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NHS
Bolton
NHS Foundation Trust

Bolton NHS Foundation Trust

Quality Account

2023/24

... for a better Bolton

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PART 1

Statement on the quality of services from the Chief Executive

... for a better Bolton

Statement on Quality from the Chief Executive

I am pleased to be able to share our annual Quality Account, highlighting some of the achievements, successes and challenges we have faced throughout 2023/24. This Quality Account is a summary of the standards of care we have delivered during the last 12 months, and how we plan to maintain and improve care for our service users, patients and their families.

We continue to operate under pressure, and with demand for our services being high, our focus remains on quality, performance and finance. We have reached some key milestones this year that will enable us to address some of these, over the coming months.

There are thousands of people who are waiting for treatment that will improve the quality of their lives. To reduce these waits, we opened our new £19.6m Elective Care Centre in January, and its four theatres expect to treat around 5,000 patients each year. In addition, our new Community Diagnostic Centre will provide around 80,000 diagnostic tests per year, increasing our capacity to find and treat illnesses.

We have also developed and published our five-year clinical strategy, which outlines our priorities, which will make us more effective, create a more rewarding environment for our teams and ultimately, get better results for the people we serve.

Our quality agenda has progressed at pace this year. Less patients are having avoidable falls and we have seen a reduction in category 3 and 4 pressure ulcers as a result of our quality collaboratives.

As one of the initial seven sites for NHS England's Worry and Concern Collaborative, we have trialled the Worry and Concern initiative across a surgical and a medical ward in our Trust through the utilisation of the developed illness and wellness trajectory and the rollout of Martha's Rule.

However, the age and condition of our hospital estate continues to be challenging, and just before Christmas we identified RAAC (reinforced autoclaved aerated concrete) in some parts of the hospital site, which we are working with national experts to address safely. Whilst we have done our best to avoid any negative impact, there has been some disruption caused to some of our teams. This is likely to impact our performance and the quality of care we are able to provide in some areas but every effort is being made to address it as soon as possible.

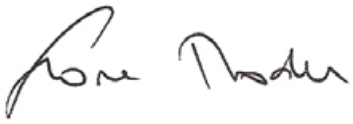
A summary of achievements from all our 2023/24 quality account improvement priorities can be found in part two of this report, in addition to a summary of our aims for our 2024/25 improvement priorities, which are as follows:

- Recognising and response to the deteriorating patient.
- Reducing Clostridium difficile infection.
- Enabling and empowering our staff through the development of quality improvement skills.

I would like to thank every single person across our organisation, who all play such a key roles in the delivery of our quality and safety agenda. I look forward to the difference we can continue to make for our patients, their relatives and carers over the next 12 months and beyond.

To the best of my knowledge, the information we have provided in this Quality Report is

accurate. I hope that this report provides you with an understanding of the focus we place and how important quality improvement, patient safety and experience are to us at Bolton NHS Foundation Trust.



Fiona Noden,
Chief Executive

Statement of directors' responsibilities in respect of the Quality Report

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.

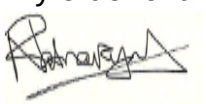
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality 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 2023/24* and supporting guidance *Detailed requirements for Quality Reports 2020/21*
- the content of the Quality Report is consistent with internal and external sources of information including:
    - board minutes and papers for the period April 2023 to (the date of this statement)
    - papers relating to quality reported to the board over the period April 2023 to (the date of this statement)
    - feedback from commissioners
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
    - the 2023 national patient survey
    - the 2023 national staff survey
    - latest CQC inspection report
- 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 Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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
27/06/2024

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PART 2

How quality initiatives are prioritised at the Trust

... for a better Bolton

How quality initiatives are prioritised in the Trust

This Quality Report identifies the progress made against the quality and safety agendas in 2023/24 and identifies the quality improvement priorities for 2024/25. Quality initiatives are chosen and prioritised based on quality, safety and experience data to ensure we focus improvement activities around greatest need and that decisions are made based on robust data.

Key quality improvement priorities for 2024/25

Following consultation with our stakeholders, we would like to highlight the following as our quality account improvement priorities for 2024/25:

1. Recognising and response to the deteriorating patient
2. C.*difficile* infection reduction - continuation from 2023/24
3. Enabling and empowering our staff through the development of quality improvement skills - continuation from 2023/24

Outline of aims and plans for the 2024/25 priorities are summarised on the following pages.

Continuous improvement of clinical quality is further incentivised through the contracting mechanisms that include quality schedules, penalties and where applicable commissioning for quality and innovation (CQUIN) payments.

Quality Performance in 2023/24:

In our Quality Account for 2022/23 we set ourselves a series of key priorities for improvement for 2023/24, these were:

- Pressure Ulcer reduction
- C.*difficile* infection reduction
- Enabling and empowering our staff through the development of quality improvement skills

Progress against each priority and next steps is summarised on the following pages.

Quality Account Improvement Priorities 2023/24

Priority 1 - Pressure Ulcer Improvement

Pressure Ulcers are a system-wide issue in Bolton, affecting not just hospital patients, but individuals in their own homes, nursing and residential care settings. Pressure ulcers are a challenge for the person who develops them and the health and social care professionals involved in their prevention and management. They can cause pain, affect a person's body image and lead to social isolation and immobility. For some people, the development of a pressure ulcer can lead to severe life limiting or life-threatening complications and treatment, such as blood poisoning, surgery/amputation, and severe disability.

The treatment of pressure ulcers is also costly and resource intensive and it estimated that treating pressure ulcers costs the NHS more than £1.4 million every day

AIM: *The overarching outcome aim is to:*

- *To reduce Hospital acquired category 2 pressure ulcers by 50% by 31/07/24*
- *To reduce Community acquired pressure ulcers by 30% by 31/07/24*
- *To eradicate category 3 and 4 pressure ulcers by 31/07/23*

***OUTCOMES**: (to 31/03/24)*

Category 2:

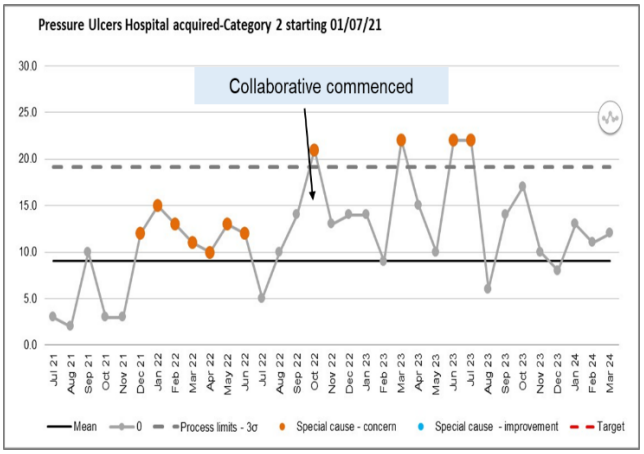
- Community acquired – special cause improvement from June 23 and lowest since March 21

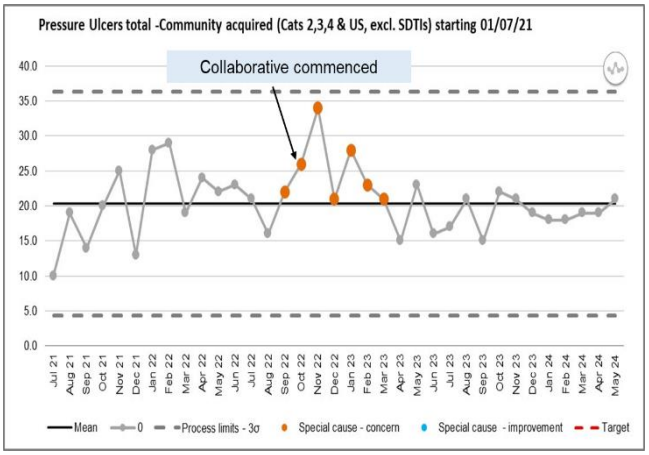
Category 3:

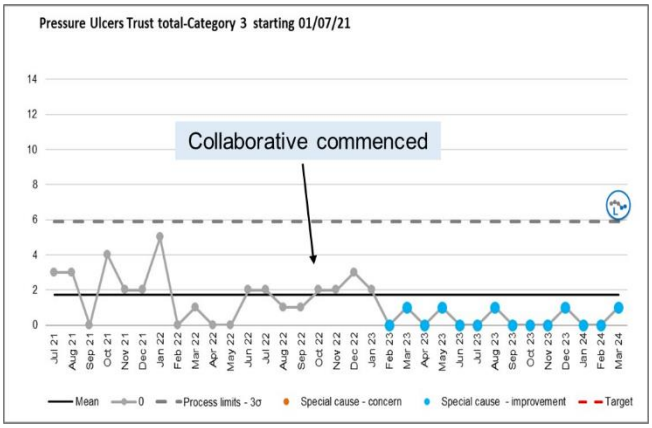
- 75% reduction in total trust acquired category 3 pressure ulcers 23/24 vs 22/23
- Community acquired sustained special cause for improvement since Mar 22, with no significant learning for 2 years plus
- Zero hospital acquired category 3 pressure ulcers for 15 months

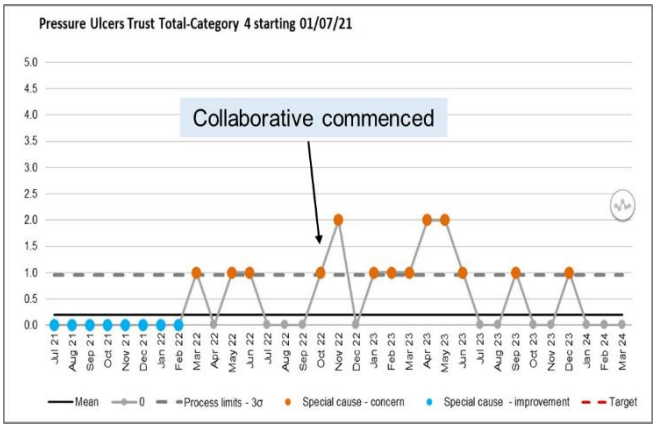
Category 4:

- Zero hospital acquired category 4 pressure ulcers for 10 months
- No significant learning following community acquired category 4 pressure ulcers for 2 years plus









No significant learning following community acquired category 4 pressure ulcers for 2 years plus

Progress to date:

We chose to run a pressure ulcer improvement collaborative for the above reasons to test and implement improvement ideas and provide the potential and opportunity to make significant improvements. The collaborative is due to conclude in July 2024, with the launch of a trust wide change package to implement these tried and tested ideas.

