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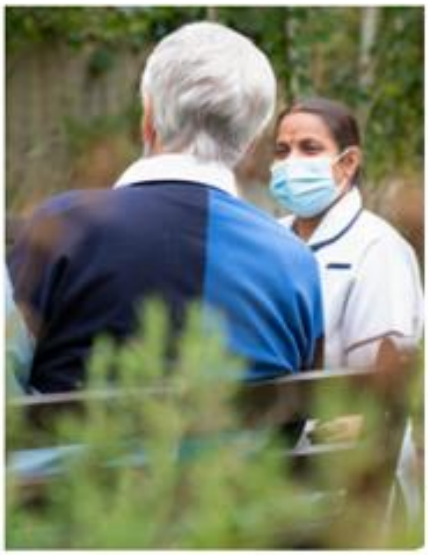
NHS
Bolton
NHS Foundation Trust

Bolton NHS Foundation Trust

Quality Account

2021/2022





... for a better Bolton

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Part 1

Statement on the Quality of Services from the Chief Executive

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Statement on Quality from the Chief Executive

I'm pleased to be able to share our annual Quality Account, which highlights our achievements, successes and challenges throughout 2021/22. This Quality Account is a summary for anyone who wants to know more about the standards of care we have delivered over the last 12 months, and how we plan to maintain and improve care for our patients their families and our service users.

The past twelve months have continued to be extremely challenging, and like the rest of the country, the ongoing prevalence of COVID in our communities has led to significant operational and staffing pressures. At many points during the pandemic Bolton had higher rates of COVID in the community than nationally, particularly during May's Delta variant wave, when we had the highest rates in the country and were at the spotlight of national attention. Our organisation was often seen as a barometer for how well the NHS coped nationally with the easing of lockdown, and with that came high degree of scrutiny.

Throughout the pandemic, our collective aim has always remained to provide the best care possible for the people of Bolton. I've always been humbled by our staff, and when you look at what they have and continue to achieve despite these significant pressures, it really is staggering. I would like to thank our workforce for their phenomenal efforts.

Whilst we continue to experience fluctuations in the numbers of patients we are caring for in the hospital with COVID, the shift over the past 12 months has moved to one where the majority of the patients we are caring for are in hospital with COVID, rather than because of COVID.

A large percentage of people in Bolton are now being cared for in the community when they have COVID, a number of which are monitored via our COVID Oximetry@home pathway. The pathway is run jointly with our community teams, primary care and the North West Ambulance Service, and helps us to make sure that we are identifying any patients whose condition may be deteriorating and that they receive hospital care quickly if needed. This innovative service is just one example of how our staff have embraced the opportunities created by the pandemic to work differently and in collaboration with our partners, for the benefit of our local community.

We continue to be the busiest emergency department in Greater Manchester, and attendances continue to increase. This coupled with the continued need to cohort patients with COVID in hospital and therefore limit our bed capacity and delivering an ambitious elective recovery programme, has meant continuous pressure on the organisation.

However, we're really proud that since we were able to fully restart all our services, many of our elective and diagnostic services are now operating above pre-pandemic levels.

We are working hard across the Bolton system to ensure that the right processes and staffing are in place to ensure our patients have a safe and timely discharge from hospital and the right levels of onward care. We continue to innovate, work in partnership and identify new ways to make positive change in the face of ongoing challenges.

Our Clinical Assessment Unit has treated over 6,500 patients requiring medical, surgical and care due to frailty over the past year. CAU has helped to alleviate some of the congestion within our emergency department, with around a third of patients seen and discharged home on the same day.

Staffing pressures have been an ongoing issue due to COVID, and we have continued with our commitment to invest in our workforce. In September, we welcomed 89 newly qualified nurses and midwives – one of our largest intakes in years. We've also made 38 offers of employment to student nurses who are due to qualify in 2022.

We've introduced a number of staff development programmes so that everyone is offered the opportunity to learn new skills and advance their careers. Specific leadership programmes for different professions have been established to equip our future medical, nursing and operational leaders with the skills and knowledge to deliver and support the very best in patient care.

We've made great strides with our equality, diversity and inclusion program and are about to sign off our five-year plan, which outlines our ambitions to be a truly inclusive organisation and enable us to create a culture where all our staff feel safe, respected and included. We've listened to the voices of our staff to understand more about their experiences and where we can support them further in the workplace, and recently launched a number of staff networks to create a safe space where our staff can raise concerns and contribute to positive change within the organisation.

