDEC for instance is removing delays in the emergency care pathway, helping us care for urgent and emergency patients within the same day of arrival as an alternative to hospital admission.

The next phases of the Emergency Village continue at pace and just some of the improvements this will introduce are a dedicated Emergency Department radiology unit, further majors' cubicles, 12 ambulance triage spaces and a new spiritual centre allowing the current Chaplaincy area to be refurbished into ED support accommodation.

To the best of my knowledge, the information in this report gives an accurate account of quality at the Trust and I hope this report will be read with an underlying appreciation of both the work delivered by the team and the commitment of every colleague to continue to make a difference for patients and their families.

I am confident the next 12 months present an opportunity to focus further on progress and the difference we can make for the population we serve and to the way we work and support each other.

Trish Armstrong-Child
Chief Executive Officer

1.1 Our Achievements

2 Priorities for Improvements and Statements of Assurance from the Board

Following the launch of our new strategy in May 2023, the Board agreed five themes and objectives deemed as critical in converting the strategy into action – these are:

- Operational transformation
- Quality and safety
- Finance and investment
- People and culture
- Partnerships and innovation

These are all closely linked and the selection of our quality priorities for 2023/24 will contribute to the achievement of the agreed objectives and the plans agreed with our system partners to continue the improvement journey we are on.

2.1 Rationale for the Selection of Priorities for 2023 / 2024

In our new strategy we agreed an objective to reduce avoidable harm events and improve patient experience and therefore, in terms of the specific priorities for our Quality Account, we have decided to continue our ongoing programmes of work and will continue to work on 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.

In addition to the above objectives, we will also continue with the following programmes:

- 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.

2.2 A Review of Quality Improvement Programmes 2022 / 2023

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	✓ ⊜ ↓
Clinical Quality Academy	Goal met	✓ ⊜
Improving the Identification and Management of the Deteriorating Patient	Close to goal	⊜
Reducing Fracture Neck of Femurs *(In partnership with local care homes)*	Goal partly met	⊜

The programmes listed above form part of the Trust's current Quality Improvement (QI) strategy (2019-2022). The Trust has now launched a new strategy and these priorities are currently being refreshed in line with the new priorities.

Quality Improvement methods help us to deliver our mission, to deliver safe, effective, sustainable care for everyone, every day. We do this 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 are to:

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

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

- The "Blackpool Clinical Quality Academy", to build our improvement capability, with ten medically led teams each undertaking a QI project with a focus on reducing avoidable harm.
- "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 facilitate this work, the Trust has an established QI Directorate, called the QI Hub, who support improvement from concept to delivery of outcomes.

2.2.1 Clinical Quality Academy (CQA)

What?	Deliver the first Blackpool Clinical Quality Academy
How Much?	By the end of 2022, ten clinically led teams will deliver projects to improve care, whilst developing advanced improvement science, knowledge and skills.

As well as facilitating the large-scale improvement programmes, the Trust aims 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 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 the Trust, there are now around 1,000 people who 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.

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). 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.

The CQA is designed to deliver 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.

In 2022, the first ten clinically led teams graduated and by July 2023 a total of twenty teams (104 staff) will have graduated and delivered projects to improve care, whilst developing advanced improvement science, knowledge and skills.

This programme was successfully shortlisted for the "Changing Culture" HSJ Patient Safety Award in October 2022.

Outcome	Ten teams graduated CQA in July 2022, having delivered improvement projects to achieve their safety related aims.
Progress	A further ten teams will graduate the CQA in July 2023

2.2.2 Improving the identification and management of the deteriorating patient

What?	To reduce the number of cardiac arrests (outside of critical care units)
How Much?	Achieve and sustain a mean Trust cardiac arrest rate of 1.0 per 1000 admissions by September 2023

Patient deterioration can be defined as:

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

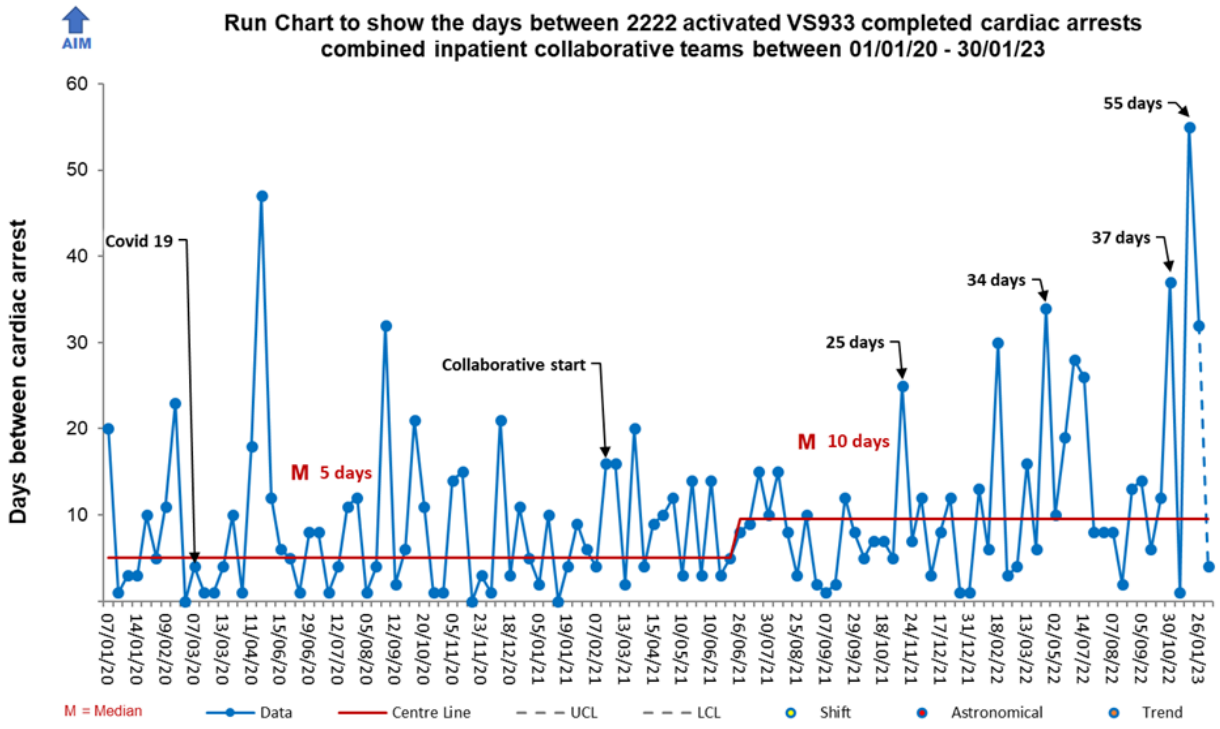
Patients of all ages are known to suffer harm if deterioration in their condition is not detected or acted upon in a timely and effective manner. Inadequate clinical monitoring and failure to act on deterioration is associated with preventable deaths and severe patient harm, such as cardiac arrests.

Analyses of nationally collected data have highlighted the need for improving identification and management of deteriorating patients. 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 below.

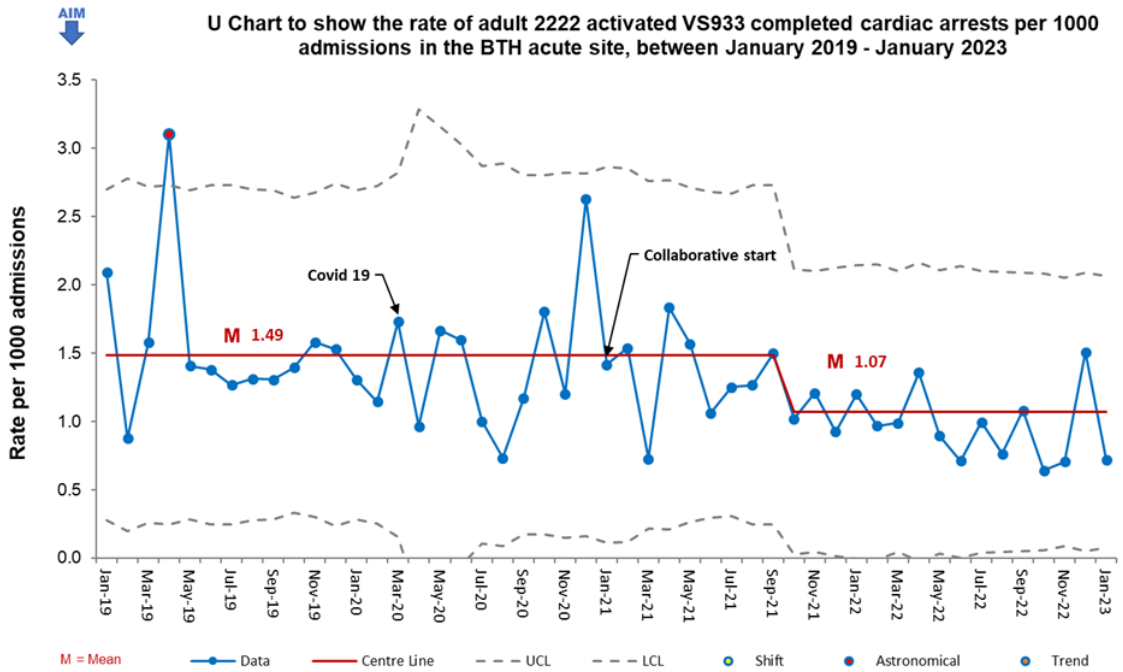
Primary Drivers	Primary Drivers	Secondary Drivers	Change Ideas
In the next twelve months we aim to reduce the number of cardiac arrests outside of critical care areas by 50%	Culture, teamwork & accountability	• Leadership attention • Clearly defined protocols and pathways • Shared learning from effective root cause analysis and mortality reviews • Awareness of human factors and psychological safety • Team development and learning	• MDT mortality reviews, LFD app • RECALL proforma – CCOS reviews • Safety culture awareness
	Assessment & observation	• 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	• Use of NEWS2 boards, magnets & aids • Testing the use of the term “watcher” • Treatment & escalation plan (TEP) document
	Response	• 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	• Simulation training • Awareness of barriers to immediate review • Openness to all queries • Escalation document sticker
	Patient flow and communication	• 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	• Ward round checklists & standardisation • Effective safety huddles, handovers & improved communication • Debrief tools • Engagement of patients & families in decision making

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.

Change package interventions tested by teams during the collaborative process have led to improvements, e.g. 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.



The number of days between 2222 activated cardiac arrests for the inpatient teams involved in the collaborative, a statistically significant shift seen in June 2021, from a median of 5 days to a median of 10 days, continues to be sustained. In January 2023, the combined collaborative inpatient teams achieved 55 days between 2222 activated cardiac arrests.



The monthly cardiac arrest rate per 1000 admissions shows an improvement in the mean rate from 1.49 to 1.07 per 1000 admissions.

Now, the focus of this programme is to sustain the improvements seen and to further reduce incidences where cardiac arrest calls could be avoided. To help sustain improvements, specific change package interventions, that teams have identified as likely to have the biggest impact, are being focussed on. These interventions continue to be tested and are being spread and scaled across the hospital. Teams have access to team specific time between cardiac arrest run charts updated weekly and a monthly drop-in virtual “café’” to access improvement coaching and peer support.

This programme was successfully shortlisted for the “Deteriorating Patients and Rapid Response Initiative of the year” HSJ Patient Safety Award In October 2022.

In line with our aim to reduce preventable deaths, in September 2022, a new collaborative was launched to improve compliance of the sepsis pathway.

Outcome	Aim to achieve 1.0 per 1000 admissions not yet achieved, however statistically significant improvement has been achieved and sustained.
Progress	The monthly cardiac arrest rate per 1000 admissions shows a sustained improvement in the mean rate from 1.49 to 1.07 per 1000 admissions.

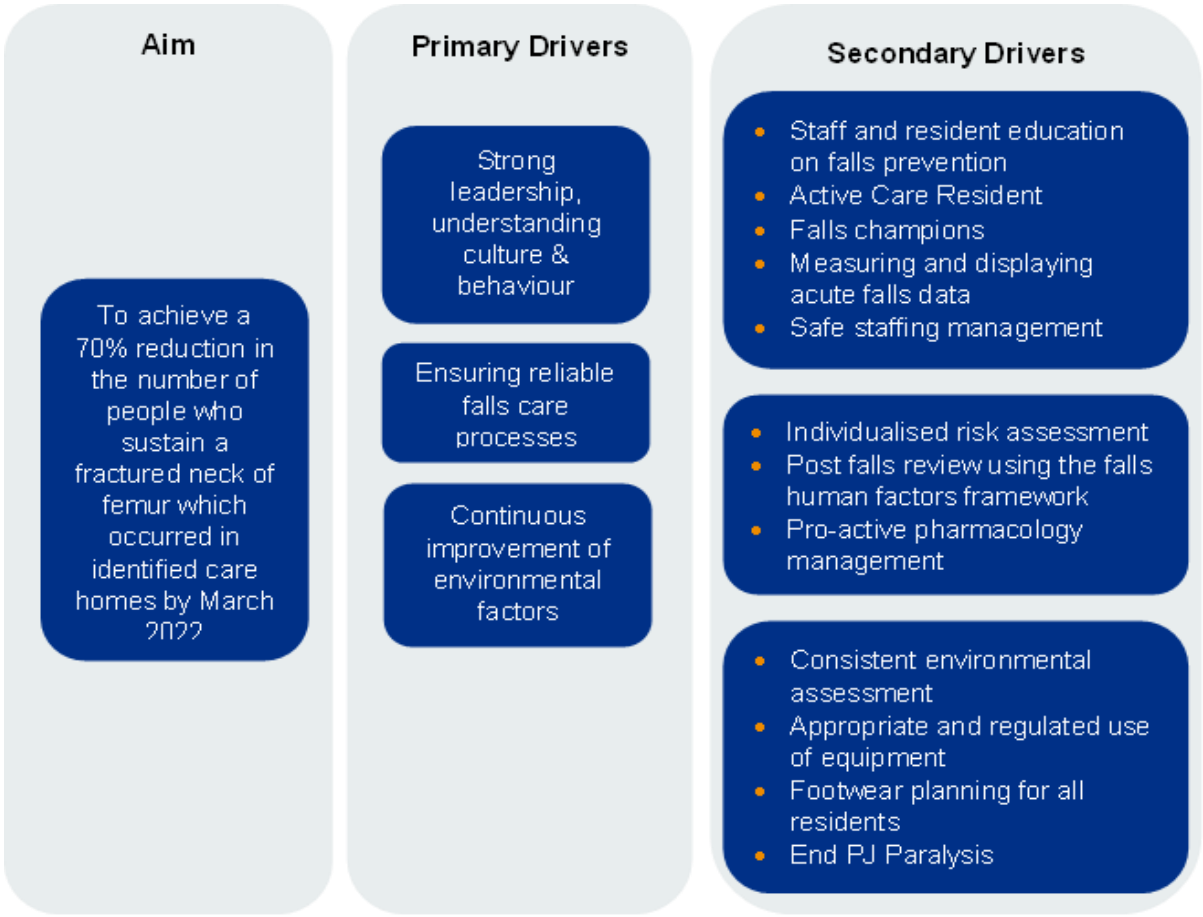
2.2.3 Improving the Last 1000 days of Life: Preventing Fracture Neck of Femur (#NOF)

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 following driver diagram highlights the programmes aim in detail.

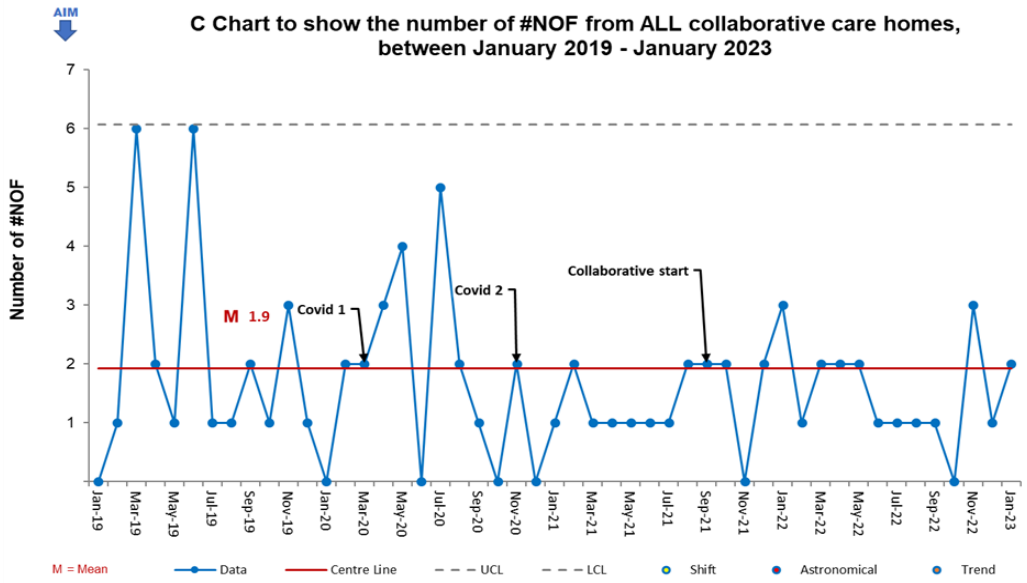


A change package has been created to provide care homes with tools to assist in reducing the number of people whose falls require their admission to hospital. It explains both the technical and, just as importantly, the cultural and behavioural shifts needed to make this improvement programme succeed. It is part of a wider support package that included regular visits to care homes, check-in phone calls and workshops. From the launch of the collaborative in September 2021, care home teams have been supported to undertake projects aligned to the change package which aim to improve the number of falls and #NOF in a care home setting. That included looking at individual resident journeys and preventing admissions to A&E where community support and treatment is available to residents in their own care home.