There are currently teams, from across health and social care participating in the collaborative, key areas of focus are summarised below:

Staff education:

- Raise awareness of pressure ulcers, encouraging early detection and reporting
- Increased pressure ulcer training from Tissue Viability Team
- Pressure relieving equipment training – focus on community pressure damage prevention
- Pocket sized PU identification guide with guidelines and escalation procedures

Equipment:

- Standardisation of equipment checks and maintenance e.g. bed pumps, mattress inflation
- Appropriate equipment for specified need e.g. NIV masks
- Increased number of community equipment prescribers
- Trial of smart mattress

Patient Information:

- Pressure Ulcer prevention and management leaflet- available in a variety of languages
- Child friendly/parental resource or the prevention of pressure damage outside of the child's routine environment.

- Moisture lesion leaflet – early intervention to prevent skin breakage.

Routine, repositioning and exercise:
- Ward routines:
    - Standardising times to reposition patients/regular turns for bed-bound patients
    - Standardising the time for nutritional support - food first/ hydration approach
    - Daily skin checks
    - Body map Tuesdays
- Patient education and exercise programme - a simple bed-based exercise programme for patients with reduced mobility or bed bound.

Skin care:
- Bed bound/Critical Care patient – Use of incontinence products and skin care products are appropriate.

Documentation:
- Use of Purpose T risk assessment in all patients facing areas for initial assessment (not just nursing based) - e.g. therapies, homeless and vulnerable adults. Treatment rooms, admission avoidance.
- Standard admission documentation standards (checklists), body map completion on admission and timely skin checks
- AHP use of body map and onward DN referrals

Data analysis:
- Use of measurement for improvement methodology e.g. SPC (Statistical Process Control) charts
- Development of interactive pressure ulcer dashboard

National guidance and learning from pressure ulcers:
- Implementation of recommendations from the National Wound Care Strategy
- Learning from pressure ulcers, in line with PSIRF principles - testing and introduction of Swarm Huddles (immediate learning on detection of pressure damage)

Next Steps:
The Pressure Ulcer Collaborative is due to conclude in Summer 2024, from which a change package of successful improvement ideas will be launched and implemented in the wider organisation to become business as usual.

Reporting our progress:
All our improvement projects and workstreams follow an established governance structure, which monitors and measures performance and progress

The forums and governance committees which will continue to provide progress, oversight and accountability for pressure ulcer improvements are below:

- Pressure Ulcer Faculty
- Divisional Governance meetings
- Divisional and Trust IPM
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Priority 2 - Clostridium Difficile Infection Reduction
Clostridium difficile (also known as “C. difficile” or “C. *diff*”) is a bacterium that can be found in

people's intestines (their "digestive tract" or "gut"). However, it does not cause disease by its presence alone; It can be found in healthy people, about 3% of adults and two-thirds of babies with no symptoms. It causes disease when the normal bacteria in the gut, with which C. difficile competes, are disadvantaged, usually by someone taking antibiotics, allowing the C. difficile to grow to unusually high levels. This allows the toxin they produce to reach levels where it attacks the intestine and causes symptoms of disease.

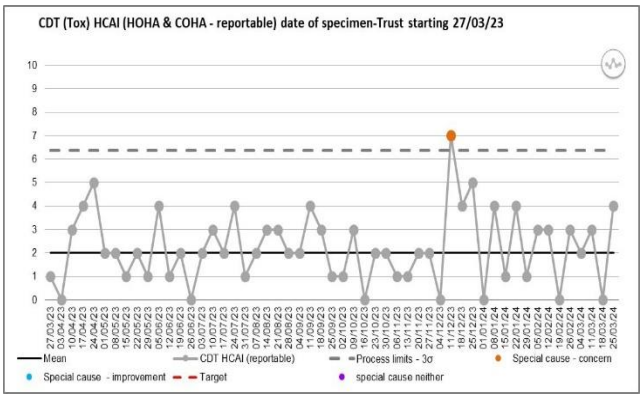
Bolton has a high rate of Healthcare Associated C.*diff* cases. Thematic review of C.*diff* cases highlighted common themes of delays to stool sampling, delays to isolation once a C.*diff* case has been confirmed, poor documentation of the detection and management of C.*diff* and fundamental standards in terms of hand hygiene and the ward environment.

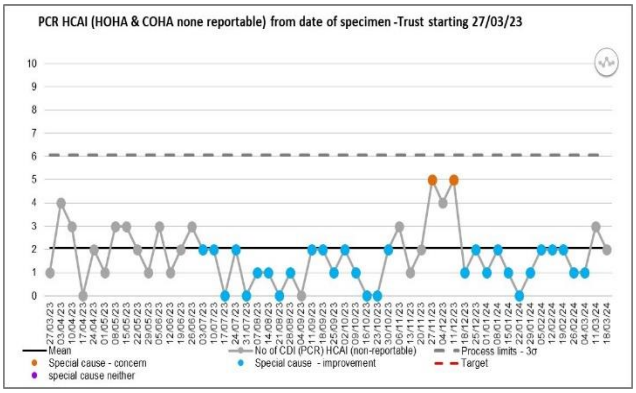
AIM: *The overarching outcome aim is to:*

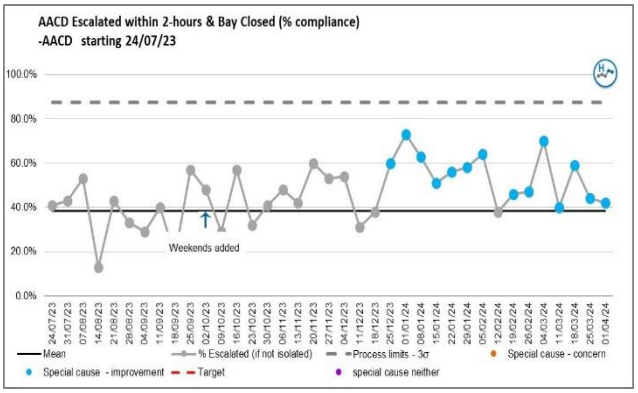
Reduce Healthcare associated C.*diff* Toxin (CDT) positive cases by 33% by 30/06/24, with a sustained reduction to the Greater Manchester peer mean (50%) by 31/12/2024

***OUTCOMES**: (to 31/03/24)*

- Seven less CDT cases in 23/24 compared with 22/23
- PCR (C.*diff* present but not producing toxins)- special cause improvement 18/12/2023 – 04/03/24
- Escalation within 2 hours of loose stool and bay closed – Acute Adult Division – special cause improvement since December 23







Progress to date

A C.*diff* improvement collaborative was launched in May 2023; iinitial stages of the collaborative focused on:

Staff awareness:

- Dispelling myths and increasing staff education and awareness around C.*diff*
- Trust protocols regarding appropriate management

Data analysis

- Use of measurement for improvement methodology e.g. SPC charts
- Stratification of data to understand causes of C.*diff*
- Thematic review of C.*diff* RCAs

From this we focussed on the following main drivers:

Ward based routines – for the prevention and early detection of C.diff

- Isolation
- Escalation
- Timely sampling
- Use of bowel habit chart

Antibiotic Stewardship:

- Antimicrobial prescribing dashboard:
- Data on key standards to drive improvements in safe and appropriate antimicrobial use
- Antibiotic Review Kit (ARK)
- Aim to improve the proportion of antimicrobials stopped as soon as possible

EPR/IPC documentation:

- Working through enhancements to electronic documentation that will assist nursing staff in documentation, removing duplication and created a trigger for when sampling is required

Environment:

- Rapid red clean post C.*diff* infection detection – standard work how to request and prepare for “Red” clean.
- Visual management of “Red” clean status in flow office to assist with flow and bed management following closure
- Testing of alternative cleaning methods e.g., UV

Learning from C.*diff*

- Two step Swarm huddle approach

Next Steps:

C.*diff* improvement will continue to be a Quality Account priority for 2024/25, with two more learning sessions to take place, the outcomes of which will create a change package to be implemented in the wider organisation.

Reporting our progress:

All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress. The forums and governance committees which will provide progress, oversight, and accountability for C.*diff* reduction are summarised below:

- C.*diff* Collaborative Faculty
- Divisional Governance meetings
- Divisional and Trust IPM
- Infection Prevention Control Committee
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Priority 3 - Enabling and empowering our staff through the development of quality improvement skills and knowledge

Bolton NHS Foundation Trust has made a commitment to using quality improvement as THE method for all improvement and as a result are investing in our workforce, so our experts (our staff) are empowered and equipped with the knowledge, skills, and permission to create tangible and sustained improvements in their area of work. That is why we have focused this quality account on improving staff knowledge on the fundamentals of QI

AIM: *The aim for year one was to:*
25%* increase in Bolton NHS Foundation Trust Staff who have an awareness of the fundamentals of Quality Improvement by 31/03/24 (baseline – those accessed any QI training in 21/22 and 22/23 N=100)
***OUTCOMES**: (to 31/03/24)*
142% increase on baseline 242 staff members completed QI Fundamentals in 23/24

Progress to date:
The key drivers and interventions for 2023/24 are summarised below:

Establishing the vision:

- Development of QI Plan with stakeholder engagement
- Development of QI infrastructure – central team of QI expertise to support the organisation

QI Skills learning and development academy

- Development and delivery of Level 1 - QI Fundamentals
- Launch of QI coaching clinics
- QI incorporated into leadership programmes and departmental development

Incorporating QI into operational delivery

- Trust/system wide improvement collaboratives e.g. pressure ulcers and C.*diff*
- BoSCA
  - White to Silver – QI test of change with QI Team support
  - Gold Teams – QI project up to 12 months

Establishing the standards

- Utilisation of trust system to track QI engagement – ESR
- QI workbook/templates - e.g. driver diagrams

- Registering your improvement project mechanism

QI Comms and Engagement

- Development of QI comms and engagement plan
- Social media promotion and networking
- Internal electronic promotion, media and resources – intranet, team brief, staff bulletin

Working with our partners/horizon scanning

- National and local changes and strategies in relation to QI

Next Steps:

Quality Improvement capability building will continue to be a Quality Account priority for 2024/25. We will continue to deliver the QI support as established in year one, but will also build and strengthen our offering, summarised by the following:

AIM:
• 30% increase in staff trained in the fundamentals of QI • 30% of those trained in to run their own improvement project

Vision:

Launch of QI Plan 2024 – 2028

QI Skills learning and development academy

- Development and launch of Quality Improvement Practitioner - “Managing your improvement Project”
- QI Fundamentals – alternative methods of delivery
- Focus on our future workforce – QI for Doctors in training and student nurses/midwives etc.
- QI offering, or signposting at Trust Induction

Incorporating QI into operational delivery

- Improvement collaboratives e.g. Recognising and response to the deteriorating patient (see next page)
- Urgent Care – using QI methodology on length of stay improvements
- Environmental standards – testing the use of 5S
- BoSCA – Platinum accreditation

Share and learn and celebrate:

- Central library of QI activities past and present, with electronic case studies
- QI showcase events to celebrate and share learning

Reporting our progress:

All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress

The forums and governance committees which will provide progress, oversight and accountability for Enabling and empowering our staff through the development of quality improvement skills are summarised below:

- Clinical Governance and Quality Committee
- Quality Assurance Committee

Quality Account Improvement Priorities 2024/25

We have chosen to extend the following priorities into a second year (see previous pages for progress and plans for 2024/25.