As part of our commitment to improving services we continue to invest in our estate and infrastructure, including a £1.3 million investment to enhance Wi-Fi and remote working for our community services. The expansion of our electronic patient record across community and maternity services is progressing; including the streamlining of a number of different maternity systems to provide consistency across Greater Manchester and allow pregnant people the ability to access their own notes digitally.

Investment in digital schemes and projects will have a big impact on the working lives of staff, and ultimately patient care and experience. This year we have increased our digital interaction with patients to give them the opportunity to be communicated with in a different way, and to reduce the costs incurred by missed appointments. This technology will support patients with wider accessibility options, which helps our progress towards achieving the national Accessible Information Standard (AIS) – one of our Quality Account priorities for the coming year.

Providing quality care is something that is expected of the NHS, though there are times when we don't always get it right. Learning from these times and using that learning to make quality improvements is something that we take very seriously.

Following the publication of the Ockenden Report, an independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust, we continue to learn lessons from the standards set. Our hypoxic-ischaemic encephalopathy (HIE) rate continues to compare well with other peer organisations, However, work is still ongoing to prioritise further safety improvements in our maternity services, for instance we are a pilot site for the OASI 2 bundle – a national project to focus on obstetric anal sphincter injury (OASI).

A summary of achievements from all our 2021/22 quality account improvement priorities can be found in part two of this report, in addition to a summary of our aims for our 2022/23 improvement priorities, which are as follows:

- Antibiotic prescribing standards
- Rheumatology
- Improving information to patients
- National early warning score (NEWS) - improving the response to escalation
- Accessible information standards

The end of the year is often a time to reflect and to work towards goals for the future. As we move into 2022/23 and beyond I would like to touch on some of our plans, which if approved will have a hugely beneficial impact on the way we work in Bolton.

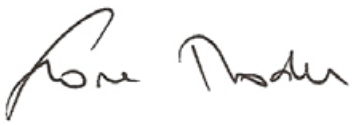
We have submitted a £250million bid for funding to the Health Infrastructure Plan for a new state-of-the-art hospital including the development of women's, maternity, day case and chemotherapy unit. If we are successful we will be able to bring services and staff together in one place so that patients see not only an improvement in their health and wellbeing but in their experience as well. This aligns with our long term ambition to continuously improve our services for the people of Bolton by streamlining our pathways and connecting our staff across health and care. We expect to have a decision in Spring.

This year will also see changes to the NHS structure and with it how health services are commissioned. We have been working with our partners on developing a plan for us to take the next step in our integration journey across health and social care. This means that if approved, we will become responsible for the commissioning and provision of healthcare. Our aims would be ensuring our services focus on treatment and the prevention of ill health, and delivering more health and care in the community. It's a big change organisationally but one with a number of benefits, which are already playing out across our integrated care partnership.

On a final note, the past year has seen some changes to our executive leadership team and I would like to take this opportunity to thank our outgoing Chief Operating Officer, Chief Nurse and Director of Corporate Governance/Trust Secretary for all their hard work and dedication over the last 12 months and beyond.

I'd also like to formally welcome all our new staff to the organisation, who will be key in the delivery of our quality and safety agenda. I am delighted to have them on board as we continue to do all that we can, to provide the services that our patients deserve for a better Bolton.

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

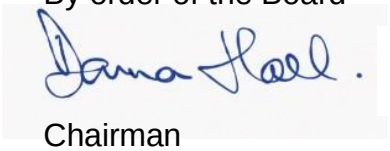
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality 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 2021/22* and supporting guidance *Detailed requirements for Quality Reports 2020/21*
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2021 to (the date of this statement)
    - papers relating to quality reported to the board over the period April 2021 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 2021 national patient survey
    - the 2021 national staff survey
    - latest CQC inspection report dated 11/04/2019
- 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

15th June 2022

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Part 2

How quality initiatives are prioritised in the Trust

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How quality initiatives are prioritised in the Trust

This Quality Report identifies the progress made against the quality and safety agendas in 2021/22 and identifies the quality improvement priorities for 2022/23.