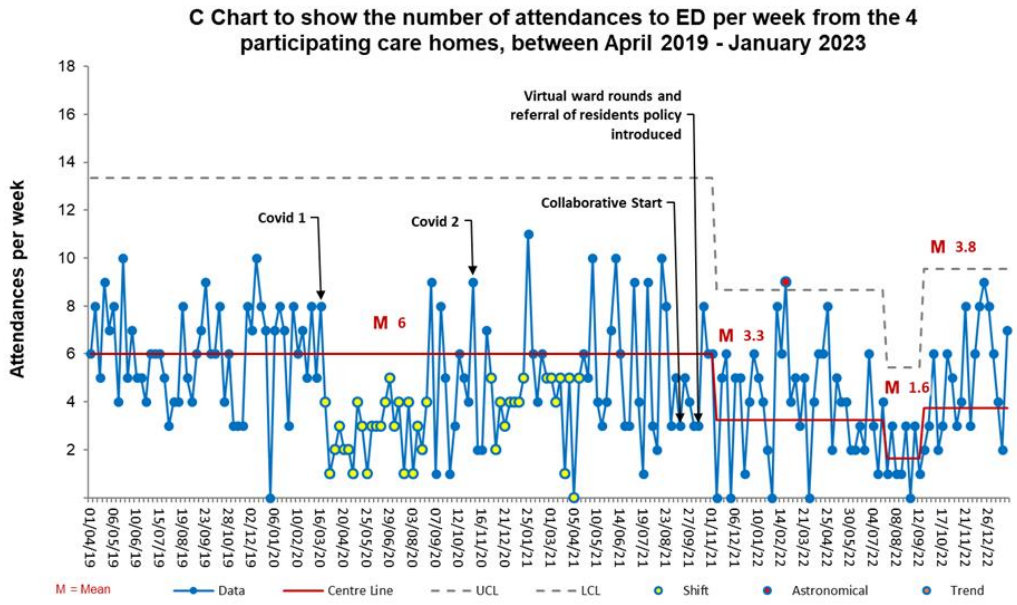
The following change ideas were developed by the teams in a mnemonic to help remember the falls prevention ideas:

- Education – Providing falls prevention to all staff and developing resources such as leaflets, posters and guides for staff, residents and families.
- Safe staffing – Reviewing falls data and looking for patterns to see where more staff may be required.
- Champions - Specially trained colleagues who help to ensure that strategies and interventions are being implemented efficiently and to support teams.

- Active care Resident - Helping staff to provide residents with an individual care timetable depending on their needs, which is similar to intentional rounding in hospitals.
- Proactive medicines management – Actively looking for signs a patient may need a medication review by a trained healthcare professional more urgently than their usual medication reviews.
- Assessments of environment and equipment, and post-falls – using assessment tools to review environments and equipment on a regular basis and for assessing risks for residents, post-fall.
- Displaying data – Using boards to display falls related data and learning from falls prevention with all staff, residents and families.
- End PJ Paralysis – Encouraging residents to get up, dressed in their own clothes and moving, to help reduce functional decline.
- Suitable Footwear – Following guidance on appropriate footwear and ensuring footwear is not too big, poor grip, poor support or lack fastening features.



Although there has been no statistically significant improvement in the number of #NOF, we are no longer seeing the higher numbers experienced prior to the collaborative (reduced variation). Individual care homes have achieved statistically significant improvement.



The number of attendances to the emergency department has reduced from 6 per month to 3.8 per month. Following a review of attendances, 88% of the attending residents were admitted to hospital for treatment.

At the end of September 2022 system leaders met to discuss the findings and results of the Last 1000 days programme and agree on the next steps. It was agreed that learning from the first cohort should be extended to a second cohort which is planned to start in 2023 with care homes, GP's, community nurses and social care teams participating to reduce harms in our local care homes. A new aim will be developed, with focus on reducing Emergency Department (ED) attendances and keeping residents safe in their last 1000 days of life, giving back the gift of time.

The programme was awarded the "Best use of integrated care and partnership working in patient safety" Health Service Journal Award in October 2022.

Outcome	Reduced variation in #NOF. Aim under review and Trust continues to work on this programme.
Progress	As #NOF are relatively rare events, the days between falls have been monitored and statistically significant improvements have been seen in some participating care homes.

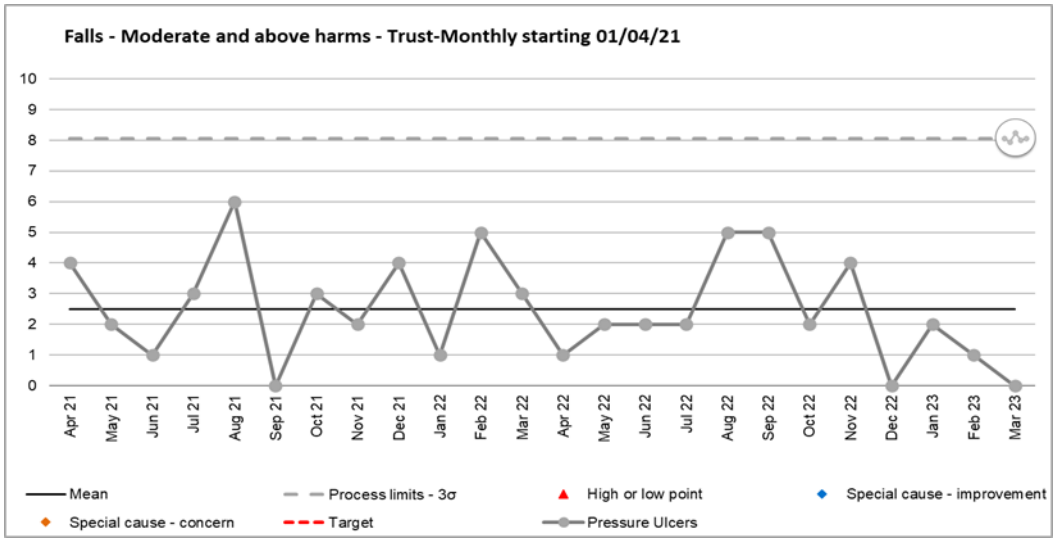
2.2.4 Reducing Patient Falls

What?	Reduce the number of patients experiencing harm as the result of a fall.
How Much?	To achieve a 10% reduction by March 2023.

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" at the 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"

The total number of falls reported in 2022/23 was 874, which is an increase on the year before. There were 25 of these falls which resulted in moderate or serious harm, which is a reduction from the previous year of 29.



A steering group has been convened and following completion of a gap analysis of current practice, will work to develop a change package that can be used by teams to reduce falls in their areas. The group's expert panel is from a wide multi-disciplinary workforce including nurses, allied health professionals, practice development sisters and pharmacy staff. 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 redesign of the falls risk assessment that now includes lying and standing blood pressure and the supporting falls policy has been concluded and is now in practice.

The risk assessment assists in identifying the level of risk that a patient is at of potentially having a fall. This enables preventative measures to be introduced thus reducing the risk and ensuring a safe environment is maintained.

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.

Following consultation and review with clinical teams, the intentional rounding tool has been updated to include a risk assessment and guide for staff to appropriately manage patients in either a red, amber, or green category. In support of falls reduction, this ensures:

- Call bells are within easy reach
- Footwear is appropriate
- Falls monitoring equipment is safely applied
- Patients are given the necessary supervision and support with mobility dependant on need
- Patients / relatives are included in the risk assessment and subsequent care planning

Outcome	Target not met - during 2022/23, the number of patients who had a fall increased by 10.7%. However, there was a decrease in the number of patients who suffered a moderate or above harm of 14%.
Progress	Whilst the overall number of falls increased during 2022/23, the number of falls resulting in a moderate or above harm decreased.

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 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

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.

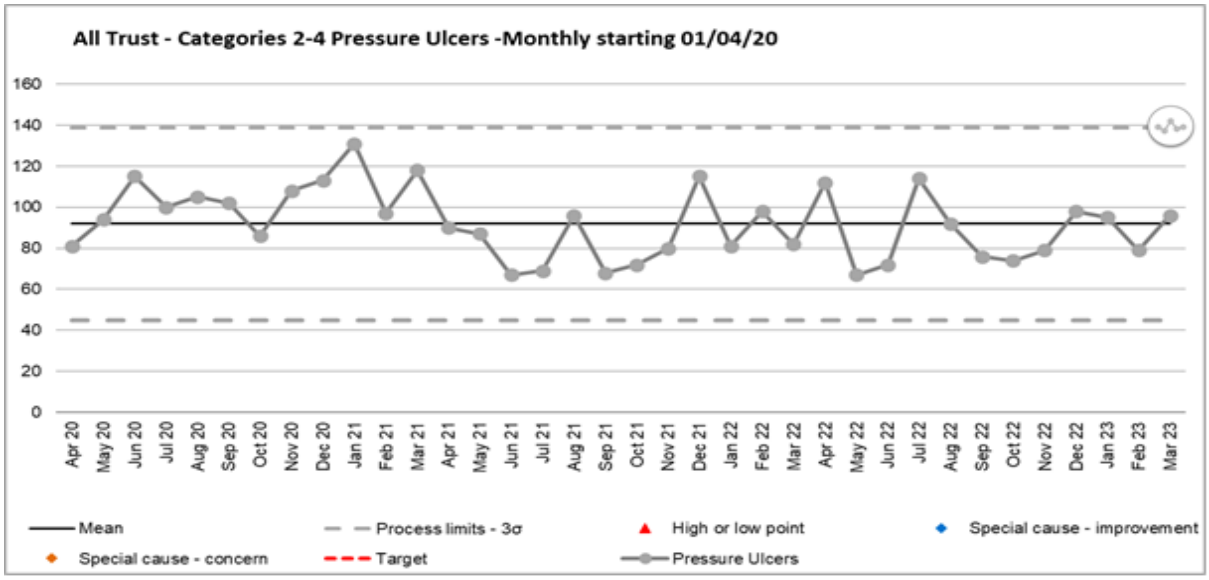
In the 12 months between 2022-2023 the Trust recorded 903 Category 2 pressure ulcers; 43 people sustained Category 3 pressure ulcers, and a reduction from 25 to 11 people sustaining Category 4 pressure ulcers.

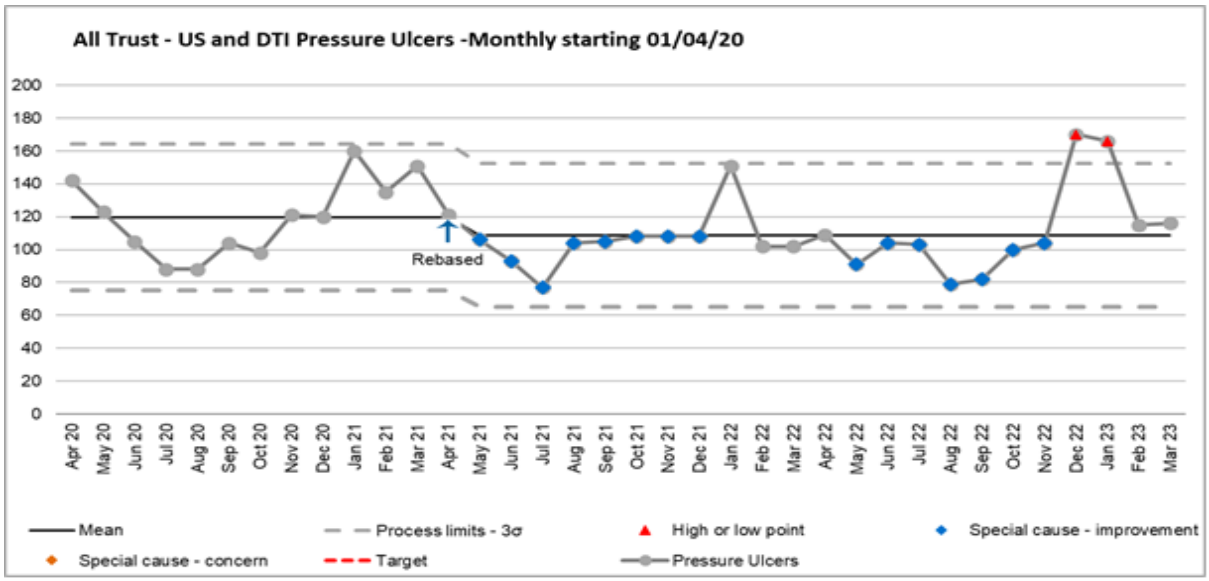
The Tissue Viability service continues to validate reported pressure ulcers face to face within the in-patient services and remotely via wound photography within community services (except for community patients with category 3 and 4 pressure ulcers who are seen face to face). Validation helps to ensure 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 commenced in July 2020 and concluded in September 2022, and the change package was spread throughout all acute and community teams. To ensure that the lessons learned are sustained and improved upon, the weekly pressure ulcer data review, led by the tissue viability team, that monitors performance continues, and each divisional senior nursing team now attends bi-monthly skin integrity committees, where all acquired skin and tissue damage is reviewed and improvement plans monitored.

The charts below show all Trust pressure ulcers over the previous 12 months, identifying category 2 – 4 in normal variation and two astronomical data points above the line for deep tissue injuries / unstageables (DTI/US). A thematic review of this is underway and will inform further improvements that will be shared across the acute and community settings.

The Tissue Viability team will also support the introduction of Purpose T as the tool for risk assessment and a new intentional rounding document that aligns to this risk assessment approach in the coming 12 months.





Outcome	Target not met
Progress	Across the Trust (acute and community), in 2022, category 2 pressure ulcers decreased by 0.3%, category 3 pressure ulcers increased by 36.4% and category 4 pressure ulcers decreased by 37.5%.

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 updated the sepsis bundle since the last submission and following this there has been an increased adherence to all elements of the bundle from a mean of 24% to a mean of 46%, since its introduction in May 2022. Clinical audit shows that the time to the key task of administration of antibiotics in the first hour following suspicion of sepsis is below the mean of 66 minutes.

To support continuous improvement, the Trust launched the sepsis improvement collaborative in September 2022, supported by an expert faculty that included the sepsis trust and a patient representative, 8 clinical teams took part including the Emergency Department, Haematology, Oncology, Maternity and Clifton Hospital.

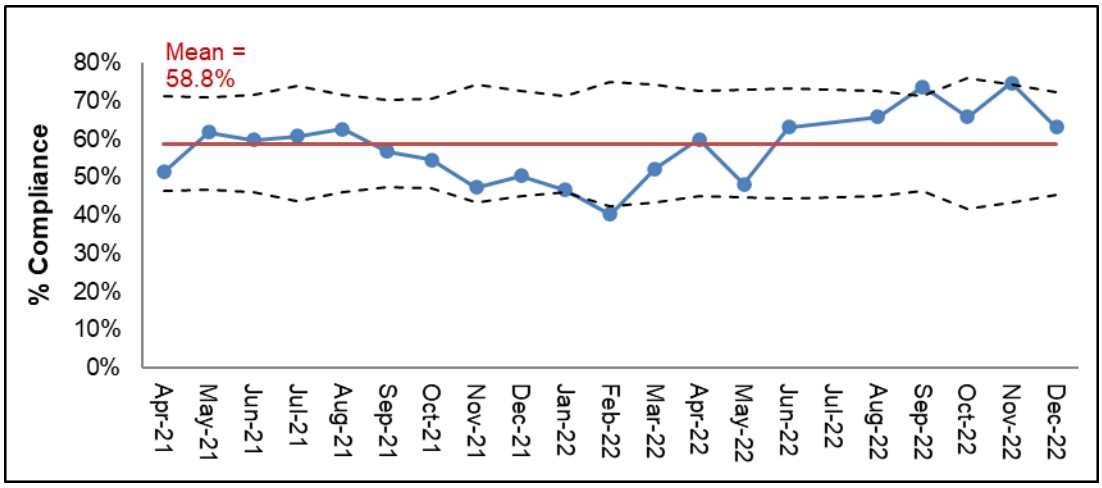
With coaching from our Quality Improvement leads, and a driver diagram framework to improve practice of reliable recognition and assessment, response and escalation, and culture of safety, continuous improvement tools and practice have been developed that will be shared widely across the organisation.

Improvements include 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. The maternity team identified improvements that would improve safety in the national badger net system and have successfully influenced this to be updated.

The Trust has an Associate Director of Mortality Governance and Clinical Audit who is providing medical leadership, regarding Sepsis, in conjunction with the Associate Director for Harm Free Care, act as leads for sepsis across the organisation and ensure the delivery of the overall strategy to improve compliance to the sepsis 6. The Trust continues to contribute to the AQUA audit for peer review and has also introduced an internal audit of approximately 40 patients per week to identify good practice and areas of improvement.

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 is hoped early intervention will reduce the rate of readmission to the acute Hospital site. The Trust has also introduced two corporate practice development nurses who are ensuring availability of robust training packages that can be easily accessed and shared.



Improved monthly compliance to all sepsis indices (>70% November 2022)

Outcome	• AQuA Sepsis NEWS Audit Composite Process Score (CPS) 59.7% (January 2022 to December 2022). • Sepsis Antibiotics administered within an hour 48.6% (January 2022 to December 2022). • Rolling 12 months for Sepsis SHMI maintained below 100 (90 in September 2022 – 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.