- **Priority 1** - C.*difficile* infection reduction
- **Priority 2** - Enabling and empowering our staff through the development of quality improvement skills

The new Quality Account improvement priority for 2024/25 will be:

Priority 3 - Recognising and response to the deteriorating patient

A deteriorating patient refers to an individual whose medical condition is worsening or declining. This can occur in a variety of health care settings and manifests through worsening vital signs, increasing symptoms and length of stay, a decline in overall health or even cardiac arrest and in some cases death. Timely recognition and appropriate intervention are crucial to prevent further deterioration and ensure that the patient receives appropriate care.

We have recently brought together workstreams focusing on Sepsis, National Early Warning Score (NEWS) and deterioration into one Recognition and Management of Deterioration Group, which will mirror work at system level by the ICB Deterioration Group. The key drivers the group will focus on include the following:

Sepsis and NEWS:
- Revision of trust policy in line with new NICE Sepsis guidelines
- Implementation of new policy to drive practice – ward-based tests of change
- Fundamentals of care, reliability in patient observations and when to escalate

Worry and concern
- Identify and test a wellness trajectory system to identify deterioration and prompt appropriate response
- Providing a method by which patients, families or carers can directly escalate a patient for critical care review (which is now known as Martha's Rule)

Recognition of deterioration when a person is reaching the end of their lives
Importance of recognising deterioration to implement timely palliative care for those in whom this worsening of their condition indicates they are reaching the end of their lives

This is as important as recognising deterioration that requires escalation for intervention. We can improve patients' comfort when they are dying. Earlier recognition will facilitate that.

Staff awareness and education
- Roles and responsibilities guidance - clear processes and structures to ensure staff are aware of the appropriate responses expected of them.

- Deteriorating patient education offer:
    - Foundation doctors training programme
    - Acute Illness Management (AIM) training programme
    - Sepsis Study Days
    - Sepsis E-learning Sepsis Link Nurses

Technology and innovation

- Redevelopment of EPR (Electronic Patient Record) - to ensure easier workflows and visual triggers for responding to deterioration
- Data dashboard – knowing our performance at a glance

Patient Safety Improvement Collaborative:

As improvements in recognising and responding to the deteriorating patient are complex, multi-disciplinary and across the trust –we have decided to focus our next improvement collaborative on this topic. It will run similarly to the C.*diff* and pressure ulcer collaboratives, however, due to the nature and complexities is likely to be longer in duration will a phase approach to testing and implementing change ideas. We are currently scoping the collaborative and will aim to launch in Q3 24/25.

Measuring our impact:

There are several metrics we will track and analysis to understand performance and highlight areas to focus on, example of which are below:

- Avoidable cardiac arrests
- Sepsis screening and treatment
- Completion of observations as per schedule
- Escalation of elevated NEWS and/or sepsis screening as per protocol
- Thematic analysis of incidents
- Learning from deaths
- Training uptake

Reporting our progress:

All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress

The forums and governance committees which will provide progress, oversight and accountability for recognising and response to the deteriorating patient are summarised below:

- Deteriorating Patient Group
- Mortality Reduction Group
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Statement of assurance from the board

Review of services

During 2023/24 Bolton NHS Foundation Trust provided and/or sub-contracted 13 relevant health services. (as defined by the CQC) across 41 specialties.

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

The income generated by the relevant health services reviewed in 2023/24 represents 100 % of the total income generated from the provision of relevant health services by the Bolton NHS Foundation Trust for 2023/24.

Participation in Clinical Audits and Research Activity

The NHS published a list of 88 Quality Accounts (*of which several fall under the same programme of work) in 2023/24.

During that period, Bolton NHS Foundation Trust participated in 56 out of 59 (95%) national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries, which it was eligible to participate in.

The Trust did not participate in the following audits:

Not Applicable

- Mental Health Clinical Outcome Review Programme
- Muscle Invasive bladder cancer
- Cleft Registry and Audit NEtwork (CRANE)
- National Audit of Cardiovascular Disease Prevention
- National Audit of Pulmonary Hypertension
- National Bariatric Surgery Registry
- National Congenital Heart Disease Audit
- National Audit Cardiac Surgery
- National Clinical Audit of Psychosis
- National Obesity Audit
- Neurosurgical National Audit Programme
- Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry
- Prescribing Observatory for Mental Health
- UK Cystic Fibrosis Registry
- National Audit of Percutaneous Coronary Intervention
- Paediatric Intensive Care Audit (PICANet)
- Adult Respiratory Support Audit
- UK Renal Registry Chronic Kidney Disease Audit
- Child Health Clinical Outcome Review Programme - Juvenile Idiopathic Arthritis
- National Audit of Care at the End of Life (NACEL) – Pilot only
- National Audit of Dementia - *Memory Services Spotlight Audit* (not to be confused with the *Care in General Hospitals Audit* which the Trust does participate in)

Did not participate

- Fracture Liaison Service Database
- National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standard QS138
- British Hernia Society Registry

The national clinical audits and national confidential enquiries that Bolton NHS Foundation Trust did participate in during 2023/24 are as follows:

	Project Name	Additional Information/Individual Studies/Data Range	No. of cases submitted
1	BAUS Urology Audits	BAUS Nephrostomy Audit - October-November 23.	5
2	Breast and Cosmetic Implant Registry	2023/24	10
3	Case Mix Programme (CMP)	Apr - Sept 2023	287
4	Child Health Clinical Outcome Review Programme	Testicular torsion	100%
5	Elective Surgery (National PROMs Programme)	Absolute numbers of scanned questionnaires by procedure: Hip Knee	 140 135
6	Emergency Medicine QIPs	Care of Older People	87
7		Mental Health (Self-Harm)	299
8	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls (NAIF)	2
9		National Hip Fracture Database (NHFD) (Jan-Jun23)	230
10	IBD Registry	Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	88
11	Kidney Audits	UK Renal Registry National Acute Kidney Injury Audit 2023 Q1-Q4. Stage1 Stage2 Stage3	 3143 581 361
12	Learning disability and autism Programme	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	14
13	Maternal, Newborn and Infant Clinical Outcome Review Programme *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MNI-CORP: MBRRACE-UK)*	Late fetal loss: Stillbirth: Early neonatal deaths: Late neonatal deaths: Post neonatal deaths:	2 23 13 1 0
14	Medical and Surgical Clinical Outcome Review Programme	Community Acquired Pneumonia	3/8 Questionnaires 1/1 Org. Proforma
15		End of Life Care	5/5 Questionnaires 1/1 Org. Proforma
16		Endometriosis	4/6 Questionnaires 0/1 Org. Proforma
17		Epilepsy	6/6 Questionnaires 1/1 Org. Proforma
18	National Adult Diabetes Audit (NDA)	National Core Diabetes Audit Type 1 Type 2	 265 860

19		National Diabetes Footcare Audit (NDFA)	Jan 23-Dec 23
20		National Diabetes Inpatient Safety Audit (NDISA)	100%
21		National Pregnancy in Diabetes Audit (NPID)	53
22	National Respiratory Audit Programme (NRAP)	Adult Asthma Secondary Care	130
23		COPD Secondary Care	447
24		Children and young people Asthma	224
25		Pulmonary Rehabilitation	66
26	National Audit of Cardiac Rehabilitation	Starting core rehabilitation Rehabilitation assessment 1 Rehabilitation assessment 2	184 138 125
27	National Audit of Dementia	Care in General Hospitals	52
28	National Cancer Audit Collaborating Centre	National Audit of Metastatic Breast Cancer	8
29		National Audit of Primary Breast Cancer	199
30	National Cardiac Arrest Audit (NCAA)		49
31	National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	37
32		National Audit of Cardiac Rhythm Management (CRM)	364
33		National Heart Failure Audit	276
34	National Child Mortality Database (NCMD) Programme	*NCMD is not a clinical audit even though it has been commissioned by HQIP. NCMD is a database that collects information from Child Death Overview Panels (CDOPs) in England. The information that must be submitted to NCMD is all entered by the Child Death Overview Panels (CDOPs) from the information they have collected from the various agencies that have been involved with the child. NHS Trusts do not have to enter any data into it.*	Not required
35	National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Cohort 5 (closed 14 Jan 2024) Cohort 6 (ongoing until 14 Jan 2025)	67 45
36	National Comparative Audit of Blood Transfusion	Currently submitting data to be completed within deadline 28th April 2024	10 patients
37	National Early Inflammatory Arthritis Audit (NEIAA)		17
38	National Emergency Laparotomy Audit (NELA)	Cases Locked 01/04/2023 - 31/3/2024	138 (27/02/2024)
39	National Gastro-Intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit (NBOCA) Apr 23 - Mar 24	226
40		National Oesophago-Gastric Cancer Audit (NOGCA) Apr 22 - Mar 23	74
41	National Joint Registry	2023	486

42	National Lung Cancer Audit (NLCA)	2022	98.3%
43	National Maternity and Perinatal Audit (NMPA)	Total births (Maternity Services dataset): Total bookings (Maternity Services dataset):	3810 3900
44	National Neonatal Audit Programme (NNAP)	Babies: Mothers:	133 130
45	National Ophthalmology Database Audit (NOD)	National Cataract Audit Apr - Mar	1810
46	National Paediatric Diabetes Audit (NPDA)	*(Final date for data submission for Quality Accounts 2023-24 is: 24 May 2024)*	143
47	National Prostate Cancer Audit (NPCA)	2023 Report covering 1st April 2021 and 31st March 2022	181
48	National Vascular Registry (NVR)	01/04/2022 - 06/02/2024	10
49	Perinatal Mortality Review Tool (PMRT)		39
50	Perioperative Quality Improvement Programme (PQIP)	number of patients recruited to PQIP per week. Jan23 - Feb24	61
51	Sentinel Stroke National Audit Programme (SSNAP)	*(Apr-Jun 2023 & Jun-Sep 2023 total only. Total cases submitted since Sep 2023 are not yet available from SSNAP)*	135
52	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Jan-Dec 23	32
53	Society for Acute Medicine Benchmarking Audit (SAMBA)	Winter SAMBA24	75

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
List applicable NCEPOD Studies and status

End of Life Care
Publication date: Autumn 2024

	Requested	Submitted
Case notes	6	6
Organisation Proforma	1	1
Clinical Questionnaire	6	6

Endometriosis
Publication date: Autumn 2024

	Requested	**Submitted**
Case notes	6	6
Organisational Proforma	1	0
Clinical Questionnaire	6	4

Note: Juvenile Idiopathic Arthritis is not applicable to Bolton Hospital NHS Foundation Trust

Epilepsy
Publication date: Autumn 2024

	Requested	**Submitted**
Case notes	6	6
Organisational Proforma	1	1
Clinical Questionnaire	6	6

Maternal, Newborn and Infant Programme (managed by MBRRACE UK)

The results concern stillbirths and neonatal deaths among the 5,486 babies born within Bolton Hospital NHS Foundation Trust in 2022, EXCLUDING births before 24 weeks' gestational age and all terminations of pregnancy. Neonatal deaths are reported by place of birth irrespective of where death occurred.