Key quality improvement priorities for 2022/23

Following consultation with our stakeholders we would like to highlight the following as our quality account improvement priorities for 2022/23:

Quality Account Improvement Priorities 2022/23

- Improving the response to escalation from clinical teams following a deterioration in a patients National Early Warning Score (continuation from 2021/22)
- Antibiotic prescribing standards
- Rheumatology
- Improving information for patients
- Accessible Information Standards (AIS)

Outline of aims and plans for the 2022/23 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. *Please note CQUINs were postponed in 20/21 and 21/22 due to the COVID pandemic. CQUINs will recommence 2022/23*

Quality Performance in 2021/22:

In our Quality Account for 2021/22 we set ourselves a series of key priorities for improvement for 2021/22, these were:

- Diabetes
- Pneumonia
- Improving radiology reporting times
- Improving safety in maternity services
- National Early Warning Score (NEWS) – improving the response to escalation

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

Although not formally selected as a quality account improvement priority for 2021/22, an extensive amount of work was focused on mortality – this work will continue into 2022/23 and beyond and therefore we have summarised achievements to date and next steps on pages 31 -32.

Quality Account Improvement Priorities 2021/22 – Diabetes

In Bolton, diabetes is more prevalent than nationally and is currently diagnosed in approximately 19,500 patients (giving a prevalence of 8%). Recent audits of hospital inpatients show that at any given time up to 20% have diabetes. Whilst improvements have been made for these patients it was felt that more could be made to improve outcomes for patients with diabetes.

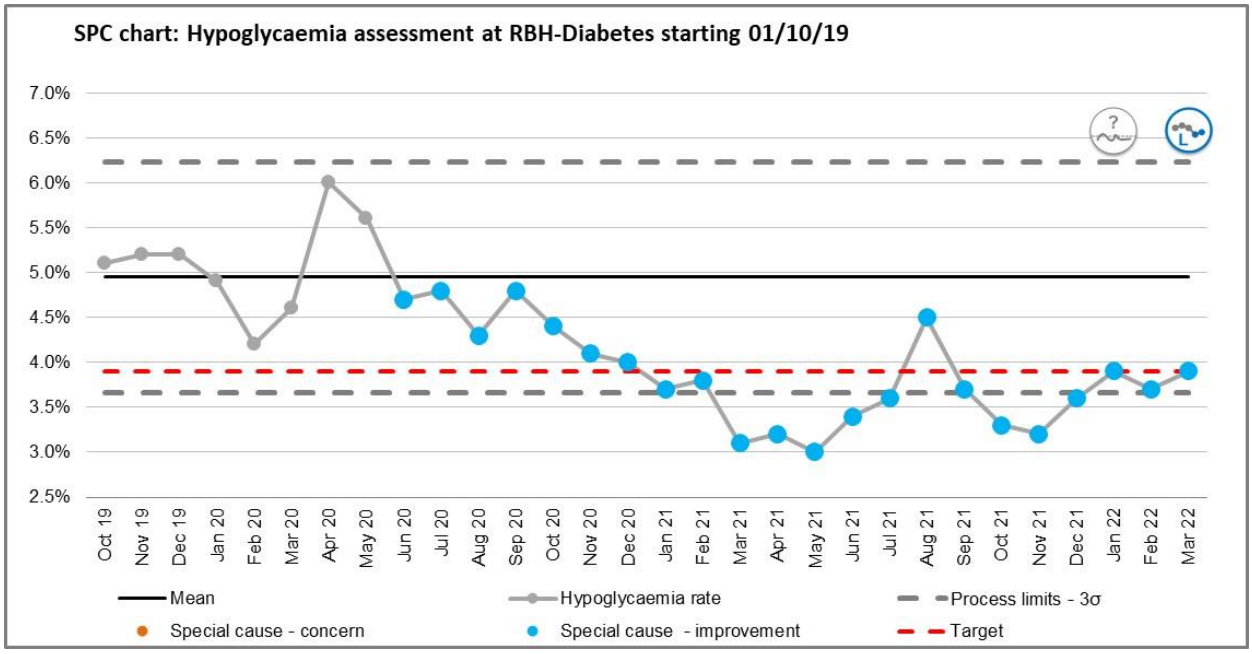
This was our third year of focusing on Diabetes as a Quality Account improvement priority, continuing to progress towards demonstrable improvements in relation to patient safety and patient experience.