During the financial year 2022/23 - 25,000 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.

Incidents are investigated in accordance with their level of harm and the national serious incident framework; with moderate, severe harm and unexpected death incidents requiring a higher level of investigation using recognised investigation tools. The root cause analysis (RCA) 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.

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, Integrated Care Boards (ICBs) and with the coroner, in the event of an inquest.

The Trust ensures that harm investigation findings, conclusions, and learning are shared widely across the organisation. The Trust has in place a '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 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 Incident summary report to the Trust's Quality Assurance Committee, which provides assurance on the management of incidents, SIs, 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 (Crown, 2014; Public Health England, Updated 5 October 2020).

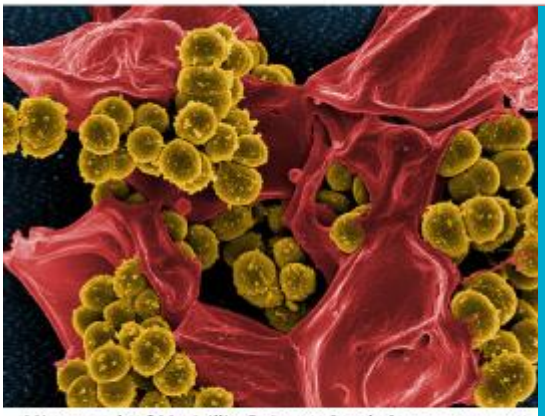
In addition, the Trust makes every effort to keep patients, or their NOK/family informed of the progress of investigations and offers to share the outcome of investigations and our learning, preferably through face-to-face meetings, or if this is not possible, by sharing the investigation report with a covering letter and providing contact details of a Trust representative.

The Trust's compliance against the Duty of Candour Regulation, is monitored by the Incident and Risk Team and reported through the Trust's Quality Assurance Committee. The Trust have demonstrated 100% compliance with all elements of Duty of Candour in between 1st April 2022 and 31st March 2023.

2.2.9 Infection Prevention

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

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



Micrograph of Meticillin-Reistant *Staphylococcus aureus* (MRSA) and a dead human neurophil (Credit: National Institute of Allergy and Infectious Diseases (NIAID)

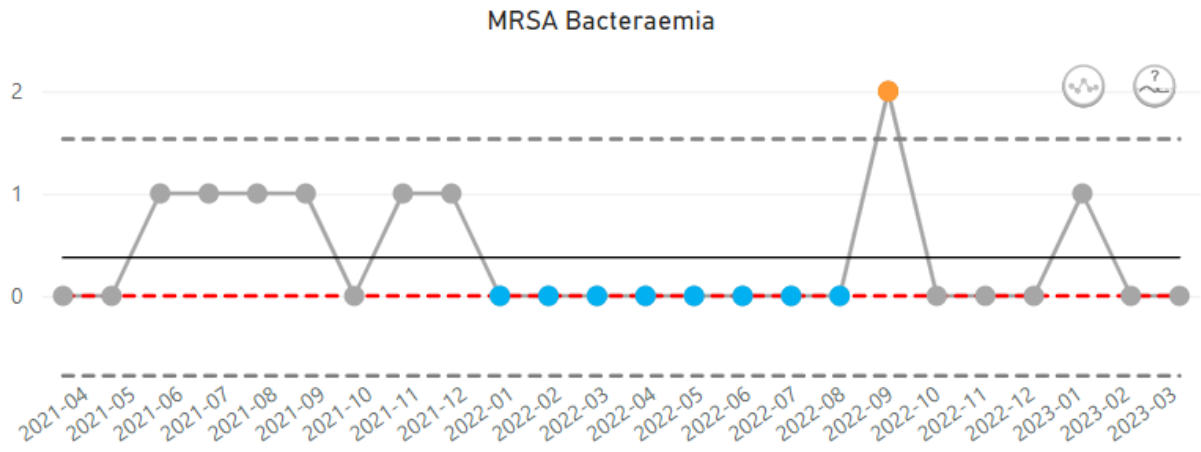
Staphylococcus aureus (*S. aureus*) is a bacterium that commonly colonises human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or during a medical procedure.

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 Meticillin-Resistant Staphylococcus aureus (MRSA) and often require different types of antibiotics to treat them.

The NHS Standard Contract 2022/23 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 three cases of MRSA blood stream infection were attributed to the Trust during 2022/2023.



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).

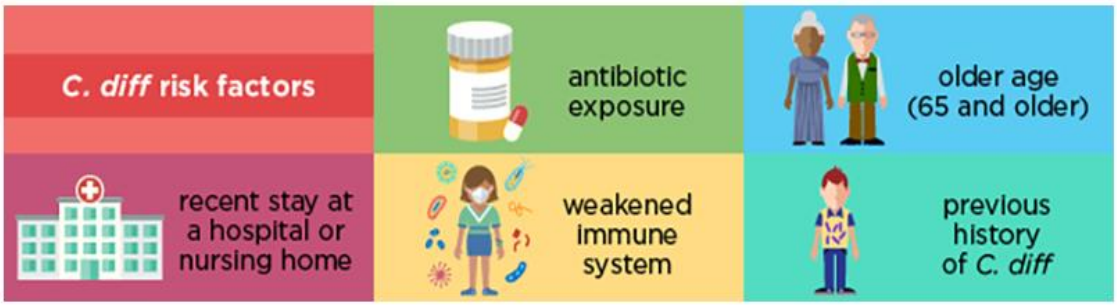
One case was defined as 'Community-Onset Healthcare Associated' (COHA) – where days from admission to specimen date is equal to or less than 2 days (where day of admission is day 1), and patient has been discharged from the reporting trust within the last 28 days of this specimen date (where day 1 is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

One of the HOHA cases was linked to a lapse in care relating to inappropriate antimicrobial prescribing. There was also a delay in starting topical treatment. An action plan was developed to address these issues and progress was monitored by the Whole Health Infection Prevention Committee.

Outcome	Three 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?	109 cases of CDI

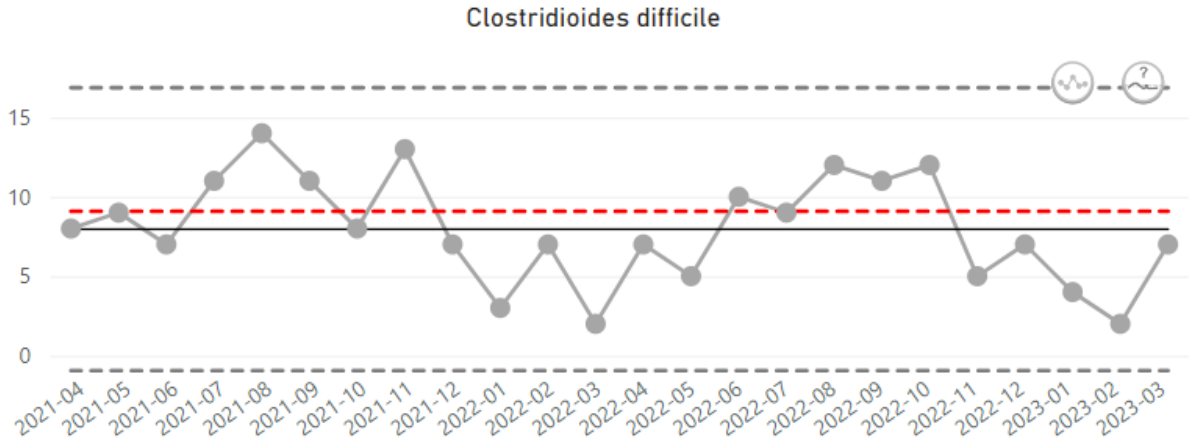


Clostridioides difficile (*C. difficile*) is a bacterium that's found in people's intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies).

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 have taken antibiotics, particularly the elderly and people whose immune systems are compromised.

A total of 91 cases were attributed to the Trust in 2022/2023 against an NHS Standard Contract threshold of 109.



62 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)

29 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).

This equates to a 9.9% reduction compared with 2021/22. Furthermore, 2022/23 data provided by NHS England shows that BTH was one of only seven of the 24 acute trusts in the Northwest, and the only acute trust in the L&SC ICB, to remain within the NHS Standard Contract threshold for *Clostridioides difficile* infections (CDI).

Outcome	91 cases of *Clostridioides difficile*
Progress	Target achieved

2.2.9.3 COVID-19

Virtually all national COVID-19 infection prevention guidance was stepped down in April 2022 and instead, NHS trusts were advised to follow the National Infection Prevention and Control manual (NIPCM).

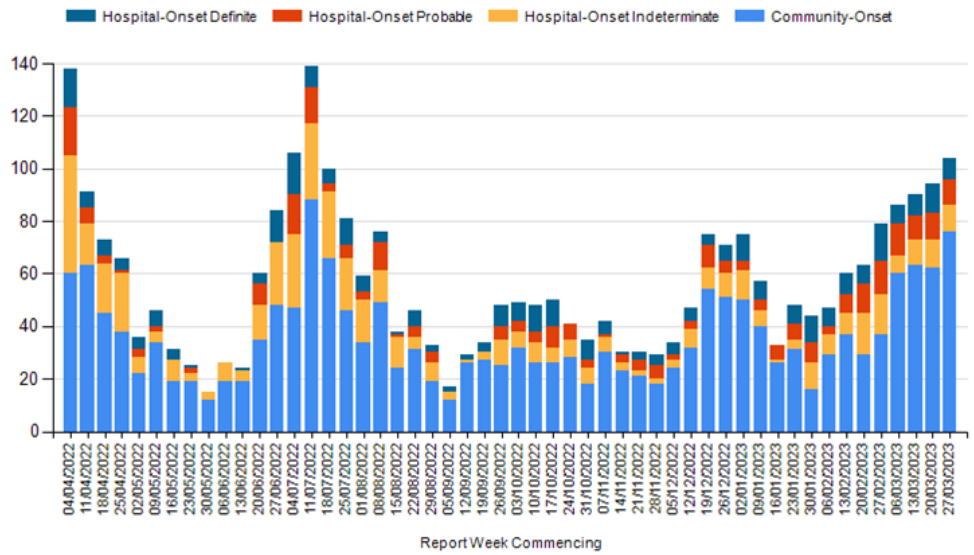
However, the pandemic continued to impact on services at BTH during 2022-23. The ongoing need to test and isolate patients with COVID, even when asymptomatic, had a particular impact on patient flow from admission to discharge.

The situation was made worse by the return of other seasonal respiratory infections such as influenza and Respiratory Syncytial Virus (RSV), as well as increases in other infections such as Norovirus.

Individual trusts were advised to make local decisions about the universal use of facemasks based on local COVID-19 prevalence data. This led to the scaling up and down of facemask use throughout the year.

Updated national SARS-CoV-2 testing guidance was also issued in August 2022 which saw the end to asymptomatic inpatient and staff testing. Further guidance is due to be published in April 2023 that is likely to further reduce testing requirements for patients.

The chart below shows the number of inpatients who have tested positive each week throughout the year and each peak corresponds with increased community prevalence.



The Omicron variant remained dominant throughout 2022/23 and despite multiple peaks of infection during the autumn and winter months, most cases resulted in mild illness. This is credited to a highly vaccinated population and increased access to COVID-19 therapeutics. Indeed, there is evidence to suggest that the likelihood of being admitted to hospital for SARS-CoV-2 is lower than influenza. Hence all asymptomatic patient testing, which impacts on services and patient flow, is due to end in April 2023.

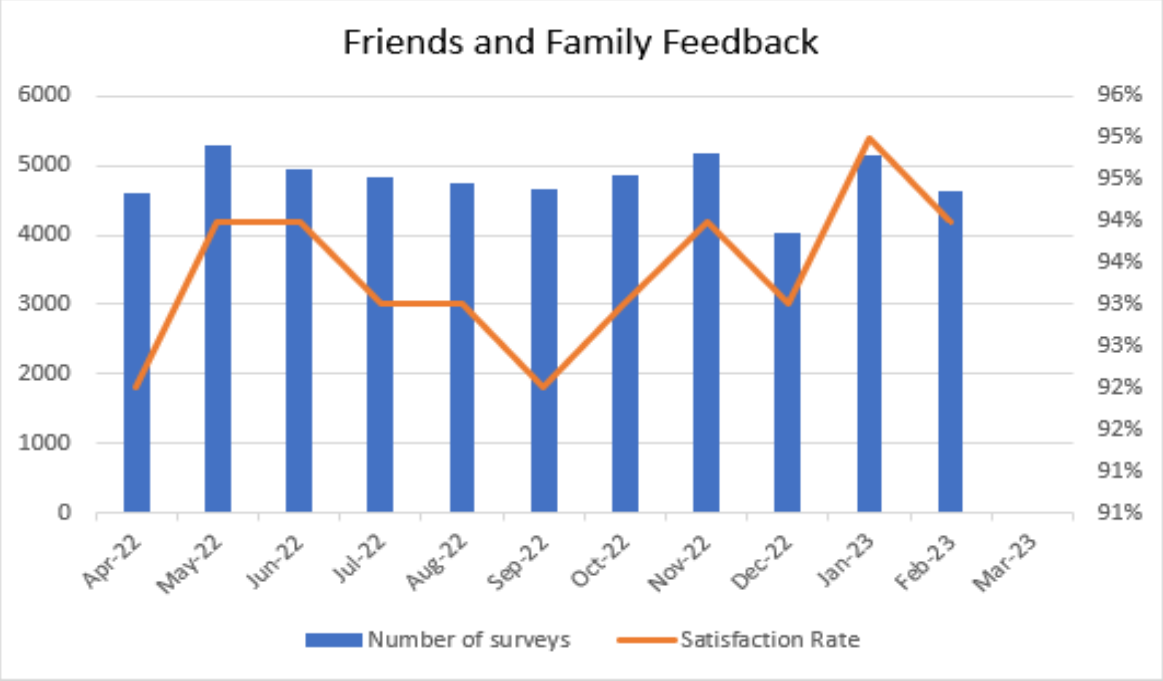
2.2.10 Patient, Family and Carer Experience

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 2022 was that 98% of patients would rate our services as good or very good in the NHS Friends and Family Test survey (FFT).

The Patient Engagement Team have been working throughout the year to promote the importance of the NHS Friends and Family Test survey (FFT) survey with Trust staff and increase the number of survey responses from patients and their families. This work has seen the number of responses grow consistently over 4000 per month.

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 52% of surveys completed by paper in 2022-23.



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.

Outcome	In 2022/23 BTH surveyed 57,209 patients using the FFT survey. 93% of patients rated their care as good from April 2022 – March 2023.
Progress	FFT satisfaction rates have been affected on a national level in 2022-23 by the significant pressures post Covid-19 pandemic and unprecedented demand, especially in emergency and urgent care. Nationally the current satisfaction rate in the Emergency Department is around 83%. There has been an increase of 17,425 surveys when compared to 2021-22. 27,534 of the FFT surveys in 2022-23 were collected via online and SMS text, compared to 8817 in 2021-22. SMS text implementation continues to be rolled out across the Trust. The FFT survey is now available in easy read and the six languages most spoken in Trust services, Urdu, Bengali, Romanian, Polish, Arabic, and Kurdish Sorani. To ensure robust implementation this piece of work was submitted to the Clinical Quality Academy as a quality improvement project.
Actions for 2023/24	• Continue to provide visible evidence in public places throughout the Trust to demonstrate what actions have taken place because of FFT feedback. • Continue the roll out of the SMS texting to cover Mental Health services. • Increase the number of actions recorded on the platform, empowering the staff to respond to these in a thorough manner.

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.

Acknowledging 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.

The Patient Engagement Team has visited pop-up events in the community over the last 12 months, engaging with local communities about the different opportunities available at the Trust for co-production involvement.

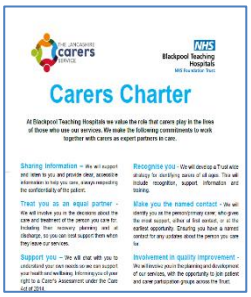
During 2022-23 the Trust has launched its 'Expert by Experience' programme of work. Where Experts by Experience are recruited as partners, they have personal experience of using or caring for someone who uses our health, mental health, or social care services.

Our Experts by Experience provide the critical and unique perspective required to reshape the system, and they bring strengths and networks to support improvement.

One of our Experts has been involved in the Clinical Quality Academy work, around the adoption of cardiology outpatient virtual appointments. The team involved has found their input extremely beneficial, whilst the Expert has really enjoyed the experience and looks forward to attending and contributing to the project.

Other areas of Co-production:

- A carers guideline is under development to support and embed the co-production work highlighted at the Carers Charter consultation workshops.
- Continued work to improve relationships with N-Vision, Healthwatch, Lancashire Carers, SPARKS network, Blackpool Council etc to increase partnership working and engagement in and around local communities.
- The Influence Panel work together with staff advising and supporting on new ideas and projects across the Trust. The Trust's Influence Panel work continues across the Trust with the membership growing this year by 9 new members.
- The implementation of the Future Collaboration Platform across the Expert by Experience and Influence Panel groups to encourage and support joint working, the forum space allows the groups to share thoughts, ideas and generate new ideas for areas of work.
- Hidden disabilities continues to be highlighted, actively used and supported across the Trust. With over 8000 pieces of hidden disabilities promotional materials being handed out.
- #Hellomynameis yellow badges continue to be available for staff to order across the Trust, with over 10,700 ordered and distributed. A recycling scheme has now been implemented for any areas with surplus badges to return for reissuing to new staff members.