Type of death	Number	Crude rate	Stabilised and adjusted rate	Comparison to the average for similar Trusts & Health Boards
Stillbirth	23	3.28	3.59	3.61
Neonatal death	18	2.56	2.12	1.82
Extended perinatal	37	5.83	5.73	5.42

During the 2023-24 Quality Accounts, MBRRACE-UK published seven individual reports:

- **Perinatal Mortality Surveillance:** *UK Perinatal Deaths for Births from January to December 2021. - State of the Nation* [published September 2023]
- **Saving Lives, Improving Mothers' Care State of the Nation Surveillance report:** *surveillance findings from the UK Confidential Enquiries into Maternal Deaths 2019-21.* [published October 2023]
- **Saving Lives, Improving Mothers' Care State of the Nation Themed report:** *lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-21.* [published October 2023]
- **Saving Lives, Improving Mothers' Care State of the Nation Themed report:** *on the lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth.* [published October 2023]
- **Perinatal confidential enquiry report:** *Comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death* [published January 2024]
- **Perinatal confidential enquiry report:** *Comparison of the care of Black and White women who have experienced a stillbirth or neonatal death* [published January 2024]
- **Perinatal Mortality Review Tool (PMRT) Fifth Annual Report:** *Learning from Standardised Reviews when Babies Die* [published February 2024]

In accordance with funder requirements, the findings of the MBRRACE-UK Confidential Enquiry into Maternal Deaths and Morbidity (CEMD) are now presented as multiple outputs instead of one report as produced previously.

The reports, and the recommendations contained within, were forwarded with a gap analysis to the relevant members of staff for completion, to identify the Trust's current compliance with MBRRACE-UK's national recommendations. The recommendations are recorded on the Safeguard system as actions, and these monitored through the Family Care Divisional Governance Board Committee. A summary of the recent recommendations and actions from the maternal death & perinatal documents has been received.

Below is a list of recommendations that remain non-compliant or partially compliant, and which national report/guidance they were taken from. These recommendations can also be found in the 'Existing Recommendations' section of the latest MBRRACE national reports.

Report: *Lessons learned to inform maternity care from the UK and Ireland Confidential*

Enquiries into Maternal Deaths and Morbidity 2016-18 [December 2020]

- Produce guidance on which beside tests should be used for assessment of coagulation and the required training to perform and interpret those tests [non-compliant]
- Ensure that the response to obstetric haemorrhage is tailored to the proportionate blood loss as a percentage of circulating blood volume based on a woman's body weight [partially compliant]

Report: *Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012* [December 2014]

- Repeated presentation to the general practitioner or community midwife or alternatively repeated self-referral to the obstetric triage or day assessment unit should be considered a 'red flag' and warrant a thorough assessment of woman to investigate for signs of sepsis [partially compliant]

Report: *NICE Clinical Guideline CG110- Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors* [September 2010]

- To facilitate discussion of sensitive issues, provide each woman with a one-to-one consultation, without her partner, a family member, or legal guardian present, on at least one occasion [partially compliant]

Report: *FSRH Guideline – Contraception after Pregnancy* [January 2017]

- Services providing care to pregnant women should be able to offer all appropriate methods of contraception, including Long-Acting Reversible Contraception (LARC), to women before they are discharged from the service [non-compliant]

Report: *NICE Guideline NG128- Stroke and transient ischaemic attack in over 16s: diagnosis and initial management [May 2019, updated 2022]* - Use a validated tool, such as FAST (Face Arm Speech Test), outside hospital to screen people with sudden onset of neurological symptoms for a diagnosis of stroke or transient ischaemic attack (TIA) [non-compliant]

There were **30** deaths of babies born within our organization between 01 Apr 2023 and 11 Feb 2024. A breakdown of the details of these deaths is below:

Type of death:

- Late fetal loss: 1
- Stillbirth: 19
- Neonatal death: 10

Timing of death:

- Antepartum stillbirth: 17
- Intrapartum stillbirth: 1
- Stillbirth of unknown timing: 2
- Early neonatal death: 9
- Late neonatal death: 1

Gestational age (weeks):

- 20-21: 1
- 22-23: 7
- 24-27: 10
- 28-31: 2
- 32-36: 6
- 37-41: 4
- >=42: 0

Mother's age at delivery (years)

- <20: 1
- 20-24: 9
- 25-29: 5
- 30-34: 10
- 35-39: 1
- >=40: 4

Mother's ethnicity:

- White: 14
- Asian or Asian British: 7
- Black or Black British: 7
- Mixed: 0
- Other: 1
- Missing or declined: 1

The BAME confidential enquiry documents have not yet been reviewed, as they were only recently published by MBRRACE-UK in January 2024, and the gap analysis is within the 3-month deadline for completion. The gap analysis is due for completion by 15th April 2024.

The MBBRACE-UK perinatal confidential enquiry reviewed the care of 34 Asian women (3 Asian Bangladeshi, 10 Asian Indian, 18 Asian Pakistani and three Asian Other (one Syrian, one Iranian and one Kurdish (Iraq)) and 35 White women (including four Eastern European).

Key findings:

• There was variation and inconsistency in the recording of ethnicity, nationality and citizenship status.
• Identifying and responding to language needs are inadequate across all ethnic groups.
• Inconsistent use of independent interpretation services was noted for all women who required it, with inappropriate use of family members and healthcare professionals.
• Social risk factors were recorded as being present less for the Asian women, with evidence of inconsistent identification and referral across both groups.
• Access to care and engagement (late booking, number and follow-up of non-attendance) was similar between Asian and White women. However, more Asian women declined routine combined screening.
• There was a lack of personalized care, which was both kind and compassionate.

The MBRRACE-UK perinatal confidential enquiry also reviewed the care of 36 Black women (22 Black African, 11 Black Caribbean and three Black Other women) and 35 White women (including four Eastern European women).

Key findings:

• There was variation and inconsistency in the recording of ethnicity, nationality and citizenship status
• Identifying and responding to language needs are inadequate across all ethnic groups
• Inconsistent use of independent interpretation services was noted for all women who needed it, with inappropriate use of family members and healthcare professionals
• Access to care and engagement (late booking, acceptance of routine combined screening and follow up of non-attendance at appointments) was similar between Black and White women
• Compared with White women, fewer Black women had evidence of routine mental health questions being asked. Few women in either the Black or the White groups were asked routine mental health questions in the postnatal period.

• Black women were more likely to experience barriers to accessing specific aspects of care or advice that were offered which resulted in some women not taking prescribed medicines, taking their own discharge against advice, and not attending specialist appointments.
• Many complex social risk factors were not recorded systematically. However, they were more commonly identified in White women.
• There was a lack of personalized care, which was both kind and compassionate.

National Clinical Audits: Actions to Improve

The reports of 34 national clinical audits were reviewed by the provider in 2023/24 and Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit title	Learning/Actions
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **- Children and young people asthma combined clinical and organisational audit**	• Working towards ARTP compliant spirometers, issues with IT compatibility, requirements. Currently one working spirometer - need to obtain Vitalograph calibration syringe to ensure working to national standards • Diagnosis of asthma in children is complex – aim to use spirometry to aid this. Already have FeNO available. Training staff to perform spirometry, to ARTP standard • Respiratory nurse specialist trained in the care of children and young people with asthma: need to liaise with Community based Respiratory nurse team - more specialist nurses/additional training for reactive nursing team • Ensuring people admitted with an exacerbation of asthma are reviewed by a respiratory specialist within 24 hours, 7 days a week: Aim to improve local inpatient management review of asthma - this will contribute to improved long term outcomes • Recording smoking status for all children and young people (>11 years) admitted to hospital with an asthma attack: QI project focused t this and recording across all of paediatrics with a plan to improve smoking cessation advice and support (both Trust wide and Bolton wide)
National Asthma and COPDAudit Programme (NACAP) **- Adult Asthma & COPD** **- Pulmonary Rehabilitation Audit**	There are no open actions from the latest Asthma & COPD national report, all applicable recommendations are compliant. • Pulmonary Rehab - currently not meeting waiting time targets - cleanse waiting list and increase assessment/class capacity. • Only centre based rehabilitation due to current staffing resource. Plans to offer home-based rehab option. Once staffing resources are available we will ensure that current evidence-based guidelines are followed.
Falls and Fragility Fracture Audit Programme (FFFAP)	The 2023 National Audit of Inpatient Falls report on 2022 clinical data, following recommendations: • Use own data to inform the focus of local improvement activities. • To focus initiatives to improve the quality of MFRA. • Delirium assessment completed on admission and monitored. • Staff are competent in post-falls checks • Patients who sustain a hip fracture in hospital are given analgesia within 30 minutes of falling.

National Pregnancy in Diabetes Audit	• Pregnancy outcomes for women (and babies) have improved in type 1 diabetes. Widening gaps in care and more serious adverse pregnancy outcomes for women in early-onset type 2 diabetes • Pre-pregnancy care is particularly inadequate in women with early-onset type 2 diabetes, and those from deprived groups and ethnic minorities
National Emergency Laparotomy Audit (NELA)	The 2023 Report made the following recommendations • NELA leads for radiology appointed in each department, with specific job planned time to coordinate MDT review and radiology events and learning meetings • Conclusions should be shared where applicable with providers of outsourced reporting services. • MDT in emergency, surgical, perioperative, acute and critical care should create local optimised pathways to streamline diagnosis • Clinical and managerial teams to work together to identify gaps in antibiotic administration standards • Establish local pathways for administration of antibiotics preoperatively for those with suspected intra-abdominal infection or sepsis, following guidance from the Academy of Medical Royal Colleges and the Surviving Sepsis Campaign. • Clinical/nursing teams ensure that locally agreed pathways support the administration of antibiotics, without delay • Surgeons, anaesthetists and intensivists ensure a formal assessment of mortality risk is performed at time of decision to operate, taking into account the significant impact of frailty. • Clinical teams to refer a high-risk patient for postoperative monitoring in critical care, even if not currently critically ill. • Trusts/health boards should ensure critical care capacity meets demand. critical care capacity shortfall should be reviewed as part of departmental and hospital-level clinical governance. • Formal assessment of frailty performed for all patients >65 • Surgeons, anaesthetists and intensivists ensure frailty taken into account when assessing the mortality risk of their patients as the NELA risk score does not take frailty into account. • Trusts/health boards work towards improving capacity for experts in elderly care to review all elderly, frail and vulnerable patients postoperatively.
National Gastro-intestinal Cancer Programme	The 2023 Report recommendations: • Review patients with stage 4 disease to identify opportunities for earlier detection • Review patients diagnosed after emergency admission and undertake root cause analysis to identify opportunities to reduce rates of emergency diagnosis. • Review the oesophago-gastric cancer care pathway and identify ways to reduce patients waiting >104 days from referral to first treatment. • In regions with high rates of surveillance or non-treatment, review if patients with high grade dysplasia are being considered for endoscopic treatment, in line with current BSG recommendations. • Review data collection practices for NOGCA and improve case ascertainment in regions where this is low.
National Audit of Cardiac Rehabilitation (NACR)	• There are no outstanding actions for this national audit. • Data entry responsibility to be moved to the Clinical Audit & Effectiveness Team