AIM: As this was a continuation of work from 20/21, the overarching outcome aim was to:

- Sustain and continue the 30% decrease the amount of inpatient hypoglycaemic incidents by 31/03/2022 (target 3.9% or below)

OUTCOME: ACHIEVED
The average percentage of hypoglycaemic events is 3.9%

Evidence suggests Bolton Hypo rates are now below the national average



What we have done:
We had a comprehensive improvement work plan. The key drivers and interventions and progress made in 2021/22 are summarised below:

a) Improving ownership and accountability of Diabetes care across the Divisions

- Drafted a critical care diabetes policy (including the insulin calculator) – to be enhanced by inclusion of ward round checklist.
- Scoping use of online insulin calculator in critical care as its use shows a 30% reduction in hypoglycaemia in the population group. The aim if for this to be implemented within critical care as part of the critical care blood glucose policy if approved by the critical care governance process.
- Launch of diabetes care pathway EPR - This provides staff with fundamentals that are required to ensure patient safety on admission and prompts who requires referral to the specialist team. Also available are documents which advise on inpatient management and discharge checklist. The implementation of the care pathway on admission is monitored through ward based monthly KPIs. Since relaunch in November uptake has vastly improved
- EPR real-time identification of insulin dependent inpatients and those at higher risk of development hypoglycaemia – enabling DSN in reach to advise on insulin prescribing and prompt safe use of self-administration of insulin for applicable patients (see below)
- Diabetes dashboard – providing each applicable ward/unit/inpatient area with a summary of hypoglycaemia numbers, incidents and training compliance data. DSNs will identify the wards which have higher incidences of hypoglycaemia and will focus their attentions in working with that specific team in supporting a reduction
- Introduction of diabetes related criteria to KPI monthly audits, assessing standards relating to completion of the diabetes care pathway within 24 hours of admission and the percentage of hypoglycaemic events against trust target.
- The Diabetes Specialist Nurses support the BOSCA process auditing against standard 17; Diabetes Care and Management. The inpatient DSN team have developed virtual ward areas and will work alongside the link nurses and ward managers to improve compliance.
- Ward managers, diabetes link nurses and diabetes service work in collaboration to support improvements highlighted by KPI and BoSCA scores
- Staff awareness weeks including, World Diabetes Day, Hypo Awareness Week and Insulin Safety Week ‘Celebrating 100 years of insulin’ – specific focus on staff education of safe practice (e.g. self-administration of medicines policy, and using correct terminology
- Simulation training for Healthcare Assistants
- Ad hoc and structured training for FY1 doctors including insulin safety, prescribing and use of variable rate insulin infusions
- Appointment of Endocrine Nurse to the Diabetes and Endocrinology service to support GIRFT recommendations.
- Inpatient contacts for the diabetes team have increased by more than 50% in 2021, demonstrating increased awareness of the service.

b) Promotion and expansion of self-management of diabetes for inpatients

The Diabetes and Endocrinology service in partnership with Pharmacy support the patient self-administration and management of insulin in hospital project, recent developments include:

- Expansion of participating wards to include CCU, C4, E3, C1, F3, F4, G3, G4, B1 B3, D4 and H3
- The self –administration of insulin criteria has been included within the inpatient BoSCA to support the roll out.

- EPR prompt message on for patients who are self-administrating their insulin to act as an aid memoir for staff
- Continue to monitor the participating wards that are taking part in the roll-out of the self-administration project with monthly updates submitted to the Diabetes Safety and Quality Group**.**
- An audit of the pilot wards thus far confirms that the self-administration of insulin roll-out has been embedded into current practices.
- Initial scoping of use of Improving the perioperative pathway for people with diabetes (IPD3 model) - This model has been successfully rolled out to 10 trusts, with improvements such as reduction in length of stay, care planning, improved would healing, improved satisfaction, improvement in HbA1c and reduced surgical complications.

c) Participation in National Diabetes Audits

The annual national diabetes inpatient audit (NaDIA) was postponed in 2021/22 due to COVID, however, during this time all diabetes related national audits were reviewed and the NaDIA audit has been merged into the new - National Diabetes Inpatient Safety Audit (NDISA). The emphasis will be placed on the importance of the safety aspects when managing diabetes care for patients whilst they are in hospital. Along with supporting the GIRFT recommendations for diabetic inpatient care, detecting and reducing avoidable harms in the diabetic inpatient community is seen as a key deliverable.