Outcome	Achieved
Progress	Workplan for 2022-27 in progress.
Actions for 2022/23	Continuation of objectives and actions held within the 2022-27 Workplan.

2.2.11 Workforce Experience

Percentage of staff not experiencing harassment, bullying or abuse at work from other colleagues (historical comparison):

2018	2019	2020	2021	2022
79%	77%	79%	82%	81%

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

2018	2019	2020	2021	2022
57%	59%	61%	61%	60%

Please note that the national survey coordination centre has amended scoring for the above question. This has been amended for historical data too.

Summary of Performance

The Trust's response rate reduced slightly in 2022/2023 to 51%. But this response rate is significantly above the average for Acute and Community Trusts of 44%.

National benchmarking of Acute and Acute and Community Trusts placed BTH in the top 20% of Trusts for six of the seven NHS People Promise themes.

The survey highlighted some areas for the Trust to focus on improving, however this is to be expected given the challenges faced by the NHS in the previous couple of years. 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 colleagues who attend these sessions is used to develop meaningful divisional improvement action plans.

Progress against divisional improvement plans will continued 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 has had a Freedom to Speak Up Service (FTSU) in place since 2017. The Trust remains committed to listening and encouraging all our staff to have a voice to speak up.

The table below shows the yearly figures for concerns raised and dealt with during 2022/23, compared with 2021/22:

	2022/23	2021/22
Concerns Raised	289	65

Analysis of our data shows that there is an increase in the number of medical staff speaking up and a reduction in the number of anonymous concerns raised.

In October 2020, a review was carried out at the Trust by the National Guardian's Office (NGO). The NGO exists to help people working across the NHS to speak up about any issues or concerns through the Freedom to Speak Up initiative and team of FTSU Guardians.

The report was published in October 2021, almost a year after the review. Due to the delay in the publication of the report the Trust was able to evidence that progress had already been made against several of the identified recommendations. This included the Trust:

- Making sustained improvement in the quality of safe and effective clinical services;
- Prioritising improvements and investing in Freedom to Speak Up – with a team of Guardians in place;
- Scoring above the national average for the number of concerns raised across all categories, which was improving year on year;
- The NSS results for 2020 demonstrating an improvement in staff feeling supported to speak out - two thirds of people saying they felt safe speaking up.

The Trust made this difference by listening to people including staff, our F2SU Guardian and the NGO and learning from and acting on feedback with real initiatives. This is something we will continue to do to help us progress even further in the future and the NGO report recommendations will form part of that.

The National Guardian's Office conducted a review at the Trust. The Trust were given thirty-seven recommendations to improve its speaking up culture. There were six areas of focus, including:

- Freedom to Speak Up Guardian
- Identifying something might be wrong
- Speaking up
- Examining the facts
- Outcome and feedback
- Reflecting and moving forward

These recommendations were implemented and signed off by NHS England in March 2023.

In October 2022, members of the Board completed the Freedom to Speak Up self-assessment tool. This resulted in the production of an action plan aimed at further improvements to creating a safe, speaking up culture. This process also identified the need for all staff, managers and Board members to complete Speaking Up training. Speaking Up training will become mandatory training for all staff from April 2023.

In May 2022, the Trust disbanded the joint Freedom to Speak Up office it had in place with East Lancashire Hospitals Trust. Blackpool Teaching Hospitals now has its own dedicated Freedom to Speak Up service.

2.2.13 Improving Care for Patients Living with Dementia

Blackpool Teaching Hospitals NHS Foundation Trust is committed to improving patient experience and delivering improvements in clinical outcomes. During 2022/2023 our workforce was recovering from the response to the COVID-19 pandemic. As we started to restore our services back to pre-pandemic levels, reset learning, how we innovate, and consider how we maintain improvement; we also had different ways available to us in how we could do this. This different world is no less important for the people living with dementia who experience the care and treatment we provide. This delivery plan sets out our ambitions to provide the best care without waits, without harm and effectively use the resources available. Key to this is the education of our staff and as one of the key commitments within this delivery plan this will support improvement in conjunction with our Quality Improvement team and be demonstrated through our lived experiences, measured through participation in local and national audits and shown through our COAST (ward accreditation) programme.

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. 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:

- Dementia Friendly Environments
- Person-centred approach to dementia care
- Improve the hospital experience
- Educated and informed workforce
- Living Well at Home
- Partnership working
- End of Life care

Each of the 7 Key commitments has an identified lead to take forward the associated work stream. The progress of each workstream, as well as the 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 Trust’s Quality Assurance Committee.

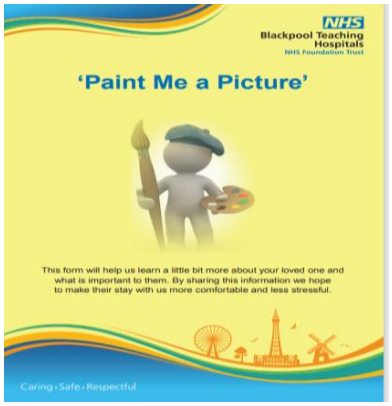
Dementia Champions

Dementia champions meet monthly and are part of clinical and non-clinical teams across the trust. Their role is to promote awareness around supporting people living with dementia as well as being the “go to person” for dementia resources in their area.

We currently have 62 active champions who have received appropriate training and have agreed to the responsibilities of being a champion. The ambition is to increase this number so that all clinical areas have at least one champion.

Butterfly Scheme

The trust subscribes to and is committed to the Butterfly scheme with close links to its founder. It is used to as an alert on tracker and the newly rolled out “what matters to me most” back of the bed boards. This alert acts as a quick reference 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. COAST review the use of this as part of their assessments.

Education

Identified as commitment 4 the education and training of our staff is an important part of our delivery plan. Reported through the Trust’s Quality Assurance Committee this is also monitored through COAST assessments.

Tier One Training

This training is currently available on the Trust's Electronic Staff Record (ESR) to all staff and will be a core training requirement from April 2023. It is provided on a face-to-face basis to all new Healthcare Assistants (HCA's) and as part of the Registered Nurses' Induction days.

Tier Two Training

This package has been revised and is now provided over two days, to ensure it meets the requirements of Health Education England (HEE). Training sessions take place monthly with good attendance and very positive feedback received. This training is available to all staff who have direct contact with people who have dementia.

Feedback from candidates on the course:

All the course was clinically beneficial and relevant and enlightening.

The entire 2 day course has been amazing and very informative.

Learning more about people living with dementia

So much more empathy for patients and their family.

Barbara's story. Very lively and interactive presenter.

Face to face interaction and discussion with other colleagues. Facilitator is amazing.

What will staff take back to clinical areas?

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. Development of this is to be included as part of a new Carers policy so that if appropriate, relatives and carers can support and enhance the care that is provided to all patients in Hospital, rather than just those living with dementia.

National Dementia Audit

Participation in this National audit forms an important measure of our performance as an organisation. Phase One was completed in December 2022, with 40 patients identified for the case note audit. Phase Two started on the 6 March 2023, and will identify a further 40 patients in order to complete the audit. Results are expected by quarter three 2023/2024. During the audit patient, carers and staff surveys were sent out, which will form part of the overall outcome report. The process for gaining this feedback will however continue as part of our delivery plan and improvement has already been identified as part of this audit and influenced the content of both the tier 1 and tier 2 training.

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 to 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 increased interaction and engagement will have therapeutic advantages and moves away from a culture of providing 1:1 care through a medical model approach to a partnership in care approach, a holistic model. This policy will be reviewed alongside the development of the Carers policy.

COAST Ward Accreditation Assessments

COAST assessments have led to an increased understanding and awareness of a dementia friendly hospital, and areas of good practice and areas for improvement have been identified. The lead nurse for learning disabilities and dementia, now sits on the planning meetings for any new builds or improvements that are carried out in the Trust, to ensure a dementia friendly approach is considered.

2.2.14 Palliative, End of Life and Bereavement Care

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 one.

It has been another busy year for the Hospital Palliative Care, End of Life and Bereavement Care Teams. The teams are led by a Consultant for Palliative Medicine, as Head of Department and a newly established role of Lead Nurse for End of Life & Bereavement Care. There is an Executive and Non-Executive Lead for End of Life Care represented on Trust Board.

The team continues to develop and invest time in quality improvement and improving education and training for our colleagues across the Trust.

There has been year on year a rise in referral numbers, and since the commencement of seven day working, weekends are becoming increasingly busy. There is a plan to undertake a review of 7 day working as part of a team away day in April 2023, to look at plans for the service and future staffing models over the next year. This will align to the Fylde Coast End of Life Strategy 2023-27, currently in development, with a major focus on advance care planning and education.

The team were also awarded the Trust's Pakho Li Special Recognition Quality Improvement award for the Emergency Department's In-Reach project.

97 % patients seen within 24 hrs of referral

Trinity launch virtual ward & Living Well Service

Team win QI Pakho Li award for the Emergency Department in reach project

The final National Audit for Care at End of Life (NACEL), cohort 4, was submitted in October 2022. Overall performance was good with the trust achieving above average scores across most domains, when compared with the rest of the UK.

In particular, the staff survey demonstrated that the majority of staff feel confident when caring for a dying person and well supported by the hospital palliative care team.

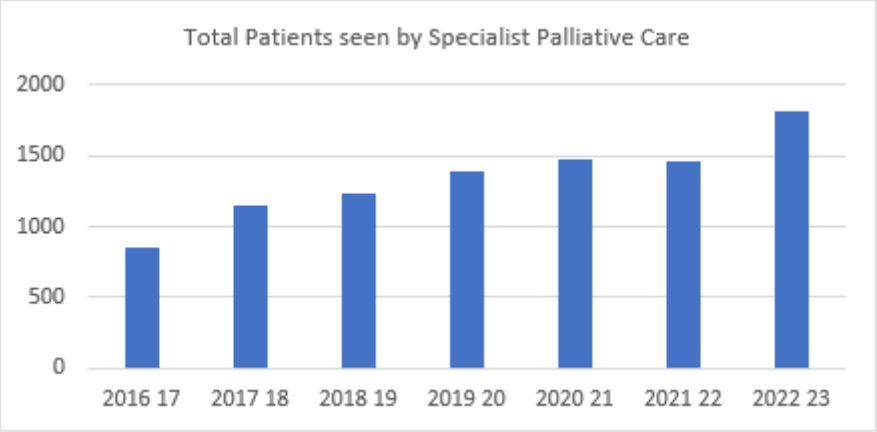
Areas highlighted for improvement included increasing the of use of the individualised plan of care for the dying person & individualised nursing care plans. We will be reviewing our documentation in the light of these findings.

NACEL has now ended and we await updates from the National team with regard to how the national audit programme will look going forward. In the meantime, we will continue to undertake regular audits of our own of documentation across the Trust.

A quality survey reported that relatives also felt well supported, when compared with the national average, although a low number of quality surveys were returned. We have reviewed and relaunched our Trust Bereavement Survey earlier this year. We have seen a 53% reduction in complaints involving bereavement or end of life issues

Palliative Care:

- The number of referrals has risen by over 200 this year.
- Response rate remains high with 97% of patients being seen within 24 hours of referral
- To date the team have undertaken 5768 weekday face to face visits and 1291 weekend face to face visits.
- There were 1773 more face to face contacts and 276 more phone calls made by the team so far this year.
- Palliative Care Emergency in reach continues with 107 patients having been seen in the department and 18 admissions avoided. The Emergency Department in reach project has been highlighted as an area of good practice by NHS England Benchmarking January 2022
- Referrals for non-malignant patients have increased due to close working with frailty and liver disease specialities and accounts for 54% of the case load.



Swan & Bereavement Team

- We welcomed new members to the team including a new Clinical Lead
- The service commenced 7 day working across both acute and community in January 2023
- The number of referrals has risen to a total of 557 in 2022/23, compared to 549 in 2021/22 and 257 in 2020/21.

- The service provided 740 ward visits to support staff, patients and families
- All bereaved loved ones have access to bereavement support – this is offered to all and the service is promoted and offered through ward teams, bereavement office staff and also within our bereavement booklet.
- The team support education and training and have provided training sessions for 476 staff throughout the year
- The team worked alongside Occupational Health and established a monthly drop-in staff bereavement support café
- Established new roles and service with a Swan Bereavement Midwife and Support worker joining the existing Specialist Nurse to enable Maternity Services to have improved access to immediate and ongoing support after loss in pregnancy
- Our Bereavement Midwife was nominated in two categories and winner of Compassion in Care at this year's Celebrating Success Awards

Community End of Life Team

- We have a community end of life team who support teams across the primary care networks including care homes
- The teams provide education and training across the acute Trust and community services and are involved in quality improvement programmes
- Swan End of Life Care Champions

Our Champions meetings were held monthly utilising Microsoft teams which continued to support the teams across acute and community care and care homes and nursing homes. The Champions' feedback has informed development of the education programmes to support and develop them in their role.

Education and Training

The Education Programme has undergone an extensive review, which included training needs analysis across all staff groups, benchmarking against national markers for required competences and analysis of projected numbers of staff required to attend. This is in line with CQC requirements. There is now a defined competency matrix which makes it clear what training and competencies are required in terms of end of life, palliative and bereavement care, according to role.

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 476 staff members.

Support for staff in care homes has been delivered through the End-of-Life Educator/Facilitator. A bespoke education and support package has been developed and piloted with a group of care homes. Work is now underway to roll this out further and ensure meaningful engagement with care homes across the Fylde Coast

There are several quality improvement projects underway within the End of Life Team.

- Verification of Expected Death – increasing the number of registered nurses able to verify expected deaths in acute and community settings. Aim to reduce the amount of time spent waiting for a person to be verified after death.
- Electronic Communication of Advance Care Planning – looking at developing electronic communication mechanism to allow Cancer CNS' (pilot group) to notify GPs when an advance care planning conversation has taken place in order for an accurate EPaCCS record to be created.
- Electronic Palliative Care Coordination Systems – project focussed on maximising the quantity and quality of EPaCCS records across the Fylde Coast as well as improving accessibility of the information contained within them.

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 Dying Matters Week in May 2022 and National Grief Week Campaign during December 2022 which coincided with our annual remembrance services - "Tree of Lights"" and Baby Remembrance Service" and we held a Child Memorial Snow Drop Service in February 2023.

2.2.15 Mortuary

The Mortuary at BTH has a main body store which has capacity for 124 deceased patients in both refrigerated and freezer storage. Two additional separate refrigerated units can accommodate 60 deceased patients. 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 an increase in the number of both hospital and community deaths. Average occupancy has remained higher than previous years, indicating the length of stay for deceased patients has increased. This is likely due to a higher number of deaths within community settings, leading to a decrease in available storage at funeral homes.

The mortuary perform post mortems on behalf of the Blackpool & Fylde and the Lancashire with Blackburn & Darwen Coroners. The past 12 months have seen a slight increase in the number of post mortems performed. The Mortuary also run a successful Care of the Deceased Patient training session. This is open to all staff who care for the deceased patient and/or their relatives, or are involved in the bereavement process and would like to gain further understanding of our Mortuary and Bereavement Services to ensure that high standards of care, dignity and respect are maintained. From April 2022 – March 2023, over 90 members of staff have attended the training. The following is examples of the positive feedback we have received following the training:

Area	Comments
ED	*"I found the training excellent. I feel it is very much needed especially for staff in the ED"*
Chaplaincy	*"I have heard good things about this training which is why I decided to go. I hoped to understand the patient journey from death on the ward to leaving in a hearse. My expectation was achieved and I also learnt about other activities that the Mortuary staff are involved with"*
Ward 5	*"The course exceeded my expectations. I didn't expect the course to be as interesting as it was. I had no idea just how much goes on in the bereavement office and in the whole department"*
ED	*"It was lovely to meet all the staff responsible for ensuring all patients are well cared for following their death and every member of staff I met was lovely and it shows they really care"*
Clifton 2b	*"I now feel very confident regarding any questions I may be asked by next of kin/relatives of a deceased patient. Therefore, able to support if necessary"*

Alongside the Care of the Deceased training, the mortuary also provide training for Forensic Medicine and Anthropology students at UCLan, new starters as part of the End of Life Core training programme and post mortem examination training for ST1s from around the region.

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

Deaths	2018-19	2019-20	2020-21	2021-22	2022-23
Number Hospital Deaths	1887	1847	2105	1855	2000
Number Community Deaths	643	642	661	724	730
Total Number Deaths	**2530**	**2489**	**2766**	**2579**	**2730**

Post Mortems (PMs)	2018-19	2019-20	2020-21	2021-22	2022-23
Number Coroner PMs	467	458	245	528	471
Number Hospital PMs	1	2	0	0	1
Number Infectious PMs	81	80	241	61	127

Number Home Office PMs	30	15	14	27	18
Number Independent PMs	9	0	21	0	1
Number of CT PMs	94	93	101	120	110
Total PMs Combined	**682**	**648**	**622**	**616***	**618**

**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), and the system was due to be extended to community deaths from April 2022. The date for mandatory scrutiny for all non-coronial deaths has now been pushed back to April 2023, with a likely extension on this deadline until Summer 2023. Throughout 2022-23 the Trust has employed a number of MEs and Medical Examiner Officers who are working with Lancashire and South Cumbria Integrated Care Board to gradually expand the scrutiny into community settings. Currently the team are reviewing deaths from Trinity Hospice, Highfield and Fernbank surgeries.