National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	The Trust is fully compliant with all recommendations from the latest Epilepsy12 national report.
National Bowel Cancer Audit (NBOCA)	The following recommendations were made in 2023 report • Ensure everyone with bowel cancer has access to a clinical nurse specialist (CNS)
National Cardiac Audit Programme (N**CAP) -Myocardial Ischaemia National Audit Project (MINAP)**	• Hospitals not sufficiently admitting heart attack patients to a cardiac ward should review systems and bed allocations to maximise access to cardiac care. This may require use of dedicated multi-specialty `high care' beds and provision of cardiac outreach services to those cared for elsewhere: ED Pressures results in long ED waits so impacts on flow to wards. Trying to pull through patients to C1 and CCU using on call cardiologist to prioritise • Redesign MINAP audit form, investigate use of EPR in data collection. Long term consider business case for staffing resource to be added to job plans of team
National Cardiac Audit Programme (NCAP) -National Heart Failure Audit (HF)	• PARTIAL COMPLIANCE- inpatient echocardiography for patients with acute HF review clinical pathway and ensure that Echo is performed, within the first 48 hrs. of admission - New Cardiac Physiologist in post Nov 2023 to try and echo before discharge high compliance. • PARTIAL COMPLIANCE - Patients referred for Cardiology & Specialist HF Nurse follow-up, discharged with an appointment. Hospitals should review their pathways for referral to cardiac rehabilitation to allow greater access and uptake for HF patients - Due to Maternity post discharge appointments not within 2 weeks so no dates given on discharge. Will resolve when staff return.
National Cardiac Audit Programme (NCAP) -National Audit of Cardiac Rhythm Management (CRM)	The National Audit of Cardiac Rhythm Management 2023 summary report published September 2023 with four recommendations. Gap Analysis received, and the Trust is compliant with all the report's recommendations.
National Lung Cancer Audit (NLCA)	The 2024 report made the following recommendations • Ensure people aged 55-74 at high risk of lung cancer are having targeted lung health checks • Ensure hospitals can perform surgery for patients with early-stage NSCLC. • Improve time from diagnosis to treatment of lung cancer. • Ensure 70% of applicable people with advanced stage non-small cell lung cancer systemic anti-cancer therapy. • Make sure that vital information is recorded for patients with lung cancer
National Maternity and Perinatal Audit	The Trust is fully compliant with all recommendations from the latest NMPA report.
National Neonatal Audit Programme (NNAP)	National Neonatal Audit Programme Summary report on 2022 data published in October 2023, the recommendations are related to: • Outcomes of neonatal care • Optimal perinatal care • Parental partnership in care • Neonatal nurse staffing Gap analysis received confirming partial compliance:

	Actions added to Safeguard as per completed gap analysis, with review dates for 30/06/2024.
National Ophthalmology Database (NOD)	Review patient pathways to maximise the recording of both preoperative and postoperative VA data for every operation
National Paediatric Diabetes Audit (NPDA)	National Paediatric Diabetes Audit Admissions report, the Trust is compliant with all recommendations except: • "Should be aware of the different case mix managed by their paediatric diabetes teams across their respective areas and recognise where higher proportions of children and young people with certain demographics (adolescence, non-white ethnicity, female sex, and living in a deprived area) are associated with higher rates of admission" • Current practice: The Paediatric Diabetes service is aware of significant health inequalities within the region The team are planning work to address inequalities, including technology access, and have raised the issue as a risk (ref 5868) • Review of service underway and business case is in draft
National Prostate Cancer Audit (NPCA)	The 2023 report made the following recommendations • Investigate why men with high-risk/locally advanced disease are not considered for radical treatment and aim for 75% offered radical treatment • Review variation between providers in rate of GU/GI complications and 90-day readmission rates • Cancer Alliances should review processes of care to ensure equitable implementation of innovative technologies and pathways of care as evidence evolves
National Vascular Registry (NVR)	• Patients with chronic limb threatening Ischaemia (CLTI) receive care as recommended in the VSGBI Quality Improvement Frameworks (QIF) for peripheral arterial disease and are treated with sufficient urgency • Patients who have major lower limb amputation receive care as recommended in the VSGBI Quality Improvement Framework (QIF) and avoid prolonged delays to surgery after vascular assessment. Below knee amputation should be performed whenever appropriate. • Pathways for patients with aortic aneurysms avoid undue delays, aim to meet recommended 8-week standard for elective repair of abdominal aortic aneurysms (AAA) • Timely referral/expedited surgery for symptomatic carotid disease and reduce waiting times to carotid endarterectomy (CEA)
Perinatal Mortality Surveillance Report (PMSR)	PMRT national report has been published Feb 2024, recommendations from the report below, • Evaluate parent engagement, ensure staff are trained and use the PMRT Parent Engagement materials, particularly in trusts and health boards where fewer parents are engaged with the review process • Provide adequate resourcing of PMRT review teams, including administrative support • Provide adequate resources to ensure the involvement of independent external professionals in review teams • Use local PMRT summary reports the national report to prioritise resources for key aspects of care and quality improvement activities identified • Improve service quality improvement activities implemented because of reviews by developing ‘strong’ actions targeted at system level changes and audit their implementation and impact

Sentinel Stroke National Audit Programme (SSNAP)	SSNAP Annual Report 2023 (care received in 22/23 2022) National recommendations: • Reverse the decline in hyperacute specialist access for stroke. • Increase the proportion of patients receiving the appropriate imaging immediately on arrival at hospital, to accelerate the identification of patients eligible for reperfusion treatments. • Increase the proportion of days on which people recovering from stroke receive rehabilitation therapy, both inside and outside hospital. • Increase the proportion of patients accessing stroke/neuro ESD and/or CRT. • Reverse the decline in the proportion of stroke survivors who receive formal follow-up 6 months after their stroke.
Inflammatory Bowel Disease National Clinical Audit Project	• The IBD Registry has been the representing organisations for IBD on the annual NHS England Quality Accounts programme since 2018. this will be withdrawn from April 2024 • The IBD Registry has completed 2023 data collection
National Audit of Dementia (NAD)	NAD published the national report for Round 5 of the audit, following recommendations: • Monitoring of Tier two education and identification of people living with Dementia - Compliant • Use of Bolton pain assessment tool used - Not compliant, • An action plan is already in place following the Outlier report drafted in response to Bolton's underperformance in Round 5 and extensive work is ongoing to achieve compliant status for Round 6 • The second recommendation will remain open until the Royal College of Psychiatrists analyses Bolton's performance in Round 6 and provides results. Currently awaiting Round 6 of the National Audit of Dementia to determine if Bolton remains an outlier - assurance the 4AT (not mandatory at the time of Round 6) is now a mandatory field on EPR. The SQUID for Bolton was not developed during round 5 or 6; this will be operational ahead of Round 7.
Diabetes Inpatient Audit	The annual national diabetes inpatient audit is based on the themes collected by the NaDIA audit, this includes a patient experience survey and assessment of whether individuals are aware of access to the diabetes team during their hospital stay. Patients with diabetes should know the diabetes team on admission to the hospital, and there are proposed changes to add this to the nursing assessment documentation on EPR. Following the completion of the audit several KPIs have been developed, including • Episodes of hypoglycaemia target 3.9% or below for each individual ward or department to maintain a 30% reduction - dashboard is circulated monthly so wards can track their progress. BoSCA assessment includes diabetes best practice standards. • Foot checks on admission – the purpose T assessment has been adopted as the process to complete a foot check, aligning to standard practice. The trust is compliant at 100% under monthly audit. • Compliance and monitoring by division of mandatory diabetes training in hypoglycaemia, insulin safety and foot assessment. Target 85 %

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Those eligible to self-administer insulin whilst in hospital – audited every three months. Target 80%
Monitoring of GIRFT standards
Hypoglycaemia readmission within 30 days of discharge, (Target 14.3%)
Hypoglycaemia length of stay, (Target 9.8 days)
DKA readmission within 30 days of discharge, (Target 14.3%)
DKA mean LOS 7.5 (Target 5.3 days).
Patient Satisfaction survey and Local in-patient diabetes audit completed in November 2023

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<tr><td>National Audit for Care at the End of Life (NACEL) - Hospital and Community sites</td><td>
Fourth round of the audit (2022/23) bespoke dashboard was received in February 2023. Action for non-compliance:

Staff confidence below national average.
In-house communication skills training now in place.
End of life practice educator in post and has training strategy.
Advance Care Planning Project Board in development
Ongoing programme of education for junior doctors in palliative and end of life care and SIM sessions in ‘Difficult conversations’

Record of Care for the Dying Person being reviewed and adapted for EPR as currently a separate paper document
Launch of the National Audit of Care at the End-of-Life 2024

Case Note Review and Quality Survey data collection January 2024 – will involve inviting bereaved carers to participate in the NACEL Quality Survey from January 2024 – December 2024

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<tr><td>UK Parkinson's Audit - Transforming Care</td><td>
Summary of 2023/2024 improvement include:

New patient review includes an early referral to our Neuro therapy team for a new patient assessment.
New patient group - allowing early therapy intervention with an hour physio led session by our neuro physios. This is then followed by a 30-minute session led by a different professional/MDT member each week including Nursing, Physio, OT, SLT and Parkinson’s UK for benefits advice etc. This increases the awareness of what MDT services/support would be available to them through their journey
At diagnosis, our patients are now given a new patient pack which includes resources around PD, local support and exercise groups, driving/insurance information, PDNS/CNRT contact details
Promotion of ‘Get It On Time’ medication campaign providing wards with resources for patients with Parkinson’s as a visual prompt for staff regarding their Parkinson’s medications.
Submission to PDuk to develop new PD Clinic through external funding.
Specialist PD nurse undertaking non-medical prescribers' course to further improve service.