However, in order to assess performance against previous years an in-house audit and patient questionnaire based on the previous NaDIA national criteria was conducted in October 2021. The Diabetes and Endocrinology services have review the audit findings and a plan to address any areas for improvement is reported to the Inpatient Quality and Safety governance group and Diabetes Governance group.

See National Clinical Audits: Actions to Improve for further information.

d) Reducing time to surgical intervention for those requiring diabetic foot surgery

- Agreement for on-going podiatry input for in-patients with diabetic foot wounds, who may require diabetic foot surgery.
- Agreement of core attendance inpatient, diabetic foot ulcer ward round to including Consultant, Vascular Practitioner; Diabetes Specialist Podiatrist, In-Patient Specialist Podiatrist, future input from Vascular Consultant); and this is now consultant-led with clearer guidance relating to which patients should be referred for inclusion; how ward staff can refer appropriate patients; agreement relating to development of care plans and how these should be implemented and reviewed prior to discharge.
- Development and ratification of referral pathways including:
    - peripheral arterial disease (PAD),
    - podiatric outpatient
    - podiatric surgery
- Completion of diabetic foot audit
- Development of diabetic foot pathway in collaboration with orthopaedics and vascular specialties to ensure the seamless care for the management of patients requiring associated foot surgery.
- Initial service level agreement and pathway discussions Manchester University Foundation Trust.

Next Steps:

This work will continue to be progressed at a divisional level via the Inpatient Quality and Safety governance group and Diabetes Governance group. Key areas of focus being:

- Focused work with divisions to encourage ownership of and improve training performance and compliance
- Continued expansion of insulin self-administration project
- Collaborative working with surgical services, anaesthetics and pre-operative assessment team to scope an individualised care plan for patients with diabetes attending the pre-operative assessment.
- Final approval of the pathway for Bolton patients requiring foot surgery.
- Working with external stakeholders to promote the use of de-escalation guidance and alternative therapies. For instance, *"Management of diabetes among our frail and elderly patients*" guidance
- Redesign the in-patient variable rate insulin infusion (VRII) chart to reflect total daily insulin doses and take into account those who are more insulin sensitive (to reduce hypoglycaemia).
- Commence discussions with NWAS to explore usage of "*hypos can strike twice"* pathway.

Quality Account Improvement Priorities 2021/22 - Pneumonia

In the UK, pneumonia affects around eight in 1,000 adults each year. Between 1.2% and 10% of adults admitted to hospital deteriorate and are managed in Intensive Care. The mortality in these patients can be as high as 30%. Pneumonia can affect people of any age, but it is more common – and can be more serious – in certain groups of people, such as the very young or the elderly. More than half of pneumonia related deaths occur in people older than 84 years.

At any given time, 1.5% of hospital patients (England) have developed hospital acquired infections of which more than half are hospital-acquired pneumonias. This is estimated to increase hospital bed stay by about eight days and commands a high mortality rate.

For a period of time, we had been an outlier for pneumonia mortality when compared nationally and to local peers, hence the focus on this area for a quality account priority to make significant improvements (2020/21) and sustain those improvements made (2021/22)

AIM: As this was a continuation of work from 20/21, the overarching outcome aim was to:

Maintain compliance with evidence based care as per national guidance:

- Pneumonia Care Composite Score (CPS) – 80% by 31/03/22

Stretch measures:

- 80% compliance with the individual clinical parameters

OUTCOME: PARTIAL ACHIEVEMENT

- Pneumonia Care Composite Score (CPS) – 70%
  See below for individual clinical parameters

	YTD to Feb 2022	NW Average
Pneumonia Care Composite Process Score (CPS)	70%	78%
Individual clinical parameters (target 80%):		
Oxygen assessment within 4 hours of arrival	81%	98%
Chest X-ray within 4 hours of arrival	67%	79%
Initial antibiotic dose within 4 hours	67%	62%
Use of CURB 65 tool	53%	59%
Appropriate antibiotic selection	86%	91%

Bolton vs Northwest peer performance (AQuA). Composite score and individual clinical parameters. Up to December 2021 CPS was consistently above target (>80%) and above Northwest average. However, there has been a general deterioration in performance both locally and across the region, which may reflect winter pressures, COVID omicrom variant and a decline in quality of data input.

Consistent documentation of CURB 65 score is the main challenge and focus of improvement work going forward.