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 15 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 2022-23 they had 501 emergency calls to attend the hospital, 282 (56%) of which were out of hours, this is the highest number of urgent call outs we have had in a 12-month period. We have also led on 55 contracted funerals for the hospital.

There is a Chaplaincy Service Level Agreement with Lancashire and South Cumbria Mental Health Trust to meet the spiritual care needs of patients at The Harbour.

There is also a Chaplaincy Service Level Agreement with Trinity Hospice and Brian House, helping to facilitate a continuity of spiritual care for patients, carers, and family members across the Fylde Coast Healthcare community.

The annual bereavement service, Tree of Lights, was held in December 2022. As a team we also helped facilitate the Light up a Life event (Trinity Hospice), Baby Remembrance Service (at the Winter Gardens), Butterfly Service (Brian House remembrance service), and Snowdrop Remembrance Service (at Stanley Park).

The Chaplaincy and Spiritual Care Department continue to deliver an education programme to staff that promotes good spiritual care, religious needs, spiritual assessment, and staff health. Increasingly the training is delivered in collaboration with the other teams we work closely with, such as Swan and Patient Experience.

Plans are underway for the relocation of the Chaplaincy and Spiritual Care Department in 2023. This gives an opportunity to improve the facilities we have available to patients, visitors, staff, and volunteers.

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, co-production 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

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 Quality Improvement (QI) areas:

National Benchmarking Exercise

The Trust participated in round five (2022/2023) of the learning disability improvement standards project. The findings of this exercise have been incorporated in the delivery plan and training programmes.

Community Teams

The Adult Community Learning Disability Team is an integrated team with Blackpool Council which is made up of different professional groups. They are a long established team and strive to promote health equality for people with Learning Disabilities.

The Children and Young Persons Learning Disability Team is a small team that became operational in September, and this is the first time this support has been available in the Trust. The team has strong links with other Children and Young

People (CYP) services such as: CAMHS, Youtherapy, Mental Health in Schools Team and other paediatric services.

Together, both Community Learning Disability Teams offer a robust, evidence-based transition process called “moving forward together” this new way of working promotes integration to ensure the best outcome for those this service supports across their life span and aims to prevent avoidable hospitals admissions and ensuring reasonable adjustments in care is paramount.

Champions

The learning disability champions meet on a monthly basis and are from 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.

DNACPR

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

John’s Campaign

The Trust signed up to John’s Campaign and this is now embedded within the clinical areas. Although initially set up to support patients with Dementia, this has been utilised to support anyone who would benefit from having family members or carers present during a hospital stay. Within the ‘Oliver McGowan’ training, it is identified that supporting family and carers is seen as a reasonable adjustment and staff are encouraged to promote John’s Campaign when caring for people with learning disabilities.

Training

Currently Learning Disability and Autism awareness training is provided on an ad hoc basis direct to teams. In line with the Government requirement to provide awareness training to all staff, an online programme ‘The Oliver McGowan’ training has been developed by NHS England and Health Education England (HEE) which is being rolled out to all Trusts. This training is currently available on the Trust’s web training platform and has been promoted to all the Learning Disability Champions and Trust staff.

Learning Disability Diamond Standard Training that has been adapted for use within the Trust continues to be carried out on a face-to-face basis. This training captures

learning from deaths, reasonable adjustments, the principles of the Mental Capacity Act (2005), diagnostic overshadowing and stopping over prescribing of medications.

The Heath and Care Act (2022), states it is a requirement that regulated providers ensure their staff receive learning disabilities and autism training which is appropriate to their role. From April 2023 this will become a required part of the trust's core skills training framework.

Learning from Deaths

The Learning Disability Lead has met with the Trust Mortality Lead and reviewed the current process for patients that have died in the Trust with a learning disability. The revised approach utilises Inpatient alerts and system management will now better capture this information. During 2022/23, there were 11 Trust cases for LeDeR review.

Structured judgement reviews (SJR) are being carried out, these feed into the regional LeDeR reviews and information from this will then be shared with clinical areas. This will ensure that lessons learned, and good practice can be fed back in a timelier manner. In addition to this a letter will be sent to clinical areas for feedback on the reviews using a revised structured approach once the review is completed. It is essential that SJR's (which can take up to 2 days to complete) are carried out in a timely manner, so identified learning can be fed back to clinical areas to improve the care that is provided. The Integrated Care Providers (ICP) will be providing recommended timescales for SJR's to be completed. Once this timescale is identified, Trust performance against this will be reported alongside the themes found through the Quality Assurance Committee.

Learning Disabilities Audit

To inform improvement against the "Getting it Right" for people with a learning disability and or autism delivery plan, a live audit of all inpatients took place on the 2 February 2023, this was the first audit carried out and will be repeated on a quarterly basis. This will be reported as part of the Quality Assurance Committee update.

Alert and symbol

A learning disability symbol continues to be promoted within clinical areas. 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 a reminder of some of the lessons learnt from the index case where a much loved and treasured blue blanket was lost, resulting in great upset and distress.

Enhanced Care

The Enhanced Care policy was launched in 2021 and this policy aims to improve the quality and patient experience of one on one care. It aims to 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 one on one care through a medical model approach, to a partnership in care approach, a holistic model.

Hospital Passports

Hospital passports are used throughout the hospital, and promotion of these person-centred documents, means clinical areas are using these tools to support individuals. The template can be accessed via the Trust's intranet site as well as the learning disability folder so staff can complete with those individuals who do not come with their own passport. These can now be added to the electronic document management system so that they follow the person during their admission.

2.3 Our Plans for the Future

The Trust's QI Strategy (2019-2022) has been delivered and we are now developing enabling plans for the Trust Strategy for 2022-2027. For all existing programmes, there are ongoing plans 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.

2.4 Our Quality Priorities 2023 / 2024

In 2023/24, we will focus on the following Quality Improvement priorities:

- To further build on our sepsis pathways, we will expand on the theme and commence a breakthrough series collaborative to improve outcomes for "the acutely unwell patient."
- Working with system partners we will launch a second phase of the "Last 1000 Days" breakthrough series collaborative in order to reduce Emergency Department (ED) attendances and keeping residents safe in their last 1000 days of life, giving back the gift of time.
- We will work with our staff to further build quality improvement capability at all levels of the organisation. We will work with staff across multiple areas and from a variety of different roles to deliver our improvement goals.

2.4.1 Statements of Assurance from the Board of Directors

Review of Services

During 2022/23, 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 2022/23.

2.4.2 Participation in Clinical Audits and National Confidential Enquiries

The Trust's participation in National Confidential Enquiries includes the National Confidential enquiry in patient Outcome and Death (NCEPOD) which also includes the Child Health Clinical Outcome Review Programme. They are supported by the Local NCEPOD Reporter (Clinical Audit & Effectiveness Lead) and NCEPOD Ambassador (appointed consultant in November 2022). The National Confidential Enquiries that the Trust was eligible for and subsequently participated in are set out in the table below.

Five Studies were identified to be eligible for Blackpool Teaching Hospitals.

Study Title	Eligible	Participated	Position
Transition	✓	✓	Ongoing
Crohn's disease	✓	✓	Ongoing
Testicular Torsion	✓	✓	Ongoing/
Endometriosis	✓	✓	Ongoing
Juvenile Idiopathic Arthritis	✓	N/A	To start in 2023/ 24 Piloted in March 2023

2.4.3 National Clinical Audits

Participation in both national and local clinical audit is a statutory and contractual requirement for healthcare providers. During 2022/2023, 86 national clinical audits covered relevant Health Services that the Trust provides. The Trust participated in 79 (92%) of national clinical audits in which it was eligible to participate in.

The national clinical audits mandated by NHS Digital and Quality Accounts that the Trust participated in, and for which data collection was completed during 2022/2023, are listed below:

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
Surgery, Anaesthetics, Critical Care & Theatres					
1	Case Mix Programme (INCARC)	Yes	Continuous	INCARC	100%
2	National Emergency Laparotomy (NELA)	Yes	Continuous	RCA	100%
3	PQIP	No	Continuous	RCA	N/A
4	BCIR	Yes	Continuous	BCIR	100%
5	National Audit of Breast Cancer in Older People (NABCOP)	Yes	Continuous	RCS	100%
6	Inflammatory Bowel Disease (IBD) programme/ IBD Registry Biological Therapies	No	Continuous	IBD Registry	N/A
7	National Gastro-intestinal Cancer Programme	Yes	Continuous	NHS Digital	100%
9	Elective Surgery: PROMs Programme	Yes	Continuous	NHS Digital	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
10	National Bowel Cancer Audit Programme (NBOCAP)	Yes	Continuous	NHS Digital	100%
11	National Oesophago-Gastric Cancer	Yes	Continuous	NHS Digital	100%
12	National Ophthalmology Database Audit	Yes	Continuous	RCOpth	100%
13	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Continuous	RCA	100%
14	National Hip Fracture Database (NHFD)	Yes	Continuous	RCP	100%
14	National Joint Registry (NJR)	Yes	Continuous	HQIP	100%
15	Fracture Liaison Service Database	No	Intermittent	RCP	N/A
16	Muscle Invasive Bladder Cancer Audit	No	Intermittent	BAUS	N/A
17	National Prostate Cancer Audit	Yes	Continuous	RCS	
Integrated Medicine & Patient Flow					
18	2022 UK Parkinson's Audit	No	Intermittent	UK Parkinson's	N/A
19	Diabetes Audit- Includes National Diabetes	Yes	Continuous	NHS Digital	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
	Inpatient Audit (NADIA)				
20	National Diabetes Core Audit	No	-	NHS Digital	N/A
21	Pain in Children	Yes	Intermittent	RCEM	100%
21	Assessing Cognitive Impairment in Older People/ Care in ED	Yes	Intermittent	RCEM	100%
22	National Asthma and COPD audit program (NACAP)	Yes	Continuous	RCP	100%
23	National Lung Cancer Audit (NLCA)	Yes	Continuous	RCP	100%
24	National Cardiac Arrest Audit	Yes	Continuous	NICOR	100%
25	Society of Acute Medicine Benchmarking Audit	No	Intermittent	SAMBA	N/A
26	National Clinical Audit for Rheumatoid and Early Inflammatory arthritis (NEIAA)	Yes	Continuous	Continuous	100%
27	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Continuous	RCP	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
Families & Integrated Community					
28	Child Health Clinical Outcome Review Programme	Yes	Intermittent	NCEPOD	100%
29	National Paediatric Asthma Secondary Care	Yes	Continuous	RCP	100%
30	Maternal, infant and new-born programme (MBRRACE UK)	Yes	Continuous	NCEPOD	100%
31	National Audit of Seizures and Epilepsies in Children and Young People Epilepsy 12	No	Intermittent	RCPCH	N/A
32	National Child Mortality Database	Yes	Continuous	University of Bristol	100%
33	National Paediatric Diabetes Audit	Yes	Continuous	RCPCH	100%
34	National Diabetes in pregnancy audit	Yes	Continuous	NHS Digital	100%
35	National Perinatal Mortality Review Tool	Yes	Continuous	NCEPOD	100%
36	National Maternity and Perinatal Audit	Yes	Continuous	NCEPOD	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
37	National Neonatal Audit Programme	Yes	Continuous	RCPCH	100%
38	Smoking Cessation Audit-Maternity and Mental Health Services	No	Intermittent	NHS Digital	N/A
Tertiary Services					
39	Acute Coronary Syndrome or Acute Myocardial Infraction (MINAP)	Yes	Continuous	NICOR	100%
40	National Audit of Cardiac Rhythm Management	Yes	Continuous	NICOR	100%
41	National Audit Cardiac Surgery (NICOR)	Yes	Continuous	NICOR	100%
42	National heart Failure Audit	Yes	Continuous	NICOR	44.51%
43	National Coronary Interventions (PCI)	Yes	Continuous	RCP	100%
44	National Audit of Cardiac Rehabilitation	Yes	Continuous	University of York	100%
45	Adult Respiratory Support Audit	No	Continuous	RCP	N/A
46	UK Cystic Fibrosis Registry	Yes	Continuous	UK CF Registry	100%

No	Title	Participation	Frequency	Coordination	Required / Sample Submission
Clinical Support Services					
47	National End of Life Care (NACEL)	Yes	Continuous	NHS Digital	100%
48	Serious Hazards of Transfusion (SHOT) UK-National Hemovigilance Scheme	Yes	Continuous	SHOT	100%
49	National Acute Kidney Injury Audit	Yes	Continuous	UK Aki Registry	100%
Corporate					
50	LeDeR- Learning from lives and deaths of people with learning disability and autistic people	Yes	Continuous	Continuous	100%
51	National Audit of Dementia	Yes	Continuous	Continuous	
52	National Audit of Inpatient Falls	No	Intermittent	RCP	N/A
53	Trauma Audit and Research Network (TARN)	Yes	Continuous	TARN	86%
54	Medical and Surgical Outcome Review Programme	Yes	Continuous	NCEPOD	100%

National Audit Participation in 2022- 2023

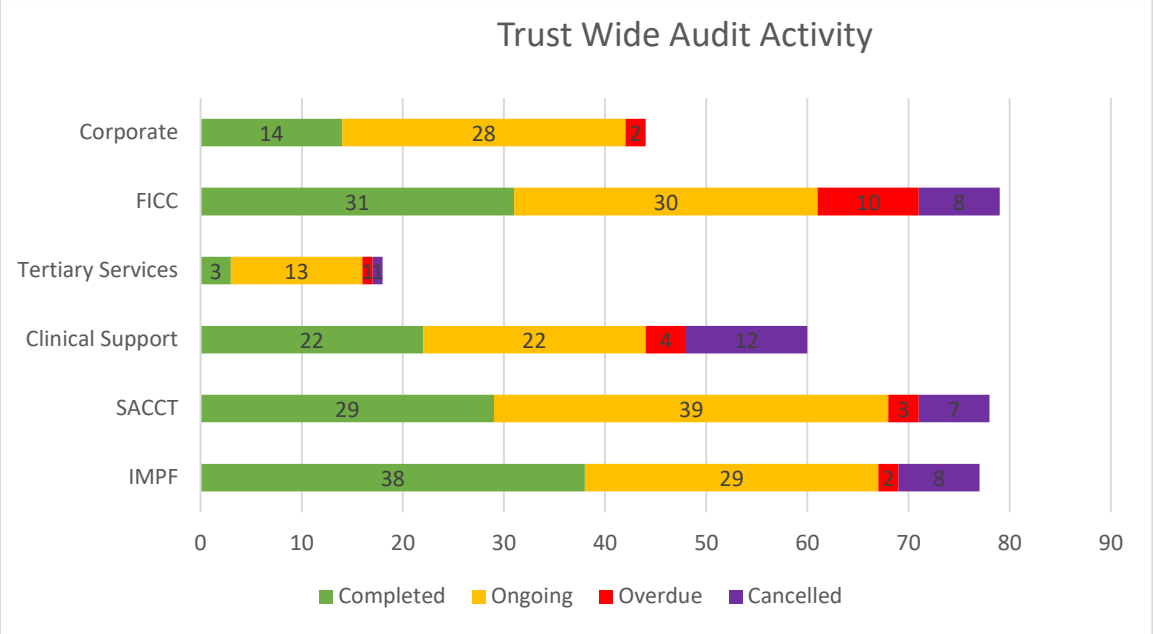
	Title	Participation	Local Ref Number
1	National Audit of Seizure Management (NASH)	Yes	DI2101N
2	BAPEN National Care Audit	Yes	PH2101N
3	CO-GENT: national Audit of Clinical Outcomes in Gentamicin prescribing and monitoring	Yes	HM2201N
4	National Comparative Audit 2022 of blood sample collecting and labelling	Yes	PA2204N
5	National Comparative Audit of Blood Transfusion 2018 major Haemorrhage Audit	Yes	PA1803N
6	National Comparative Audit of Patient Blood Management & NICE 2021 Quality standard 138	Yes	PA2101N
7	National IR(ME)R Audit	Yes	RA2101N
8	CQUIN Activity: Pneumonia & Nutrition Audits	Yes	CG2203
9	NatSSIPS/ LoCSSIPs	Yes	CG1703N
10	Safe Administration of Gentamicin	Yes	CH1910N
11	Antenatal and new born national audit FASP - SO7	Yes	OB2004N
12	Antenatal and new born national audit IDPS S05	Yes	OB2003N
13	National evaluation of accuracy of stillbirth certificates (NESTT) study	Yes	OB1911N
14	Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (Saving Babies' Lives Care Bundle Version 2)	Yes	OB2009N
15	Care of Children in Emergency Departments	Yes	AE1906N
16	Fractured Neck of Femur	Yes	AE2004N
17	Infection Prevention & Control	Yes	AE2005N
18	Adult Community Acquired Pneumonia	Yes	GM1814N

	Title	Participation	Local Ref Number
19	Implant Breast Reconstruction Evaluation IMBRA Study	Yes	GS1608N
20	Savi Scout R Radar Localization for non-palpable breast lesions	Yes	GS2108N
21	Post colonoscopy colorectal cancer audit	Yes	GAS2102N
22	Cardiovascular outcomes after major abdominal surgery (CASCADE)	Yes	GS2111N
23	Rectal Cancer management during the COVID 19 Pandemic (Re-cap)	Yes	GS2001N
24	Surgical Site Infection Surveillance Service / Getting it right first time (GIRFT)	Yes	GS1701N
25	TranEXamic Acid in elective colorectal Surgery (TEXAS)	Yes	00012
26	National Potential donor audit	Yes	CC1303N
27	British and Irish Orthoptic Society Vision Screening	Yes	OR2103N
28	Foot and Ankle Thromboembolism Audit	Yes	OR2202N
29	BAUS Renal Colic Audit 20/21	Yes	GS2009N
30	Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Yes	GS2108N
31	Percutaneous Nephrolithotomy (PCNL)	Yes	GS1615N
32	RESECT TURBT Surgery	Yes	GS2004N

** Note: - Continuous Data Collection relates to rolling audits with open submissions all year round.*

The reports of four national clinical audits were reviewed by the provider in 2022/2023 and the Trust intends to take the following actions to improve the quality of healthcare provided (see Appendix A).