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<tr><td>National Diabetes Foot Care Audit (NaDia)</td><td>
National Diabetes Audit Integrated Specialist Structures Survey
<table>
<tr><td>Month</td><td>Diabetic Patients</td><td>All Patients</td></tr>
<tr><td>Jan-23</td><td>100%</td><td>76%</td></tr>
<tr><td>Feb-23</td><td>100%</td><td>78%</td></tr>
<tr><td>Mar-23</td><td>100%</td><td>76%</td></tr>
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	Apr-23	100%	77%
	May-23	100%	78%
	Jun-23	100%	77%
	Jul-23	100%	77%
	Aug-23	100%	80%
	Sep-23	100%	77.40%
	Oct-23	100%	76.30%
	Nov-23	100%	78%
	Dec-23	100%	79%
Serious Hazards of Transfusion Scheme (SHOT) – Haemovigilance Scheme	The following 4 recommendations have been made • Appropriate management of anaemia and making safe transfusion decisions • Safe systems to ensure safe transfusions • Effective implementation of appropriate interventions following incident investigations • Learning from excellence and day-today events		

Local Clinical Audits

203 local clinical audits were registered and reviewed by the provider in 2023/24 and Bolton NHS Foundation. The breakdown is as follows:

Driver	**n**
Clinical Interest	21
Clinical Outcome (NCEPOD/MBBRA	5
CNST (Clinical Negligence Scheme for Trusts)	24
CQC	2
CQUIN	1
External Audit	1
Incident (Divisional Review)	7
Incident (SI Review)	5
Local Standard	25
Monitoring	4
National Regulations	23
NICE Clinical Guidelines (CG)	8
NICE Guidance (NG)	8
NICE Quality Standards (QS)	1
Patient Satisfaction	3
Quality Improvement	41
Record Keeping/Documentation	2
Royal College	17
Trust Policy	5
Grand Total	**203**

Local Clinical Audits, examples of learning and actions to improve

Below are some examples of the Trusts completed Local Audits which have taken place throughout the year with identified learning and actions.

Project Name	Actions
Adenotonsillectomy in children Review of Analgesia	• *Use oblation technique less painful and negates IV opiates* • *Training of ENT surgeons onto lists with patients suitable for the coblation technique*
Acute Oncology Stakeholder Survey - Annual	• Ensure all stakeholders are aware of the remit of AOS. • Provide a 7-day service
Understanding the referrals of medical patients to Critical Care	• Increased outreach/education of the support offered • Improving the quality/consistency functional baselines • Introduction of a referral to critical care document • Addition of communication to the Critical Care review documentation to improve/evidence current practice
Dignity and Care after Death	• Share report at EOLC Steering Group, ward managers/matrons, ward huddles • Training report re Care after Death to be shared at EOLC Steering Group (broken down by divisions). • Care after Death Training available via EOLC Educator, for ward staff, Care Certificate, Newly Qualified Nurses. • To be reviewed quarterly at EOLC Steering Group
Documentation audit by Appointment Type	• Communication re expected standards • Monthly monitoring prior to next audit and to address any staff member not meeting target of 90% for journals and GHABP/GHADP • To discuss in staff meeting findings of audit and how will be monitored in future. • To arrange time for 2 staff members to reconfigure journals to make more user friendly. • REMS to be checked working in all rooms – time given to complete in appointment, MA to look at times of appointments now having REMS.
Nail Surgery: How many patients return for face-to-face appointments after Nail Surgery telephone dressings appointment	• Telephone appts more cost effective than face to face appts • All follow up appts will now be by telephone • Although a few face-to-face appt will still be required, slots will be adjusted to accommodate
Addressing health inequalities for people with lived experience of homelessness	• Safely managing acute presentations in the community has potentially avoided a delayed presentation at A&E which could have led to an inpatient episode. • Scope to extend the funding of this service is currently underway • Larger sample size would allow for more in-depth analysis • More work with GPs to identify the hidden homeless on their caseloads • Future consideration of working with Northwest Ambulance Service to help prevent unnecessary A&E attendances.
Outcomes Of Emergency Caesarean Section Following Failed Instrumental Delivery	• Determination of position of presenting part and supervision from senior if there is not confirmed properly. • Use of intrapartum scanning to confirm the position and suitability for instrumental delivery. There is a need for more training sessions for intrapartum scanning. • The need for improved documentation for vaginal examination findings before instrumental delivery. • Skills and drills for instrumental delivery to improve training.

	• To modify indication for cesarean sections and to include full dilatation with other urgent indications (pathological CTG). • Re-audit in 1 year to close audit loop.
VBAC audit 2023	• Poor compliance with antenatal documentation • Poor antenatal counselling • Shared decision-making form does allow for risk discussion • Particularly good success rate at RBH (97%) • Encourage cannulation on arrival: Include in huddle • Use RCOG not GMEC decision aid and improve compliance rates: Include and induction & replace the paperwork
Delay in transfer to CDS	• Audit data indicates an obstetric review with management plan is not being completed as standard on the antenatal ward when there is a delay in transfer. However, in the 10 cases audited no significant impact of both mother and baby. • Future audit to explore the outcomes for women with delayed induction of labour following prolonged rupture of membranes. • It is imperative that daily senior obstetric reviews take place and unit escalation is occurring as per policy in relation to delay in transfer of IOL.
Aspirin Risk Assessment Audit (CNST)	• Excellent compliance with the recommendations made within the SBLV3 Implementation Tool. • 100% of cases were correctly assessed at booking (target 80) however, for pregnancies with a changed risk status (confirmation of multiple pregnancy) there was a lack of documentation re risk assessment review and Aspirin offered and prescribed where required. Therefore, this demonstrates a need for improvement. • There is a requirement for this data to be collated by the MIS and work is ongoing to achieve this with the digital system
Quarterly Audit FGR & SGA Detection Rates, including the percentage of babies born <3rd centile >37+6 weeks' gestation.	• Quarterly assessment of data to information improvements. This data is also included within the Maternity IPM Dashboard. • Improve detection rates for FGR & SGA fetuses: Updated GROW from version 1.5 to 2.0 & Commence SBL Training in line with CCFV2 • Reduce percentage of babies born <3rd centile >38+0 weeks: audit of <3rd birthweight centile babies not detected antenatally and born >38+0 weeks, to identify improvements
SDEC (Same Day Emergency Care) returners quality improvement project: Follow ups Vs National guideline-based criteria	• Numbers of returns restricted to 0-1 if additional required must be discussed with consultant/revised by SDEC lead • Creating virtual ward responsible for follow up of requested images and remote bloods (taking > 1 day to come in) • Clear pathways for SDEC patients inc. exclusion criteria. • Potential diversion to DVT clinic. • Patients requiring regular bloods facilitated by GPs/community • Re audit once in 6-12 months
An evaluation of the medical review of inpatient falls	• Particularly good compliance with application of the PFMA document (87%), events of fall (94%) and examination (87-96%) • Reviews lacking for PMH (61%), medications, especially anticoagulation/antiplatelets (58%), while antihypertensives/sedatives were comparatively better (75%) • Planning for investigations and further management (80-86%) • Aiming for 100% compliance in all areas • Re-cycle of the audit in 6 months to compare results, particularly of highlighted areas and to broaden sample size to include other complex care wards

Post colonoscopy colorectal cancer (re-audit)	• 2022- Total colons: 6022 Cancers diagnosed after colonoscopy: 209 (3.5%) Of those diagnosed - PCCRC: 6 (2.9%) • Compared with 2021- Total colons: 4882 Cancers diagnosed after colonoscopy: 132 (2.7%) Of those diagnosed - PCCRC: 4 (3%) • Endoscopists reminded of importance of photo documentation - Appendiceal orifice and retro version + F4 scope guide. This will enable greater confidence in retrospective analysis of adequate examination. • Improve bowel prep - extended bowel prep protocol created for previous inadequate prep • Awareness of the higher risk for IBD and colitis patients. • Blind spots: Flexures and behind the ileocaecal valve. • Need to repeat local and national audit due to the disparities between patient identification.
RE-AUDIT: Improving VTE assessment and prescription for patients admitted to C3 ward	• Prescribed in 40 (100%) • 38 prescribed on admission (OA) (95%), 2 post admission (5%). For the 2 patients were prescribed after 48 hours from admission • Continue re-auditing • Present findings at AQUIL to highlight change in practice • VTE review should be essential part of any senior review document on EPR • Consider making VTE prescription an essential part of the clerking sheet which cannot proceed without being completed • Reminder emails to be sent periodically for the clerking team members especially after change of rotations for doctors.
Audit reviewing the recognition, investigation and management of acute kidney injury (AKI) at the Royal Bolton Hospital (RBH)	• This review found that AKI is recognised in a timely manner and assessment of fluid balance and review of the cause of AKI is done well. • Improve awareness and rationale for urinalysis in AKI • Encourage documentation of urinalysis in POCT flowsheets • Suggest audit into catheterization of patients with AKI • Review appropriateness of advice around myeloma screening and urine sodium testing. • Review ultrasound requesting advice given NICE guidelines • Further audit into accuracy of fluid balance monitoring in patients with AKI is suggested.

Participation in Clinical Research

51 National Institute for Health Research (NIHR) Portfolio Research studies with Health Research Authority (HRA) / Research Ethics approval, were open to recruitment at Bolton NHS Foundation Trust in 2023/24. 3066 patients receiving relevant health services provided or sub-contracted by Bolton NHS Foundation Trust were recruited to participate in research during that period.

results show that bacteria are present but not producing toxins.

Goals agreed with Commissioners: use of the CQUIN payment framework

A proportion of Bolton NHS Foundation Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between Bolton NHS Foundation Trust and any person or body they entered a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2023/24 Bolton NHS Foundation Trust received £3.9m of its CQUIN target agreed with commissioners

Further details of the agreed goals for 2023/24 and for the following 12-month period are available on request

Care Quality Commission Registration

Bolton NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions". The Care Quality Commission has not taken enforcement action against the Bolton NHS Foundation Trust during 2023/24. The CQC Improvement Plan addresses the recommendations following inspections of Urgent Care, Medical Services, Maternity Services, Children & Young Peoples services and a Well-Led inspections that took place in Q3 23/24.

- The CQC inspection report for the unannounced visit to the urgent care and the medical wards contains three 'Must Do' actions and five 'Should Do' actions.
- The CQC inspection report for the announced inspection of maternity services contained six 'Must Do' recommendations and one 'Should Do' recommendation.
- The CQC inspection report for the unannounced inspection of the Children's and Young person's services contains two "Should Do" recommendations.
- This CQC inspection report also includes the outcome of the announced Well-Led inspection. The report contains seven 'Must Do' recommendations and four 'Should Do' recommendations

All recommendations have been incorporated into a trust wide CQC Improvement Plan. In total, there were, 28 recommendations from the inspections, status as at 31/03/24 below:

- 20 recommendations are complete
- 3 recommendations are on track
- 2 recommendations due in April 2024
- 3 recommendations are currently overdue

In March 2024, a programme of work commenced to test and gain assurance of the impact/effectiveness of actions to address recommendations that are marked as completed for the Urgent Care CQC recommendations. Evidence has been collated against all the actions. Audits are taking place to test whether the changes made following the completion of actions have had the desired impact, are effective and are embedded.

The recommendations for Children's and Young People Services and Medical Services will also be assessed and tested in April 2024 with any additional actions developed where necessary to ensure that there is assurance to mark them as complete and remove them from the improvement plan.