What we have done:
We had a comprehensive improvement work plan. The key drivers and interventions and progress made in 2021/22 are summarised below:

a) Monthly analysis of key parameters
- Monthly data submission regarding clinical parameters to AQuA of minimum of 25 cases/month for audit followed by analysis of feedback.
- Clinical lead education and awareness sessions with medical staff regarding the appropriate documentation of CURB 65 scores and use of the Pneumonia Care Bundle.

b) Mortality review
- Departmental review of all pneumonia deaths where SJR has been completed and a secondary review is deemed necessary
- Collaborative pneumonia mortality meetings with respiratory medicine and members of the coding team, involving randomised case note review to evaluate and audit accuracy of clinical data entry and subsequent coding process as well as any clinical learning to share with the division.
- The coding team has held training session with respiratory medicine to educate members regarding coding process, importance of correct clinical data entry and coding rules.

c) Education and Training
- Programme of junior doctor teaching at various forums, (including induction) on management of pneumonia and the use of the Pneumonia Care Bundle.
- Refresher teaching/education for medical colleagues and junior doctors regarding use and documenting the CURB 65 risk stratification tool in community acquired pneumonia and early intervention with antibiotics.

d) Avoid unnecessary care home admissions to hospital
- Advanced Care planning training sessions are ongoing. Several GPs and nurses (hospital and community) have attended.

- EPaCCS (end of life care) information is now available on EPR via GMCR. IMT trainees have been educated on how to access this.

Next Steps:
This work will continue to be progressed at a divisional level via the Respiratory Medicine and Acute Adult Care Divisional Governance Meetings, also reporting into the Trust's Mortality Reduction Group. Key areas of focus being:

- Continue monthly data submission for external evaluation and GM peer comparison by AQuA, extend training for more staff to access AQuA data entry portal (PIQS) to ensure more efficient and timely data entry/submission.
- Expansion of education and top-up teaching regarding use and documenting the CURB 65 risk stratification score and timely antibiotic intervention to staff in A&E and Physician Associates.
- Respiratory Medicine team to provide ward based teaching/education around Pneumonia care and the use of CURB 65 tool during in-reach service into the acute wards.
- Work with Medical Registrars to ensure use of CURB 65 tools is re-enforced at morning and evening medical hand-overs
- Collaborative working with Advance Care Planning project board to continue work to avoid unnecessary care home admission to hospital for patients with community acquired pneumonia.

Quality Account Improvement Priorities 2021/22 - Improving radiology reporting times

Timely diagnostic procedures are crucial when helping clinicians decide the best ongoing treatment for patients. A national review by the Care Quality Commission (CQC), highlighted significant variation in the timescales for reporting on radiology examinations and a wide range of arrangements in place to monitor and manage backlogs of unreported images at NHS hospital trusts across the country. Unreported images and imaging backlogs can have implications for clinicians, trust, and ultimately patient safety. This includes delays in diagnosis which can cause stress and anxiety for patients, potentially leading to poorer outcomes. The review called for action to address reporting delays and keep people safe from harm.

The intention to retain the focus on Radiology reporting turnaround times for 2021/22 is based on the commitment in line with national objectives to ensure that the trust has clear oversight of any backlog of radiology reports; which in turn allows accurate assessment and management of risk. This will lead to reduction in mortality and morbidity, prevent harm and enhance the patient experience.

Greater Manchester Imaging Standards – Reducing Unwarranted Variation, have outlined a number of key measures that we can utilise to support our compliance and assurance