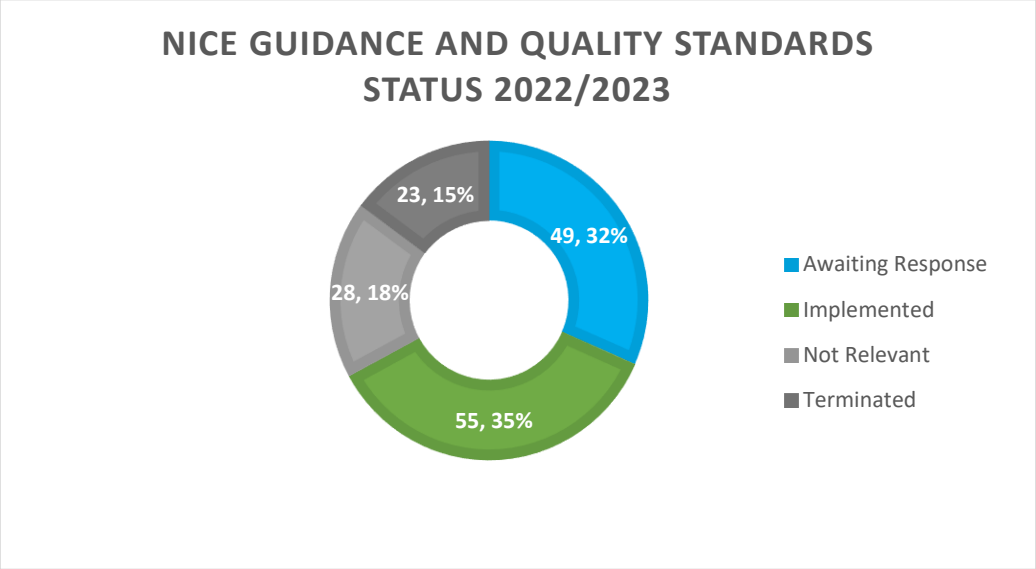
There have been total of 356 audit projects registered since April 2022 to March 2023. 137 (39%) have been completed on time, 161 (45%) are currently still ongoing, 22 (6%) are overdue and 36 (10%) were cancelled and not progressed. The actions of the 76 completed are included in the Appendix B.



2.4.4 NICE Guidance Summary

The Clinical Audit and Effectiveness team continues to maintain the Trust's NICE Guidance database in order to monitor the dissemination and implementation of guidance throughout the Trust where appropriate. The NICE database currently holds a record of all published NICE guidance including clinical guidelines, interventional procedures, cancer service guidance, technology appraisals and public health interventions, medical and diagnostic technology appraisals and highly specialised technologies.

In 2022/2023 there were 154 new NICE guidelines and 1 Quality Standard published.



Exception reporting on NICE Guidance and Quality Standards will be incorporated into Divisional Clinical Effectiveness reports and monitored through the Clinical Audit Group.

2.4.5 Participation in Clinical Research in 2022/2023

Developing new research platforms for clinical translation and integrating these into point-of-care technologies is seen as pivotal in the future NHS strategy. Such research developments enhance staff development but also serves to deliver a more efficient service to the end-user, i.e., the patient. On a number of fronts the Trust has been at the forefront of developing innovative solutions towards levelling up health inequalities.

Within the Clinical Research and Development department, there is now located the NIHR-funded Patient Recruitment Centre (PRC) and in collaboration with the Biomedical Research Centre (BRC) Manchester, the Trust's arm of the BRC. In line with this we have through the 2022-23 period initiated and undertaken 67 clinical trial studies that have recruited a total of 1,878 patients into frontline, primarily, phase 3 clinical trials. This has allowed access for our patients to the very latest in cutting-edge treatments.

The clinical trial work consisted of 20% commercial (with leading global pharmaceutical companies) and 80% non-commercial (academic, including CancerResearchUK-sponsored). In parallel, the emerging BRC initiative which kick-started in December 2022 (with five years funding) will develop research activities in the areas of oncology, genomics, respiratory, cardio-thoracic and cardiovascular, amongst others.

The vision of establishing this set-up is to integrate the early-phase research in-house and employing facilities through BRC Manchester and exploit these towards enhancing our late-phase clinical trial research. In line with this, a number of critical appointments have been made, including a research professor lead, a medical statistician and a number of dedicated research nurses.

Two studies of world-leading interest include the Northwest Cancer Research (NWCR) funded study into a prospective lung cancer screening trial through primary care and a haematology clinical trial (funded by Roche) investigating state-of-the-art blood handling techniques.

The NWCR-funded research led to the recruitment of 2000 study participants (as an NIHR portfolio study) through primary care and in parallel with CT scans and urgent referral of identified patients, has led to the potential research development of a rapid saliva test that could facilitate future, inexpensive, triage of patients. This research, developing a portable sensor-based technology harnessed to computational predictive algorithms, is being prepared for publication in leading peer-reviewed journals. The Roche-funded study recruited more than 200 patients and was deemed a significant commercial success.

Finally, significant linkages with local universities are being fostered in order to grow and develop further research activities.

2.4.6 Information on the Use of the Commissioning for Quality and Innovation (CQUIN)

The CQUIN scheme is designed to provide financial incentives for providers to maintain and improve quality in specific clinical priority areas. However due to the COVID-19 pandemic response, NHS England suspended the CQUIN financial incentive scheme for 2020/21 and 2021/22. To support the NHS to achieve its recovery priorities, CQUIN was reintroduced from 2022/23.

The CQUINs on which the Trust was monitored in 2022/23 focussed on the following quality indicators:

Lancashire & South Cumbria ICB	NHSE Specialised Commissioning
Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery.
Compliance with timed diagnostic pathways for cancer services.	Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines.
Treatment of community acquired pneumonia in line with BTS care bundle.	
Anaemia screening and treatment for all patients undergoing major elective surgery.	
Supporting patients to drink, eat and mobilise after surgery.	

The CQUIN indicators monitored by the ICB did not have a financial value attached to them in 2022/23.

The monetary value attached to the Specialised Commissioning CQUINs was £882,000. The Trust received the full value in 2022/23 after agreement was reached that any funding associated with a shortfall in performance would be re-invested in the provider to support local health economy strategic system objectives.

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

BTH is required to register with the Care Quality Commission (CQC).

Statements from the Care Quality Commission

In April 2022, the CQC carried out a follow up unannounced inspection which covered Urgent and Emergency services, Medicine, and Surgery. The surgery inspection focused solely as a follow up to the section 29a warning notice issued in October 2021. The inspection report was published in July 2022. Post inspection the CQC rescinded the section 29a warning notice, however, a section 31 letter was issued in relation to the management of Sepsis and Rapid Tranquilisation. Only medicine was re-rated and this was rated requires improvement overall.

In June 2022, the CQC carried out an unannounced inspection of our Maternity services and published their inspection report in September 2022. The overall rating for our Maternity services was inadequate.

2.4.8 Special Reviews / Investigations

As outlined above, the Trust received a section 29a warning notice in October 2021 which was rescinded in 2022 following CQC's April inspection, however a section 31 letter was issued in relation to Sepsis and Rapid Tranquilisation and conditions placed on the Trust's licence, will still remain.

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.

To respond to our ambitions, over the last year we launched a new Integrated Performance Report (IPR) and rolled this out at the committee level to support both day-to-day operations and executive oversight. We continued to provide the Operational Exception Report weekly to the Executive Team for 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 Associate Director of Business Intelligence 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 Information Assurance Group and through to the Board of Directors when required.

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.

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
- Monthly formal divisional reviews by way of the Performance, Improvement, Delivery and Assurance (PIDA) meetings, 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 are facilitated by the Trust's Performance department.

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 tracking list' meetings, where all divisions hold internal meetings and then report up to an Assurance and Escalation meeting weekly. 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 Trust's 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 2022/2023 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
- 99.9% for outpatient care
- 99.1**%** 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
- 100% for accident and emergency care.

**Data from April 2022 – February 2023*

2.4.11 Information Governance Assessment Report 2022-23

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 2022 to March 2023, 1,612 Blackpool Teaching Hospitals' patients died. This comprised of the following number of deaths, which occurred in each quarter of that reporting period:

- 377 in the first quarter
- 365 in the second quarter
- 440 in the third quarter
- 430 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 September 2022):

- Stroke
- Pneumonia
- Liver disease

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. The Trust 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. There has now been full implementation of the Medical Examiner's Office which has contributed substantially to sustained improvements.

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 continued to be inconsistent, but has increased in usage.

Actions that were identified and implemented to resolve the challenges for staff to consistently use this tool for improved reporting of learning from deaths, included:

- 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 Examiners' and Medical Examiners' Officer appointments made.
- 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 originally scheduled for April 2022, and has now been postponed until 2023-24.
- Development of a clear Mortality Improvement Strategy.
- Initiating Phase 2 of the Learning from Deaths App is on hold due to the development of an Electronic Patient Record.
- 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. An electronic tool is now available via NHS England and will be implemented in 2023-24.

- 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

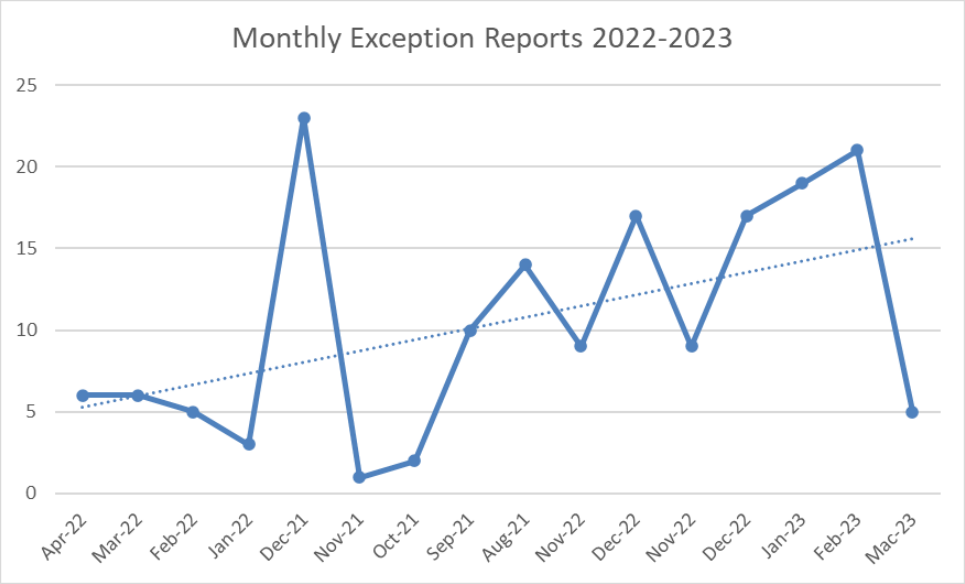
The Trust guardian of safe working hours has oversight of the issues relating to junior doctors in training. A key part of the role is overseeing the exception reporting process of rotas as stipulated in the 2016 junior doctors' contract.

Exception reports mainly relate to additional hours worked. A key factor driving this pattern of exception reporting arises from pre-existing rota gaps.

Efforts have been made in the recruitment drive to plug rota gaps to facilitate safe staffing levels especially out of hours ensuring patient safety.

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.

Exception Reports (ER) 2022-2023	
Total number of exception reports received	116
Number relating to immediate patient safety issues	3
Number relating to hours of working	94
Number relating to pattern of work	8
Number relating to educational opportunities	7
Number relating to service support available to the doctor	7



There have been concerted efforts to improve the working relationship between junior doctors in training and the rota coordinators in the respective departments and areas. This includes:

- Clear annual leave and study leave guidance
- Ensuring timely responses to email or telephone enquiries
- Senior clinical involvement in rota design and decision making
- Integrating self-development time into rota templates

ER outcomes - work schedule reviews

Specialty	Grade	Review meeting notes
General medicine	ST1 *	None
General medicine	ST1 *	None
Trauma & Orthopaedic Surgery	FY1 *	Approved
Cardiology	FY2	Reveiw with HOD

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) (October 2021 to September 2022 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. • Medical Examiner monthly forum with Medical Director. • Lead Medical Examiner reports into Medical Director			
2018/19	113	**2019/20**	109	**2020/21**	107	**2021/22**	107 (Jan-Dec 2021)	**2022/232**	107 (Oct 21–Sep 22

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 February 2022 to March 2023, taken from Latest HED information.**								
National Average	41.2%								
Where applicable – Best Performer	92.5%								
Where applicable – Worst Performer	2.0%								
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%	**2022/23**	42.8%

Domain	**Helping people to recover from episodes of ill health or following injury**		
Indicator	Patient outcome scores for hip replacement surgery		
National Average	**Adjusted National Average**	Not available	
Where applicable – Best Performer	**Adjusted average health gain – best performer**	Not available	
Where applicable – Worst Performer	**Adjusted average health gain – worst performer**	Not available	

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. • It is hoped this will lead to an increase in the Trust's average health gain for 2021-22 figures. • Monthly bulletins are circulated to the Medical Director and Director of Operations, as the Trust leads for PROMs and shared with Theatre teams. • Alternative electronic methods of collecting data have been explored, with the Trust requesting to take part in a provider trial in this area.

2018/19	0.386	**2019/20**	0.396	**2020/2021**	0.424	**2021/2022**	Data not yet available	**2022/2023**	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**		
National Average	**Adjusted National Average**	Not available	
Where applicable – Best Performer	**Adjusted average health gain – NHS Trusts best performer**	Not available	
Where applicable – Worst Performer	**Adjusted average health gain – NHS Trusts worst performer**	Not available	

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. It is hoped this will lead to an increase in the Trust's average health gain for 2021-22 figures. • 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. • Alternative electronic methods of collecting data have been explored, with the Trust requesting to take part in a provider trial in this area. •

2018/19	0.335	**2019/20**	0.308	**2020/2021**	0.315	**2021/2022**	Data not yet available	**2022/2023**	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%	**2019/2020**	7.66%	**2020/2021**	9.15%	**2021/2022**	7.14%	**2022/2023**	5.23%

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%	**2022/23**	13.59%

Domain	**Ensuring that people have a positive experience of care**							
Indicator	**Responsiveness to inpatients personal needs: - NHS Outcomes Framework Indicators**							
National Average	Not available							
Where applicable – Best Performer	Not available							
Where applicable – Worst Performer	Not available							
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. • Following the merger of NHS Digital and NHS England on 1st February 2023 the trust is reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed.							
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 2021-22 National Inpatient survey results with staff across the Trust, updating at Quality Assurance Committee, Divisional Governance Committees and Ward Manager discussion forums. • A meeting with the Senior Pharmacy Team took place to discuss reoccurring themes around medications on discharge. • 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, this took place through our Influence Panel which supported the Emergency Village plans, SDEC and Critical Care. • The Patient Engagement Team also attended local community engagement events across the Fylde Coast.							
2018/19	64.6	**2019/20**	65.7	**2020/21**	72.8	**2021/22**	Data not yet available	**2022/23**	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	95% - January 2023 – latest figure on NHS England website						
Where applicable – Best Performer	100% - January 2023 – highest figure on NHS England website						
Where applicable – Worst Performer	79% - January 2023 – 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 collecting FFT surveys, whilst our volunteers visit the wards on a weekly basis encouraging patients to fill out the inpatient's listeners survey to provide us with further feedback. Training is also offered to the Ward Managers on the Experience platform, ensuring they action their feedback. SMS text messaging is now being used as a method to support the paper feedback form received across inpatient areas.						
2019/20	96% - figure from March 2020	**2020/21**	98% - figure from March 2021	**2021/22**	97%- figure from March 2022	**2022/23**	96% - figure from March 2023

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	92% - January 2023 – latest figures on NHS England website						
Where applicable – Best Performer	100% - January 2023 – highest figure on NHS England website						
Where applicable – Worst Performer	67% - January 2023 – 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 are currently below the national average for our FFT maternity survey score. The Patient Engagement Team is working with the team on Ward D and Delivery Suite providing them with tips and advice on how they can improve their FFT performance which is discussed in our monthly meetings. Adaptions have been made to the environment based on patient feedback with QR code posters now placed in central areas. • Patient experience also submit information to the Divisional Governance meeting where themes and hot spots can be raised and shared across the Division. • 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%	**2021/22**	98%	**2022/23**	87% - figure from March 2023

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 Accident and Emergency.**						
National Average	83% - January 2023 – latest figure on NHS England website						
Where applicable – Best Performer	100% - January 2023 – highest figure on NHS England website						
Where applicable – Worst Performer	43% - January 2023 – lowest figure on NHS England website						
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 Emergency Department score. Urgent and emergency care continues to be seriously impacted by the COVID-19 pandemic recovery with patients reporting delays in receiving timely and accessible care across the country. Our Emergency Department has been under considerable pressure, 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 Emergency Department 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 opened to try and ease patient flow from the Emergency Department. The Patient Engagement Team meet regularly with the Departmental Managers to discuss their feedback and highlight any significant concerns. From these monthly meetings, we have created a 'what to expect whilst waiting in the Emergency Department' poster focusing on feedback received from the survey, highlighting information on processes within the department, what we offer to patients and any other relevant information which has been raised as a common theme during our meetings.						
2019/20	88%	**2020/21**	85%	**2021/22**	67%	**2022/23**	70% figure from March 2023.