Data Quality

Bolton NHS Foundation Trust submitted records during 2023/24, to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- **which included the patient's valid NHS number was:**
  - *99.93 %* for admitted patient care;
  - *99.98 %* for outpatient care; and
  - *99.66 %* for accident and emergency care

- **which included the patient's valid General Medical Practice Code was:**
  - *95.22 %* for admitted patient care;
  - *99.64 %* for outpatient care; and
  - *99.34 %* for accident and emergency care.

Action to Improve Data Quality

Bolton NHS Foundation Trust will be taking the following actions to improve data quality:

- The Data Quality team continues to be proactive in promoting the importance of good quality data
- In recent months, the Deputy Head of Business Intelligence (Data Quality) has attended junior doctors' induction to speak about data quality which has been very well received
- The Deputy Head of Business Intelligence along with the Chief Data Officer has created a Data Standards programme. This includes educating service managers on the 'rules' around how activity should be recorded in line with national standards. Work is also being undertaken on ensuring staff collect patient demographics which in turn will help design services fit for the population we serve
- Daily validation continues to be undertaken by the Data Quality team with a focus on the use of correct NHS numbers, GP details and responsible CCG
- A Data Quality Dashboard has been created and has been shared with relevant staff groups. This provides a visual tool to managers on 'gaps' in information
- The Data Quality team continues to provide advice and guidance to other users and supports numerous projects
- Anomalies and issues are dealt with as they arise, and users are made aware of errors to prevent further errors occurring
- Bespoke reports have been created, and continue to be created as necessary, to identify DQ issues as early as possible so that they can be rectified before activity is reported on or submitted to national bodies
- Users are signposted to the relevant training
- All training manuals for the Trust PAS continue to be reviewed by the team and updated as and where necessary
- RTT reports continue to be developed to support RTT validation
- Face to face training has been, and continues to be, delivered to Ward Clerks to ensure the accuracy of inpatient data
- Audits are undertaken and focus on suspected data quality issues. Outputs are shared with relevant staff.
- Data Quality is a standard item on various Trust group agendas

Information Governance

The Data Security and Protection toolkit which is mandated for all Trusts and measures organisations against the National Data Guardian measure. The Trust can evidence compliance against all mandated standards.

Clinical Coding Audit

Bolton NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission.

Learning from Deaths
During 2023/24 1213 of Bolton NHS Foundation Trust patients died in hospital.

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 287 in the first quarter;
- 260 in the second quarter;
- 311 in the third quarter;
- 355 in the fourth quarter.

In 2023/24 (between April 2023 and Jan 2024), 174 structured judgement case reviews and 44 cardiac arrest root cause analysis investigations (where the patient did not survive) have been carried out in relation to 1213 of the deaths included above.

Out of 174 Structured judgement cases recorded, in 3 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 287 Case record reviews in the first quarter; Investigations = 0
- 260 Case record reviews in the second quarter; Investigations = 0
- 311 Case record reviews in the third quarter; Investigations = 3
- 355 Case records reviews in the fourth quarter; Investigations = 0

6 avoidable cardiac arrests audited during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using the data provided within the cardiac arrest root cause analysis reports and learning from deaths process.

All Divisional Reviews and Serious Investigations which are generated via an avoidable cardiac arrest are identified timely by using the cardiac arrest validation clinic and have specific individual actions generated which remain the responsibility of the Division. Learning from deaths is disseminated through specialty mortality and morbidity meetings and individual feedback to the clinicians concerned.

Learning Disabilities Mortality Review (LeDeR)

The new, regional LeDeR process has now been embedded within the Bolton locality, maintaining strong links with the Greater Manchester Local Area Contact to ensure learning from Bolton reviews is shared across appropriate organisations. There is robust locality representation at the Greater Manchester panel meeting, helping to identify themes from completed reviews and ensuring locality involvement in agreeing any required actions to address ongoing health inequalities for people with learning disabilities and/or autism. Since January 2022, the programme has received death notifications for those aged 4+ who have a learning disability and/or autism. As in recent years, reviews are completed by a Greater Manchester review team.

Once completed reviews are received by locality representatives, learning is shared via appropriate forums, including the Learning Disability and Autism Improvement Group Meeting, the Learning Disability Partnership Board and Safety Improvement Review Group meeting. The new LD and Autism Improvement Group meeting evolved from the original LeDeR steering group and continues to have a clear focus on LeDeR reviews and oversight of the locality action plan to provide assurance on locality governance arrangements.

From April 2023 to date, there have been 14 Bolton death notifications made to the LeDeR platform, all adults. 13 of these have a primary diagnosis of learning disability and one is autism only notification. We have a cause of death recorded for 4 as some reviews are still in progress. Of the 4 who do have a recorded cause of death, 75% (three people) had pneumonia listed as primary or contributory cause of death. The 2022/23 Greater Manchester LeDeR report highlights that respiratory health remains a concern across Greater Manchester and remains the leading cause of death for learning disabled adults in Greater Manchester. National data evidences 12% of 2021 LD deaths were attributed to respiratory conditions, highlighting that additional consideration may be required across Greater Manchester, including the Bolton locality. The Bolton average age of death for 2023/24, to date, is 53.7 years of age, below the current Greater Manchester and national LD average age of death (Greater Manchester average age of death 2022/23 62 years of age). 64% of people notified to the platform in this period died in hospital.

There is continued concern about notifications to the LeDeR platform; 71.4% of notifications were alerted to the platform by LD specialist staff, two death notifications were made by GPs, one by NWAS (North West Ambulance Service) and one by ward staff. This is a continuing trend and raises concern that we are not routinely notified of all deaths of people with LD and autism, and therefore may fail to report the death of those who are not in receipt of specialist learning disability services. Of additional concern, is the sparse number of autism notifications, with only one autism only death being alerted this year. Given that most alerts made to the platform are made by the LD specialist workforce, there is an ongoing risk that autism only deaths will not be reliably alerted, with a resulting loss of essential learning.

Seven-day services

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. The NHS Services, Seven Days, originally developed ten 7DS clinical standards a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

The importance of ensuring that patients receive the same level of high-quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. Delivery of the 7DS clinical standards should also support better patient flow through acute hospitals. A clinical reference group that confirmed they remain relevant and important in the NHS today has reviewed the standards in 2021. The revised standards were issued in February 2022, but the national programme around this including national data collection and comparison has been terminated.

Bolton NHS Foundation use the Board Assurance Framework to assess performance against these four priority 7DS clinical standards on an annual basis and provide action plan as a result.

Raising Concerns

Effective speaking up arrangements help our organisation to protect our patients and improve the experience of our workers. Making sure all our workers have a voice and feel safe and able to speak up about anything that gets in the way of providing safe, high-quality care or affects their workplace experience. This includes matters relating to patient safety, the quality of patient care and the culture within the working environment. To support this, managers need

to feel comfortable having decisions and authority challenged. Speaking up and the matters that the issues highlighted, however difficult to hear, should be welcomed and looked at as opportunities for learning and development.

FTSU (Freedom To Speak Up) Guardians, which were implemented following the Francis Report into Mid Staffs, are an additional route for workers to speak up- but they cannot improve the speak up culture on their own. Research shows that taking a proactive approach to ensuring the health and well-being of workers and a preventative approach to poor behaviours such as bullying, harassment and incivility will have the greatest impact on the working environment. Leading by example and creating a fair, open and inclusive workplace will also positively impact culture, which then impacts patient care.

The Guardians take the lead in supporting workers to speak up safely, to thank them for speaking up, to listen to their concerns and to help resolve issues satisfactorily and fairly at the earliest stage possible ensuring workers receive regular feedback and support. Importantly, the role is independent and impartial. The Trust Guardians are supported by a diverse network of FTSU Champions whose role is to promote a speak up culture and to signpost workers to the Guardian or the most appropriate service The Guardians and Champions work in partnership with the communications team in utilising different methods of promoting the freedom to speak up approach. The Guardians meet monthly with the CEO, Executive Director of People and the Non-Executive Leads for FTSU to discuss concerns raised by workers whilst protecting staff confidentiality. The Guardians request feedback from individuals that speak up to ensure that the process has met their expectations and that they have not faced any detriment from speaking up. The themes and feedback from individuals is collated in quarterly reports to the People's Committee and Divisions and an annual report delivered by the Guardians to the Trust Board. The Guardians also provide quarterly data to the National Guardian Office.

Guardian of Safeworking – NHS Doctors in Training

The safety of our patients is the Trust's key priority, and it is widely acknowledged that staff fatigue is a hazard to both patients and the staff themselves. As such, there are safeguards in place for staff to ensure that working hours and rest periods are regulated and that these are adhered to. The Trust has appointed a Guardian of Safeworking to ensure that the Trust has an open and safe place for trainees to discuss, review and manage working conditions. These conditions are statutory as per the BMA guidance and working time directive and overseen by a BMA representative quarterly. The conditions have also been widened to encompass a more holistic, wellbeing element to ensure our trainees get the best training experience they can from the Trust

Deviations from the working conditions are reported via DRS4 system, reviewed daily, and responded to. Such deviations reflect issues including missed educational opportunities, working outside contracted hours and intensity of work. Explanations for the exemptions reflect issues such as unpredictable sickness, short notice leave and rota gaps. The exemptions are collated into quarterly reports by medical education and GOSW and presented to the Trust quarterly and then an annual summary is prepared and presented to the Trust Board.

We have been able to identify patterns of difficult rotas and trainees who are struggling to meet the demands of their post and acted swiftly and effectively to adjust the training to the satisfaction of the trainee, the Trust, and the Deanery, where this has become necessary. More general issues such as rota gaps have been managed by [over]recruiting to posts and increasing middle grade trainee numbers particularly in general surgery. Alterations to on call have also been made.

Reporting against core indicators – *latest published data to 19/04/24*

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital. An overview of the indicators is provided in the table. It is important to note that whilst these indicators must be included in the Quality Report the most recent national data available for the reporting period is not always for the most recent financial year. Where this is the case, the period used is 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.