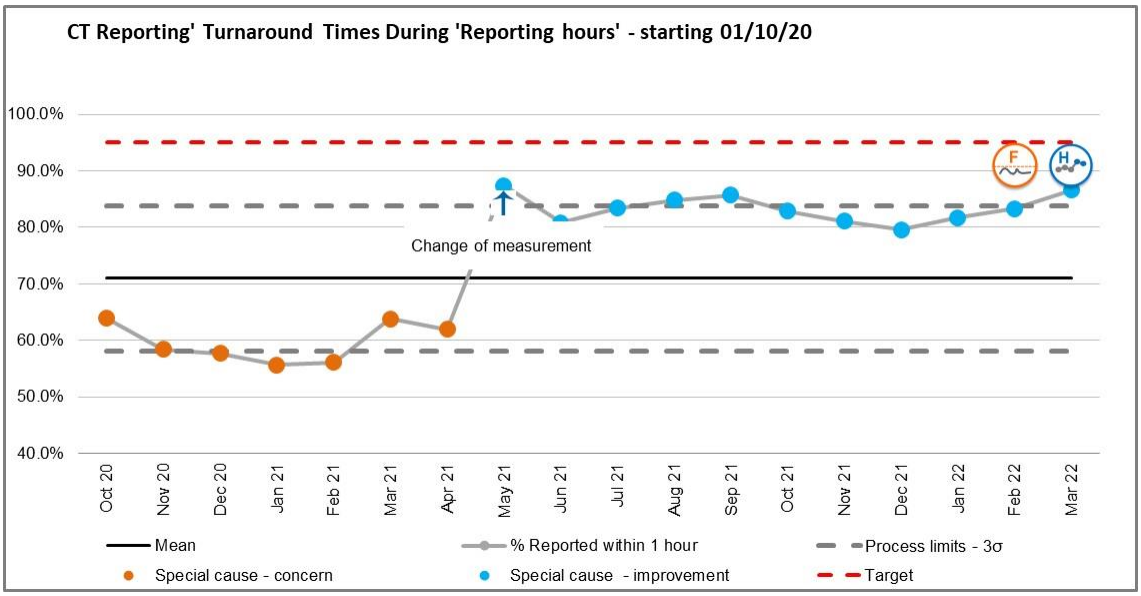
AIM: *The overarching outcome aim was to*:

To demonstrate continuous improvement in compliance against the key performance indicators (KPI) by 31st March 2022 for the following:

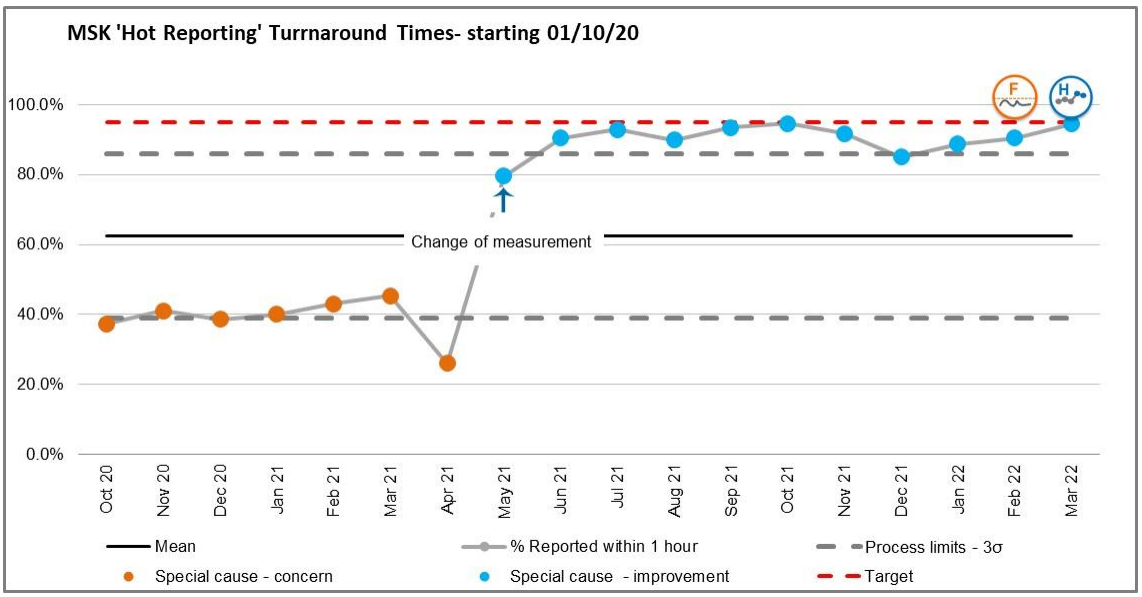
- 95% of CT scans reports within 1 hour – A&E
- 95% of MSK X-Ray reports within 1 hour – A&E

OUTCOME – PARTIAL ACHIEVEMENT

- 87% of CT scan reports within 1 hour – A&E (March 22)
  (94% reported at 90mins and 98% reported within 2 hours)
- 94% of MSK X-Ray reports with 1 hour – A&E (March 22)
  (97% reported within 90mins and 98% reported within 2 hours)



Figures show that although we have not yet met the target there is evidence of special cause improvement in the CT reporting turnaround times during core hours.