Domain	**Ensuring that people have a positive experience of care**
Indicator	**Percentage of staff who would recommend the Trust as a provider of care to their Friends or family. Staff Survey.**
National Average	61.9% (2022/23)
Where applicable – Best Performer	86.4% (2022/23)
Where applicable – Worst Performer	39.2% (2022/23)

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 2022..
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, and though engagement with staff networks. 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 staff engagement service and QI hub to improve staff and patient experience. Coast accreditations remain ongoing, while 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%	**2022/23**	58.6%

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 3.2 taken in January 2023						
Where applicable – Best Performer	0 breaches recorded by another NHS Trust in January 2023						
Where applicable – Worst Performer	478 breaches recorded by another NHS Trust in January 2023						
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 2022/23. The Trust has been escalated to OPEL level 4. There have been extremely high levels of bed occupancy / surge patients making it difficult to step down patients from all our critical care areas due to general beds not being 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:	The Trust has completed a number of building projects over the last year, with services moving into the newly opened areas, this has created some single sex ward spaces across the Trust. The Associate Director of Nursing and Head of Patient Experience conduct 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	**2022/23**	41

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:	National Audit not reinstated since Covid pandemic.								
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:	Local actions include: • ongoing monitoring and local audit. • VTE Group with a Medical Chair in place.								
2018/19	65%	**2019/20**	72.25%	**2020/21**	The audit was put on hold due to COVID	**2021/22**	Audit not reinstated since Covid	**2022/23**	Audit not reinstated since Covid.

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 (2022/2023)**
National Average	2021-2022 = 25.20 (Data for 2022/2023 not yet available)
Where applicable – Best Performer	2021-2022 = 0.96 (Data for 2022/2023 not yet available)
Where applicable – Worst Performer	2021-2022 = 78.60 (Data for 2022/2023 not yet available)

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 109 cases and the Trust reported 84 cases. Data regarding the 84 cases reported was extracted from the United Kingdom Health Security Agency (UKHSA) and Healthcare Associated Infection Data Capture System (HCAIDCS) and is governed by standard national definition. Rates per 100,000 overnight bed days and day admissions have been included in this report. 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 Trust 2021-2022 rate was 44.08. Data for 2022/23 is not yet available.
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 clinical divisions continue to undertake a root cause analysis of all cases. The outcome of these investigations determine 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	Count 60 Rate 25.69	**2019/20**	Count 127 Rate 56.68	**2020-21**	Count 92 Rate 45.56	**2021/22**	Count 101 Rate 44.08	**2022/23**	Count 84 Rate not yet available

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 2022 - March 2023)**								
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)	**2022 / 23**	0.03% (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 October 21 to September 2022, which remains the same as for the previously reported period.

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 patient experience delivery plan 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 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 2022 - March 2023)

Patient safety incidents are reported to NHS England, via the NRLS. The number of patient admissions and attendances for the year 2022/23 was 571,525 and the number of patient safety incidents reported by BTH for the same period was 24,996. This equates to a percentage of 4.37%. The number of severe harm or death incidents reported and closed within this period was seven, which equates to 0.03% of patient safety incidents reported. 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 remains high. 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 2022/23 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*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
Patient safety Outcomes	Hospital Standardised Mortality Rate (Summary Hospital Mortality Indicator)	89 (Jan–Dec 22)	106 (Aug 21 – July 22)	107 (Dec 20 to Nov 21)	111 (Dec 18 to Nov 19)	115	111
	Stroke Mortality Rate *Data Source HED:*	115 (Oct 21 – Sept 22)	107 (Jan-Dec 2021)	114 (Mar 20 to Feb 21)	107 (Dec 18 to Nov 19)	132	132

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
	Pressure Ulcer harm reduction	Category 2 0.3% decrease, category 3 36.4% increase, category 4 37.5% decrease	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.
	Reduction in harm as a result of a fall	12.5 % decrease	8.84% increase	32.04% increase	59.7% reduction	16.9% reduction	2.47% increase overall
	Opportunities to care within clinical pathways - sepsis	No longer audited. Audit changed to LIVE data collection with collaborative.	94.93% (Apr21-July 21) Audit ceased WEF 1.8.21	95.04% (Apr20-Feb21)	93%	89%	86%
	Opportunities to care within clinical pathways – AKI	No longer audited. AKI live collection commenced in February 2023.	92.25% (Apr 21 – Feb 22)	92.37% (Apr20-Feb21)	91%	84%	79%

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
	Opportunities to care within clinical pathways – pneumonia	No longer audited. Moved to Acute Pathway Group.	Audit ceased WEF 1.4.21	98.70% (Apr20-Feb21)	98%	98%	97%
	Opportunities to care within clinical pathways - Stroke	No longer audited. Moved to Acute Pathway Group	94.14% (Apr21 - Aug 21) Audit ceased WEF 1.9.21	91.33% (Apr20-Feb21)	92%	95%	96%
	Opportunities to care within clinical pathways – Fractured Neck of Femur (#NOF)	No longer audited. Moved to Acute Pathway Group	Not audited from April 2018	Not audited from April 2018	Not audited from April 2018	Not audited from 01.04.2018	75%
	Opportunities to care within clinical pathways – Cardiac Chest Pain	No longer audited.	No longer Audited	No longer audited	No longer audited	97%	98%

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
	Opportunities to care within clinical pathways – Chronic Obstructive Pulmonary Disease (COPD)	95.23% (audited quarterly Apr 22 - Nov 22). Feb 23 data not yet available.	94.64% (audited quarterly Apr21 – Feb22)	96.32% (audited quarterly Apr20 – Feb21)	99.33%	95%	95%
	Opportunities to care within clinical pathways – Abdo Chest Pain	No longer audited	No longer audited	No longer audited	No longer audited	91%	86%
	Opportunities to care within clinical pathways – Heart Failure	No longer audited	71.88% Apr 21 – Jan 22)	67.60% (Apr 20 - Feb21)	68.53%	61%	56%
Patient Experience	Percentage of Adult Inpatient who rate care as excellent / very good / good	2022 data not yet available	(2021 data) 81%	(2020 data) 83%	(2019 data) 81%	(2018 data) 81%	(2017 data) 79%

Indicators*		2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
	Percentage of Adult Inpatients who have been treated with Respect & Dignity	2022 data not yet available	(2021 data) 92%	(2020 data) 91%	(2019 data) 89%	(2018 data) 88%	(2017 data) 85%
	Percentage of Adult Inpatients who felt involved in their care and/or treatment	2022 data not yet available	(2021 data) 69%	(2020 data) 70%	(2019 data) 71%	(2018 data) 68%	(2017 data) 67%

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	2022/23	2021/22	2020/21	2019/20	2018/19
Maximum two weeks from:	GP Urgent Referral for suspected cancer to First Consultant Appointment	93%	Under achieved: Q1 88.08% Q2 78.9% Achieved Q3 93.9%	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%
	GP Urgent Referral for breast symptoms (where cancer not initially suspected) to First Consultant Appointment	93%	Achieved: Q1 93.8% Q2 96.5% Q3 97.98%	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%

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
Maximum 28 days:	Faster Diagnosis Standard	75%	Under achieved Q1 71.2% Q2 66.9% Q3 65.9%	Under Achieved Q3 66.2% Q4 68.5%			
Maximum one month (31 days) from:	Decision to Treat to First Treatment	96%	Under achieved: Q1 86.6% Q2 83.4% Q3 88.4%	Achieved: Q1 99.0% Q2 98.5% Q3 96.1% Under Achieved: Q4 92.0%	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%
	Decision to Treat to Subsequent Treatment – Drugs	98%	Under achieved Q1 94.4% Q2 66.6% Achieved Q3 100%	Achieved: Q1 100% Q2 100% Q3 100% Under Achieved: Q4 95.0%	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%

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
	Decision to Treat to Subsequent Treatment – Surgery	94%	Under achieved Q1 87.2% Q2 91.3% Achieved Q3 97.3%	Achieved: Q1 94.1% Under Achieved: Q2 92.9% Q3 93.5% Q4 86.7%	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%
Maximum two months (62 days) from:	GP Urgent Referral for suspected cancer to First Treatment	85%	Under achieved Q1 66.9% Q2 65.8% Q3 75.7%	Under Achieved: Q1 80.9% Q2 73.5% Q3 67.4% Q4 62.3%	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%
	A National Screening Service to First Treatment	90%	Under achieved Q1 46.8% Q2 35.2% Q3 56.5%	Under Achieved: Q1 31.3% Q2 25.9% Q3 25.7% Q4 35.2%	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%

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
	A Consultant Upgrade to First Treatment	No separate operational standard set	Q1 56.0% Q2 58.4% Q3 67.4%	Q1 89.1% Q2 87.4% Q3 72.0% Q4 76.2%	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%
Maximum 6 weeks for:	Patients waiting for a diagnostic test	99%	Under achieved Q1 72.5% Q2 75.1% Q3 73.8%	Under Achieved: Q1 76.9% Q2 72.6% Q3 82.3% Q4 80.5%	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%
Cancelled Operations	Percentage of Operations Cancelled	No separate operational standard set	Q1 1.32% Q2 1.29% Q3 1.11%	Data Collection reinstated from Q3 21/22 Q3 1.26% Q4 0.91%	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%

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
	Percentage of Operations not treated within 28 days	No separate operational standard set	Q1 17.71% Q2 18.71% Q3 16.45%	Data Collection reinstated from Q3 21/22 Q3 17.24% Q4 13.6%	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%
Maximum 18 weeks for:	Patients on an incomplete pathway awaiting consultant-led treatment	92%	Under achieved Q1 68.4% Q2 65.6% Q3 65.9%	Under Achieved: Q1 73.4% Q2 71.5% Q3 71.4% Q4 69.4%	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%
Infection Control	Incidence of MRSA		3 cases	Under achieved	Under achieved	Under achieved	0 Achieved
	Incidence of *Clostridioides difficile*	Threshold 109	Achieved 91 cases	Achieved	Under achieved	Under achieved	31 Achieved

National Targets and Minimum Standards*	Target	Operational Standard	2022/23	2021/22	2020/21	2019/20	2018/19
Maximum four hour wait from:	Arrival to Admission, Discharge, or Transfer	95%	Under achieved Q1 80.2% Q2 79.4% Q3 78.9%	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%
VTE Risk Assessment	Venous thrombo-embolism risk assessment	95%	No Audits undertaken due to COVID	No Audits undertaken due to COVID	No Audits undertaken due to COVID	Under achieved Q1 69.76% Q2 71.72% Q3 74.07% Q4 73.96% Q4 Data collection suspended 17th March due to COVID19	

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 the Integrated Care Board (ICB), Local Healthwatch Organisations and Overview and Scrutiny Committees (OSCs)

3.3.1 Commentary from the Lancashire and South Cumbria Integrated Care Board (ICB)

Lancashire and South Cumbria Integrated Care Board (ICB) thanks Blackpool Teaching Hospitals NHS Foundation Trust (the Trust) for producing this year's Quality Account, reporting on 2022-2023. The ICB acknowledges the achievements made during a very difficult year for the NHS, both nationally and locally, which is still greatly affected by the impact of the Covid 19 pandemic on service demand and provision of health care delivery. The ICB would like to thank all members of the Trust's workforce for their dedication, hard work and resilience in these challenging times.

This comprehensive Quality Account describes the Trust's drive towards a culture of continuous quality improvement. The launch of the new five-year strategy for 2022-2027 clearly sets out the critical themes and objectives the Trust aims to achieve, through significant engagement with colleagues, partners and stakeholders. We look forward to reviewing the impact and outcomes of the strategy in next year's Quality Account.

The ICB is encouraged to see the establishment of the Clinical Quality Academy (CQA) and the way use of data and capability-building is focused on reducing avoidable harm in very tangible and meaningful quality improvement activity. The ICB congratulates the Trust on being recognised nationally for this work. Through analysis of a range of data over the following year, the Trust will be able to evidence which approaches best sustain these improvements.

It is encouraging to see the Trust's ongoing commitment to duty of candour and that it is embedded in the Trust's safety culture. The Trust should be commended for achieving 100% compliance with all elements of duty of candour between 1st April 2022 and31st March 2023.

Another positive example of the Trust being open and transparent, has been the invitation for ICB representatives to join a number of committees/groups, observing internal governance arrangements and the ICB's participation in ward and clinical area COAST assessments. These have provided assurance to the ICB that the trust provides safe, high quality health care and has an effective internal review and governance process in place. The assessments allow wards and clinical areas to demonstrate a wide coverage of standards through key measures on quality; the identification of any issues and improvement opportunities. The Trust has achieved an appropriate and effective balance of providing support and guidance to the wards and clinical areas and promoting a high standard of care. The Quality Account highlights that the Trust will continue to put quality accreditations in place across all wards and services. The ICB will continue to monitor the evidence that the Trust has equally effective processes and escalation in place to support wards and clinical areas when assessment identifies improvements are required.

A vital component of quality improvement is engagement with groups of people with 'lived experience' and the ICB is delighted to see patient/family/carer groups now involved at the earliest stages of service design, development and evaluation. We look forward to seeing the impact of this way of working across the Trust's hospital and community services. Collaboration with other services including Healthwatch, Blackpool Council and Blackpool Carers will allow for a greater understanding of the Trust's local community, its needs and increase engagement with other out of hospital services.

The ICB continues to see an appropriate focus in the response to the Care Quality Commission inspections of urgent and emergency services, medicine and surgery and more recently maternity services. For example, cross-trust improvements in the identification and management of sepsis have been seen and we look forward to working with the Trust to ensure actions taken are having a real and sustained benefit in terms of patient safety.

The Trust is demonstrating more joined-up work around care of the elderly, end of life and in raising awareness of dementia, management of patients with dementia in an acute setting, and identifying those at risk of falls. The ICB credits the Trust on its provision of education to staff on caring for patients with dementia, particularly the implementation across the trust of the person-centred tool "Paint me a picture" which allows for a more personalised, holistic approach to a person's stay in hospital.

A notable reduction in grade 4 pressure ulcers is reported and the rolling programme of training on identification and prevention of pressure ulcers, should sustain this improvement. It is hoped with the training; the introduction of the Purpose T risk assessment tool and a new intentional rounding document, that reductions in category 3 and 2 pressure ulcers will be evident in next year's Quality Account.

The ICB has noted the ongoing work to improve the facilities in the emergency village project and how the Same Day Emergency Care (SDEC) has demonstrated a reduction in delays in the emergency pathway. The ICB is keen to work with the Trust to ensure these faster patient flows are appropriately communicated to the patients and those who support any aftercare in the community.

The ICB recognises the ongoing effort in improving the identification and management of the deteriorating patient. Although the ambitious aim of achieving a cardiac arrest rate of 1 per 1000 admissions had not yet been achieved, there had been sustained improvement in the rate from 1.49 to 1.07 per 1000 admissions. The identification and care of the deteriorating patient collaborative is clearly making an impact on this priority. Triangulation of information with incidents relating to the deteriorating patient will continue to help identify specific areas which need to be prioritised.

It is encouraging to see cases of Clostridioides difficile infections (CDI) reduced to 91 which is below the NHS Contract threshold of 109, and that the Trust are one of 7 out of 24 acute trusts in the northwest to remain within the NHS Standard Contract threshold for CDI. The learning from actions which have had impact will need to be embedded to ensure this improved position is maintained.

The ICB notes the Trust's rationale for the selection of priorities for 2023/24 and the decision to continue its ongoing programme of work on reducing pressure ulcers, improving the identification and management of the deteriorating patient and reducing fractured neck of femurs in partnership with local care homes. The ICB would like to praise the team in their achievement and engagement with the selected care homes. It is encouraging to see a 14% decrease in the number of falls resulting in moderate or serious harm within the acute elements of the Trust, however, there has been an increase in falls overall. The development

of a steering group to reduce falls that includes a wide multi-disciplinary workforce is welcomed by the ICB therefore.

It is pleasing to see that despite another 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, despite narrowly missing the Trust target of 98% positive feedback. There is also a marginal increase in positive workforce experience and the ICB welcomes the Trust's action in preparing for several listening events in the coming year. It is hoped that the responsiveness to these will boost staff morale and support an increase in the retention of the workforce.

The ICB acknowledges the Trust's participation in clinical audits and national confidential enquiries. It is commendable that during these challenging times in the NHS, only a minimal amount had to be cancelled or not progressed. This demonstrates the trust's commitment to quality improvement.

The ICB is committed to working in collaboration with the Trust in meeting its quality priorities for 2023/24; a necessary foundation on which to ensure patients across Fylde and Wyre and Blackpool receive safe, high quality and harm free care from their local NHS services. This future collaboration also extends to the ICB’s responsibilities in supporting and working with trusts to improve or maintain the System Oversight Framework (SOF) position and providing assurance to NHS England regarding quality of care across the Lancashire and South Cumbria System.

Professor Sarah O’Brien

Chief Nursing Officer

3.3.2 Statement from Healthwatch Lancashire

Healthwatch Lancashire

Response to Blackpool Teaching Hospitals NHS Foundation Trust Quality Accounts Report for 22-23

Introduction

We are pleased to be able to submit the following considered response to Blackpool Teaching Hospitals NHS Foundation Trust Quality Accounts for 2022-23.