Indicator	2023/24	Nat. Av	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2022/23	2021/22
Mortality: The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for (12/22 – 11/23) latest published data available	SHMI Value = 1.0764 (12/22-11/23) Band 2 (As expected)	SHMI value = 1.00	SHMI Value = 0.7195 Chelsea and Westminster Hospital NHS Foundation Trust Band 3 (lower than expected)	SHMI Value = 1.2564 County Durham and Darlington NHS Foundation Trust Band 1 (higher than expected)	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from NHS Digital (NHSD) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and to ensure the quality of its services by: • Monthly Mortality Reduction Group meetings to scrutinise the quality of care against the mortality metrics • Structured judgement review on patients who died, feeding into the learning from deaths process • Review of recording process across the trust	SHMI Value = 1.0817 (12/21 – 11/22 Band 2 (As expected)	SHMI value = 1.1533 (12/20 to 11/21) Band 1
The percentage patients' deaths with palliative care coded at either diagnosis or specialty level for the period (12/22 – 11/23) Latest published data	37% (12/22 – 11/23)	42%	66% University College London Hospitals NHS Foundation Trust	16% Sherwood Forest Hospitals NHS Foundation Trust	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from NHS Digital (NHSD) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • The Clinical Coding team receive weekly information on any patients who have had a palliative care or contact with the palliative care team, so that this can be reflected in the clinical coding	33% (12/21 – 11/22	34% (12/20 to 11/21)

Indicator	2023/24	Nat. Av	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2022/23	2021/22
Patient reported outcome scores for hip replacement surgery (April 22 to March 23) latest data available	67% April 22 to March 23 Measure EQ-5D Index	78%	95% UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST (RKB) Data taken from April 22 to March 23	15% SPIRE DUNEDIN HOSPITAL (NT344) Data taken from April 22 to March 23	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: Although some PROMS data was submitted for hip replacement and knee replacement – there were insufficient records to deem statistically viable and calculate any adjusted health gains, therefore not published nationally. However, national clinical audit section outlines findings from the records submitted, with actions to address	70% April 21 to March 22	92% April 20 to March 21
Patient reported outcome scores for knee replacement surgery April 22 to March 23 latest data available	76% April 22 to March 23 Measure EQ-5D Index	74% April 22 to March 23	92% SPIRE NOTTINGHAM HOSPITAL (NT30A) Data taken from April 22 to March 23	18% NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST (RAP) Data taken from April 22 to March 23		71% April 21 to March 22	75% April 20 to March 21
28-day readmission rate for patients aged 0 – 15 *	*The latest available published national data for 28-day readmission rate provided for these measures is for 2011/12. Local data for Bolton NHS Foundation Trust readmission rate is 8.7% for discharges in March 2024 *(based on PBR national guidance, exclusions apply)*						
28-day readmission rate for patients aged 16 or over *							
The percentage of admitted patients' risk-assessed for Venous Thromboembolism	98.22 04/23 to 03/24 (national submission paused since pandemic, therefore no comparative data available)	n/a	n/a	n/a	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • VTE Nurse Champion • Nurse-led DVT Clinic • VTE database • Staff Awareness • RCA of patients developing clots for continuous learning and improvement	96.94% (04/22 to 03/23)	97.19%

Indicator	2023/24	Nat. Av	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2022/23	2021/22
Rate of C.Difficile per 100,000 bed days (Hospital onset Healthcare associated amongst patients 2 of over) Rate published by Public Health England, Source *HCAI Mandatory Surveillance Data*	(22/23) 43.0	(22/23) 20.3	(22/23) 51.6 Lancashire Teaching Hospitals	(22/23) 3.8 Liverpool Heart and Chest	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: Rate as published on the Public Health Profiles. National data is published in September each year. There is no data published yet for 22/23 Therefore, latest available published data is 2021/22 Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • Continuation of an annual deep cleaning programme. • Investment in more efficient Hydrogen Peroxide Vapour. • More scrutiny in the application of SIGHT. • Hand hygiene awareness campaigns. • Harm Free Care Panels for each CDT case to identify root cause and review prescribing practices. • Regular audits of antibiotic prescribing practices. • Investment in estate in conjunction with the deep clean programme. • C'diff Improvement Collaborative • Revised guidance and policy. • IPC link nurse development programme.	32.7 (21/22)	23.8 (20/21)
Number/Rate of patient safety incidents per 1000 bed days latest data available (NRLS)	The annual publishing of this data is paused while future publications are considered in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. Most up to date data is April 2021/Mar 22	n/a	n/a	n/a	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the National Reporting and Learning System (NRLS) There is no patient safety data for 22/23 as the publishing of the annual data has been paused while it is considered how future publications are brought in line with the introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. Bolton NHS Foundation Trust Risk & Assurance team have undertaken: • Preparation for the Implementation of new national Learning from	61.5 per 1,000 bed days N = 12,420 Apr/21 to Mar/22	64.9 per 1,000 bed days N = 10,882 20/21

Indicator	2023/24	Nat. Av	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2022/23	2021/22
Number of above patient safety incidents that resulted in severe harm or death latest data available (NRLS)	The annual publishing of this data is paused while future publications are considered in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. Most up to date data is April 2021/Mar 22	n/a	n/a	n/a	Patient Safety Events Service, replacing NRLS • Preparation for the Implementation of new national Patient Safety Incident Response Framework (PSIRF)	N = 33 10 deaths 23 Severe harms Apr/21 to Mar/22	N = 24 8 deaths 16 Severe harms 20/21
Inpatient Friends and Family Test (Feb-24)	97.08% (Feb-24)	94.13%	100% THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	77.50% ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the Health and Social Care Information Centre (HSCIC) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • Increased use of Friends and Family Test – available in a variety of formats • Communicating the process to the public Implementation of the 'you said' 'we did' process for feedback	96.4% (Feb-23)	96.1%
Accident and Emergency Friends and Family Test (Feb-24)	78.29% (Feb-24)	77.82%	94.12% EAST AND NORTH HERTFORDSHIRE NHS TRUST	58.21% BARTS HEALTH NHS TRUST		87.1% (Feb-23)	85.0%

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PART 3

Performance against Trust selected metrics

... for a better Bolton

Performance against Trust selected metrics

This section of the report gives an overview of care quality across a range of indicators covering patient safety, clinical effectiveness and patient experience. We have chosen to use the same indicators as used in previous years

	Indicator/Measure	2023/24	2022/23	2021/22
Patient Safety Outcomes	Mortality - SHMI	See page 40		
	C.Diff – number of cases	See page 47		
	Pressure ulcers by category: • Cat 2 • Cat 3 • Cat 4 *Data source – Bolton NHS Foundation Trust's incident reporting system*	 256 3 7	 304 16 1	 248 50 3
Patient Experience	Friends and Family Test inpatients • Response rates • Recommendation rates *Data source – captured locally, submitted nationally, and published by NHS England*	28.2% 96.7% (Mar-24)	25.6% 96.2% (Mar-23)	21.7% 95.7%
	Lessons Learnt	See below		
Effectiveness	Sickness rates *Data source – captured via local attendance management system (E-roster and ESR), submitted nationally, and published by NHS Digital*	5.2% (Mar 24)	4.6% (Mar-23)	5.1%
	Appraisal rates *Data source – captured via local ESR and reported locally for Board report*	83.6% (Mar 24)	84.1% (Mar-23)	78%
	Mandatory Training compliance *Data source – captured via local training and development system (Moodle and ESR)*	90.3% (Mar 24)	85.3% (Mar-23)	85.4%

The above data is reflective of 2023/24 performance; national comparable benchmarking data for the same period was not available at time of Quality Account publication. Where applicable/available the above indicators are governed by national standard definitions.

Lessons Learnt:
The Trust has over the course of 2023/24 used a variety of methods to ensure that learning is captured, shared, and embedded in a timely manner.

Capture: Incidents, complaints, claims, audits, and Inquests provide us with the opportunity to reflect when our practice could have been better, the Governance Team are central to

ensuring that the intelligence gleaned from such events is accurate and focused on learning.

Shared: The Trust ensures that lessons learnt are shared with appropriate audiences across the organisation in formats that are engaging, helpful and easy to appreciate. The key example of this is the use of SBARS (Situation, Background, Recommendations, Situation) a single slide, covering an important topic that will improve patient safety

Embedded: SBARS, once published, are monitored in terms of demonstrating embeddedness via a measure in BoSCA (our in-house ward and departmental accreditation scheme) which ensures that staff in clinical settings have been made aware of the SBAR. Furthermore, the Governance Team meets with divisions to discuss progress with the completion of actions associated with complaints and incidents on a regular basis, reporting if necessary to the Clinical Governance & Quality Committee.

Performance against the relevant indicators and performance thresholds (Risk Assessment Framework and Single Oversight Framework)

Indicator for disclosure (limited to those that were included in both RAF and SOF for 2016/17)	**Apr 23-Mar 24**	**Target**	**Achieved**	**Apr 22-Mar 23**	**Apr 21-Mar 22**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway (as at 31/03/2024)	48.9% (March 24)	92%	X	60.29%	65.4%
A&E: Maximum waiting time of four from arrival to admission, transfer, or discharge (average for the year)	61.24%	95%	X	59.48%	66.84%
All cancers: 62-day wait for first treatment from:					
• Urgent GP referral for suspected cancer (04/23 – 03/24)	80.23%	85%	X	81.72%	85.35%
• NHS Cancer Screening Service referral (04/23 – 03/24)	84.73%	90%	X	82.91%	77.28%
Clostridium difficile - meeting the C. difficile objective *National data is published in September each year. Therefore, latest available published data is 2022/23*	93 (2022/23)	N/A	X	66 (2021/22)	40 (2020/21)
Summary Hospital-level Mortality Indicator included in "**Reporting against core indicators" section**					
Maximum 6 week wait for diagnostic procedures *Definition – proportion of patients referred for diagnostic tests who have been waiting less than 6 weeks* (as at 31**/03/2024)**	89.6%	99%	X	86.1%	66.9%
Venous thromboembolism (VTE) risk assessment included in "**Reporting against core indicators section"**					

NHS Greater Manchester response to Bolton NHS Foundation Trust's Quality Accounts (2023/24)

NHS Greater Manchester Integrated Care Board (NHS GM) welcomes the opportunity to comment on the Draft Quality Account for NHS Bolton Foundation Trust (FT) 2023/24. NHS GM is required to act with a view to securing continuous improvements in the quality of services for patients and their outcomes, with a regard to clinical effectiveness, safety, and patient experience.

We welcome the ongoing commitment to the values of the organisation and the locality which underpin the approach to high quality, safe and effective services for the people of Bolton. Bolton FT place particular emphasis on engagement and communication to improve quality and are open and transparent in the way in which they engage with service users, carers and staff as well as the wider public.

NHS GM reviews and monitors the performance and quality of NHS services commissioned from Bolton FT through the regular quality and contract meetings. We have continued to work collaboratively with Bolton FT to adapt how we gain oversight and assurance of quality and performance. During 2023/24 we saw Bolton FT senior leadership team attend and contribute to the Bolton Locality Quality Group. This increased collaborative working demonstrates Bolton FT's commitment to work with system partners on quality and safety.

Bolton FT places significant emphasis on its quality and safety agenda, which is further reflected in the embedding of a culture of learning to ensure lessons learned are captured and shared with staff and the commitment and participation within locality quality collaboratives.

Through this Quality Account, Bolton FT clearly demonstrate their commitment and ambition to improving the quality of care and services delivered.

To the best of NHS GM's knowledge, the information contained in the Account is accurate and reflects a true and balanced description of the quality of provision of services provided by Bolton FT.

We will continue to work collaboratively with Bolton FT in 2024/25 to ensure ongoing high-quality services are provided in line with commissioning priorities.

Mark Fisher
Chief Executive Officer
NHS Greater Manchester Integrated Care Board