Part 1: Including Chief Executive's Statement

A comprehensive statement commenting on activity across the trust including the launch of the five-year strategy. It was pleasing to learn of the achievements of the last year, especially that 93% of patients rated their care as good, and the launch of the 'Expert by Experience' programme.

Part 2: A review of Quality Improvement Programmes 2022/23

2.2.7 Patient Safety

Listed are what the trust intends to take/have taken to improve the quality of patient safety. Worthy of note is the 'Safety Focus' newsletter that is in place to share learning and patient feedback.

2.2.10 Patient, Family and Carer Experience

We would like to highlight the 'Expert by Experience' programme as it is recognised that when people are involved at the earliest stage of design and development, the quality of services improve. We are particularly interested in learning how patients are more involved with co-production as the programme progresses.

2.2.13 Improving Care for Patients Living with Dementia

We are pleased to learn of the seven key commitments the trust is committing to in order to improve the experience of those patients lining with Dementia, and pledging to the

John's Campaign. We look forward to learning more about the improvements made to environments to improve a person's hospital experience.

In accordance with the current NHS reporting requirements, mandatory quality indicators requiring inclusion in the Quality Account we believe the Trust has fulfilled this requirement. The Quality Indicators, results and supporting narrative are clear and well laid out.

Summary

Overall, this is a fair and well-balanced document which acknowledges areas for improvement and details comprehensive actions being taken to further improve patient treatment, care and safety.

We welcome these and as a Healthwatch we are committed to supporting the Trust to achieve them.

Jodie Ellams

Manager- Healthwatch Lancashire

3.3.3 Statement from Lancashire County Council Health Scrutiny Committee

The Lancashire County Council Health Scrutiny function welcomed the detail included in the Quality Accounts report on the examples of the challenges faced in 2022-23 and how improvements had been made.

The range of information that the Trust is required to reference in this report was acknowledged, and members noted the challenges in producing a report for both professionals and the public. The Quality Account is well presented and reflects the requirements to benchmark against peers.

The Committee noted that due to the complexity of the information reported, consideration could be given to producing a summary document of the report with the focus on patients and the public as the key audience. However, members welcomed the summary at the start of the report outlining the high level priorities, progress and future plans as well as the clear table of contents, use of graphics and the glossary.

Members noted that there appeared to be little information on access to services and staffing and would like to have seen more detail on these particular areas, the challenges and plans in place. In addition, it was felt that more information on progress since the CQC inspections would have further strengthened the report.

Members welcomed the information provided as part of the NHS Outcome Framework Indicators; however it was noted that a number of these did not include national data which limited the ability to contextualise the information provided.

The table of information provided as part of the 'Risk Assessment Framework' provided a useful overview, however it was felt that additional headline information on actions taken to address those areas identified as 'under achieving' would have strengthened this element of the report.

The Lancashire Health Scrutiny function welcomed the opportunity to comment on the Blackpool Teaching Hospitals NHS Foundation Trust Quality Accounts for 2022/23 and would welcome early involvement with the planning process to produce the Trust's 2023/24 Quality Account.

Samantha Parker

Senior Democratic Services Officer

Overview and Scrutiny

Legal and Democratic Services

Lancashire County Council

3.3.4 Statement from Blackpool Council Adult Social Care and Health Scrutiny Committee

The Democratic Governance Senior Adviser has provided the following response:

Thank you for your email. We have just had all our elections here at Blackpool and the Adult Social Care and Health Scrutiny Committee has not yet been reappointed by the Council, which it will do at the Annual Council on Wednesday 24 May 2023.

The Committee will therefore not have the time to contribute to the quality account process this year, however, once the Committee has been established we will send them the quality account for information.

Jodie Stephenson

Democratic Governance Senior Adviser

Democratic Governance

Blackpool Council

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 2023* and supporting guidance.
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes for the period April 2022 to March 2023.
  - Papers relating to quality reported to the Board over the period April 2022 to March 2023.
  - Feedback from the Integrated Care Board (ICB) dated 15 June 2023
  - Feedback from Healthwatch Lancashire dated 8 June 2023
  - Feedback from Blackpool Council Adult Social Care and Health Scrutiny Committee dated 22 May 2023
  - Feedback from Lancashire County Council Health & Scrutiny Committee dated 2 June 2023
  - 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 for 2022/23, however an annual summary of complaints for 2021/22 was submitted to the Quality Accounts Committee in April 2022. Quarterly reports have also been completed for each quarter within 2022/23.
  - The 2021 national patient survey results published in 2022. The 2022 survey results have not yet been published by the CQC; these are expected in August 2023..
  - The national staff survey published in 2022.
  - Care Quality Commission inspection report, published in July 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's reporting guidance (which incorporates the Quality Accounts regulations) published at: NHS England » Financial accounting and reporting updates as well as the NHS England's Quality Accounts Requirements 2022/23 available at NHS England » Quality Accounts requirements 2022/23.

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 2023	June 2023

4 Appendices

Appendix A: Actions taken following issue of National Report

Report	Action Taken
National Smoking Cessation Audit	1) Aim for 85% of patients to have a documented smoking status in the notes by the next BTS smoking cessation audit. 2) Weekly task and finish groups and three- monthly treating tobacco dependency steering group meetings.
National Maternity and Perinatal Audit	Confirmed all elements of saving babies lives 2 being implemented.
Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction- Saving babies' Lives Care Bundle V2	Improved referral system- carry our new triage system and proforma to facilitate better referral for ultrasound at appropriate gestation.
National Paediatric Diabetes Audit	1) Improve data collection in BP, HbA1c levels, eye screening, cholesterol and foot examination- changes to NEXUS 2) Emotional wellbeing support, to fill and input onto NEXUS when completing mental health check- Weekly Youth Therapy Clinics- patients newly diagnosed and following individual assessment are referred to Youth Therapy 3) Regular review of patients with elevated HbA1C- Review of sub-optimum glycaemic control pathway, to include monthly upload to NPDA and clinical review , Virtual clinics, Extra clinic appointment Structured education and use of resources- Development of personal Sick day rule cards. Sick day rules Policy.
BAPEN National Care Audit	MUST training video made. Ward based training.

Appendix B: Examples of actions taken as a result of local audits

Ref Number	Audit Title	Actions taken as a result of local clinical audit
	Integrated Medicine & Patient Flow	
GM2122	Accuracy of admissions diagnosis of UTI in the older people >65	Improvement of clerking documentation in AMU
		Avoidance of unnecessary investigation like Urine dipstick in a catheterized patient
GM2127	Preventing avoidable harm with safe IV fluid therapy	Increase knowledge about safe IV fluid prescription
		Facilitate access of NICE CG174 to prescribers
GM2210	Documentation of DNACPR	To discuss DNACPR early
		Decisions to be completed in patients notes
GM2228	Optimising anticoagulation management in atrial fibrillation amongst patients admitted to AMU	Doctors' education about importance of reviewing anticoagulation- presentation at local AMU teaching
GM2121	Pre-treatment assessment for Dapsone	Emphasise the need for regular blood tests
GM2001	Documenting the Diabetic Foot MDT	Development of comprehensive food booklet
GM2126	Atrial Fibrillation Detection in Stroke Patient	Update staff with Stroke Pathway around the importance of 12 lead ECG and AF detection: Basic ECG interpretation training
AE2102	Documentation of well's score in A&E	Reduce inappropriate requests for d-dimers
AE2007	Prescription of Critical medicines in ED	Reminder to use MAXIMS alert for Critical meds. Reminder on the shop floor and in handover.

Ref Number	Audit Title	Actions taken as a result of local clinical audit
AE2101	An investigation into sepsis pathway	1)Posters: Related to the new sepsis pathway displayed 2)Encourage utilising the sepsis pathway in the department. The Trust have introduced a new pathway.
	Surgery, Anaesthetics, Critical Care & Theatres	
AN2102	Review of documentation of Anaesthetic and recovery room care	1)Reminder for anaesthetic documentation at WH sign out 2)Dermatome map available in every recovery area- to document neuroaxial block height.
GS2203	VTE Prophylaxis in the Urology Department within 48 hours of admission	1) Clerking doctor to have discussion with Senior doctor on Ward Round to ensure Secondary Clerking document is completed fully. Reminder during WR that both VTE and medication chart to be reviewed to ensure TED/Dalteparin appropriately prescribed
OP2202	Biometry Ultrasound audit	1) Integrated data sharing with optometrists on medisight
AN2102	Review of documentation of Anaesthetic and recovery room care	1) Dermatome map available in every recovery area, Stickers available in theatres. Computers and paper already available in theatre to type note. Additional reminder at WHO sign out for documentation to be completed and reversal to be documented- reminder on WHO board
AN2104	Elective Caesarean Sections lists operational standards	1) Rota coordinator for obstetric consultants to make sure that they are aware about any changes. Consultant obs./ anaesthetists for elective sections need to push to have team brief at 8:30

Ref Number	Audit Title	Actions taken as a result of local clinical audit
CC2101	Assessment of appropriate and adequate documentation of chest x-ray findings in Critical Care procedures	1) Train doctors for documenting x-ray findings. Introduce review checklist stamp reinforced with Radiology and Critical Care Department. Add to daily nursing handover announcement Nurses to ensure stamp is complete before starting feed.
GAS2101	Compliance with NICE CG100 Alcohol Disorders and CORP/PROC/487	1) 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.
GS2109	Analysis on the safe use of intra-operative torniquets	Ongoing education and reminders on tourniquet machines. Pre-operative proforma changes to reflect BOAST guidelines
GS2110	Improving long-term follow-up of post treatment thyroid cancer patients	Blood forms available in ENT clinic to request thyroglobulin levels, Clinic letters to follow following template provided in PPT
GS2112	Re-audit of medical documentation of surgical patients	Refresher training and continuous induction sessions to emphasise . Documentation. Provision of stamps to all medical staff involved in documentation. Medchart to be escalated to all areas of the trust.
GS2202	Compliance of Trust VTE guidelines in Acute General Surgical admissions	Posters, emails and presentation sent to ensure that blood results are checked before prescribing VTE prophylaxis and, ensure the primary assessment is completed within 4hrs of admission and that the secondary assessment is done within 24hrs by post-take/on call team to maintain the 100% compliance
GS2205	Quality of Surgical wards documentation against standards	Highlight at induction to the junior doctors the importance of the other tools to be accurately documented.

Ref Number	Audit Title	Actions taken as a result of local clinical audit
GS2207	Compliance of Trust VTE guidelines in Acute General Surgical admissions re-audit	Staff education taken place in ensuring blood results are checked before prescribing, ensuring the primary VTE is done within 4hrs of admission and the secondary assessment is done within 24hrs by post-take/on call team
OP2103	Implementation of NICE Guidelines for treatment of Neovascular AMD with antiVEGFs	Number of slots available increased for same day injections. Virtual clinics to continue
GS2212	Ward round documentation	Ongoing teaching delivered in using a template form
IC2201	Improving eye care in Intensive Care Unit	Outdated prescription chart to be updated. Provide teaching to nursing team and doctors' induction, distribute posters around ICU are on eye care
	Families & Integrated Community Services	
OB2010 -	Management of severe pre-eclampsia	Document if postnatal appointment offered,, staff education - remind junior doctors to ensure documentation of postnatal follow up on discharge letter - email communication .
OB2012	Obesity in pregnancy re-audit	Change from a paper BMI proforma to an electronic form. Clinicians to use Electronic system to document Care Plan. Audit cycle completed new audit to be considered 6 months after implementation of electronic maternity record
OB2102	SBL Element 5 - Premature live births receiving Corticosteroids, Magnesium Sulphate and delivery in appropriate setting	Email sent to community midwives to ensure documentation on Euroking at booking is completed. Regular teaching sessions will occur to keep doctor's and midwives up to date with the IT system at least twice a year. Preterm risk assessment has been added to the new Badger system. LMS proforma to be created.

Ref Number	Audit Title	Actions taken as a result of local clinical audit
OB2105	Emergency Caesarean Section re-audit	Poster produced & in circulation to raise awareness of the importance of documenting time to decision to allow calculation of time interval to delivery.
OB2107	Detection and management of small for gestational age	Escalate the importance to community midwifery staff of measuring CO at booking. SBL v2 educational sessions for community midwives
OB2204	Management of miscarriage	Improved training for MVA use & recurrent miscarriage referral and cytogenetic testing (for eligible cases). VTE risk assessment proforma attached to patient record for all cases.
CH2105	Adherence to local antenatal alert policy	Alert stickers to be placed on maternal notes when Antenatal Alert form completed. Delivery Suite team updated of Antenatal alert Process. Ongoing training of new paediatric staff at induction to the department. Develop process to be able to share documented antenatal alert plan with women prior to delivery of baby.
CO2105	Prescribing and management of dental infection	Clinicians informed of their individual scoring patterns and trends. Use of SOE screen encouraged. Thermometer available for use in each clinic. Staff made aware of FGDP and BNF Guidelines
CO2201	Use of the difficult to engage escalation policy within adult community teams	Ensure staff are aware of CIT training on management of non-compliance available on patient safety training programme. Offer CIT non -compliance training package to individual teams. Distribute guidance to staff on the correct process for using the difficult to engage escalation policy.

Ref Number	Audit Title	Actions taken as a result of local clinical audit
CO2203	Clinical Supervision re-audit	Training dates sent out to all team leaders and line managers, clinical supervision booklet sent out to all team leaders and line managers, clinical improvement team rep met with the BTH Clinical Improvement Lead to establish opportunities for joint working and methods to embed clinical supervision within teams.
CO2206	Dental Radiography Quality Assurance Audit 2021	Refresher training on calibration in grading radiographs, all sites will use the radiograph tabs to enter data for auditing
Clinical Support Services		
RA2106	Compliance with Radiology Bio-Medical Research trials with Trust procedure	100% compliance findings to highlight good practice cascaded
RA2107	Compliance with justification of an exposure of ionising radiation to patients for non-medical imaging reasons as per RAD/GEN/PROC/024	Audit findings cascaded and staff asked to make themselves familiar with the policy and to carry out the guidance when required. Discussion with PACS team to develop filter/ group to ensure images are only reported by those required to do so.
RA2108	Audit of correct checks and documentation of patient's pregnancy status prior to x-ray exposure	Staff asked to make themselves familiar with best practice guidance and ensure compliance. Poster displayed in all clinical areas. LMP check reminder also displayed in clinical areas. Radiographer to be present for WHO checklist HCG blood results recorded on WHO checklist
RA2109	Audit of justification of medical exposure prior to imaging examination	100% compliance achieved staff will routinely follow the pause and check methodology
RA2110	Audit of compliance with QA testing schedule of equipment performance as Per RAD/GEN/PROC/016	The audit demonstrated that there is good compliance performing QA tests as per RAD/GEN/PROC/016 Quality Assurance Programme

Ref Number	Audit Title	Actions taken as a result of local clinical audit
RA2111	Audit of compliance with Trust procedure RAD/GEN/PROC/057 investigating suspected accidental or unintended medical exposures	Audit met target & demonstrated good compliance findings cascaded at radiology audit meeting.
RA2113	Audit of correct patient identification and documentation prior to x-ray exposure	Staff asked to make themselves familiar with best practice guidance and to always comply with this. Review of procedure RAD/GEN/PROC/012
RA2114	Audit of Collimation during x-ray exposure	Staff asked to make themselves familiar with and follow guidance as per "Pause and Check" methodology when recording patient dose.
Tertiary Services		
CAR2105	Improving the adherence to Trust Guidelines for the management of acute kidney injury on post Cardiothoracic	Ongoing education in the AKI Pathway
CAR2106	Audit of compliance with a minimum data set for transthoracic echo study in patients	Trainee education completed. Reminder on echo machine to attach ECG cables. Laminated copy of minimum dataset to echo machine. Remind trainees of need to report onto McKesson

Appendix C: Glossary of Abbreviations and Terms

Table i: Glossary of Abbreviations

Abbreviation	Meaning
SUTS	Sign up to Safety
NICE	National Institute for 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

Abbreviation	Meaning
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

Abbreviation	Meaning
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

Abbreviation	Meaning
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
COAST NACEL	Collaborative Organisational Accreditation System for Teams National Audit for Care at End of Life

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 30 days of discharge	Standardised percentage of emergency admissions to any NHS or independent sector hospital undertaking NHS commissioned activity in England occurring within 30 days of the last, previous discharge from hospital after admission.
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: NHS England » Friends and Family Test

Term	Meaning
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.
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' Statistics » National Patient and Staff Surveys (england.nhs.uk)
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: Results | Working to improve NHS staff experiences | NHS Staff Survey (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: NHS Outcomes Framework Indicators, March 2022 release - GOV.UK (www.gov.uk)

Term	Meaning
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 Statistics » Patient Reported Outcome Measures (PROMs) (england.nhs.uk)
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 Statistics » Patient Reported Outcome Measures (PROMs) (england.nhs.uk)
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

Term	Meaning
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 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

Term	Meaning
Rate of MRSA	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review); • Reports of MRSA cases includes all patients who have an MRSA positive blood culture detected in the laboratory; whether clinically significant or not, whether treated or not; • The indicator excludes specimens taken on the day of admission or on the day following the day of admission; • Specimens from admitted patients where an admission date has not been recorded or where it cannot be determined if the patient was admitted, are attributed to the Trust; 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.

Term	Meaning
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 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 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.
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.