Figures show that we met the target in October 2021 but are not yet consistently compliant. The overall position has however demonstrated a significant improvement in the compliance against the target for the hours where we provide a hot reporting service and continues to improve.

Business plan outlined in next steps section would assist with additional reporting capacity to improve reporting turnaround times further

What we have done

We had a comprehensive improvement work plan. The key drivers and interventions for 2021/22 are summarised below:

a) Improve data accuracy (input and output)

- Review of existing data quality and creation of improvement measurement performance strategy in collaboration with Business Intelligence, including
    - Creation of a live A&E performance and inpatient turnaround times to improve visibility of data and allow improved management of services
    - Measurement of performance via Statistical Process Charts(SPC) charts – see examples above
- Review and continuous monitoring of quality and KPIs for the outsourcing company compared with internal measurements
- Review of data measurements and performance of Imaging network peer group against Bolton KPI's

b) Reporting capacity review

- Capacity, demand and activity analysis
    - Increasing activity for x-ray since March 2021 returning to pre-COVID levels. Whilst no target was set for activity, the aim was for activity to return to pre-COVID levels – demonstrating service recovery.
    - A&E CT activity has been increasing since March 2021 and continues to increase in line with increased A&E attendances.
    - Improving percentage compliance turnaround times for CT Scan and MSK 'Hot Reporting' evidence of special cause improvement – see SPC charts above.

c) Flexible working options

- Remote reporting project (in collaboration with IT)
- Review of office utilisation
- Enabling logistical and other issues resolved including insurance and incurred costs to radiologist, IT support, health and safety/ergonomic assessment.
- Successful bid to GM for additional workstations to extend scope of remote reporting to Reporting Radiographers
- Development of home reporting proposal

d) Extend advanced practice in radiography – increase reporting radiographers

- Enrolment on 21/22 academic year advanced practice course - one radiographer enrolled on Chest X-ray reporting and one radiographer enrolled on MSK reporting

Next Steps:
This work will continue to be progressed at a divisional level and performance will be monitored via the measurement dashboard, plus reporting progress to divisional governance and IPM performance. Key areas of focus being:

- Development of business case for additional reporting radiographer resource and job planning agreement.
- Assess reporting demand for each modality against job planned reporting activity
- Develop a system to monitor productivity of reporters as a group to enable baseline capacity to be established
- Development of standard operating procedure for reporting allocation – agree triggers for outsourcing/insourcing
- Monitoring and comparison of productivity during home working
- Development of insourcing proposals in line with GM Strategy
- Review of split contracts to allow improved flexibility of the reporting workforce and assist with retention of staff

Quality Account Improvement Priorities 2021/22 - Improving safety in maternity services 2021/22

Maternity services at Bolton are a key part of the Trust's strategy. In Family Care Division we are very proud of the department's performance in terms of outcomes, their transparency and commitment to learning and their recent work on culture. However, as a number of national reports have shown, most recently the Ockenden reports of 2020 and 2022, it is important that quality, safe and compassionate care remain the focus of our attention.

Despite the CNST workstream being paused nationally during COVID, the trust continued to progress work in this area in order to continuously improve our services, whilst also maintaining our focus on other safety initiatives such as Saving Babies' Lives, Continuity of Carer and the MatNeo Safety collaborative.

AIM: The overarching outcome aim was to:

Demonstrate an improvement in a number of safety elements across Maternity:

- Compliance with all elements for Ockenden 2020 interim report
- CNST compliance
- Perinatal mortality rates
- Hypoxic-ischaemic Encephalopathy (HIE) rates
- Obsteric anal sphincter injury (OASI) 3rd and 4th degree tear rates

OUTCOME: PARTIALLY ACHIEVED

- Ockenden 2020 interim report – 90% compliant
- CNST compliant
- Perinatal mortality rates have increased region wide due to COVID. However, interventions summarised below have allowed us to maintain our position as benchmarking very well within the network (perinatal mortality rates fell in Q4 21/22)
- Hypoxic-ischaemic encephalopathy (HIE) rates continue to compare well with other peer organisations as does our stillbirth rate
- Obsteric anal sphincter injury (OASI) 3rd and 4th degree tear rates remain high

What we have done:
We had a comprehensive improvement work plan. The key drivers and interventions and progress made in 2021/22 are summarised below:

a) Strengthened governance around Ockenden compliance

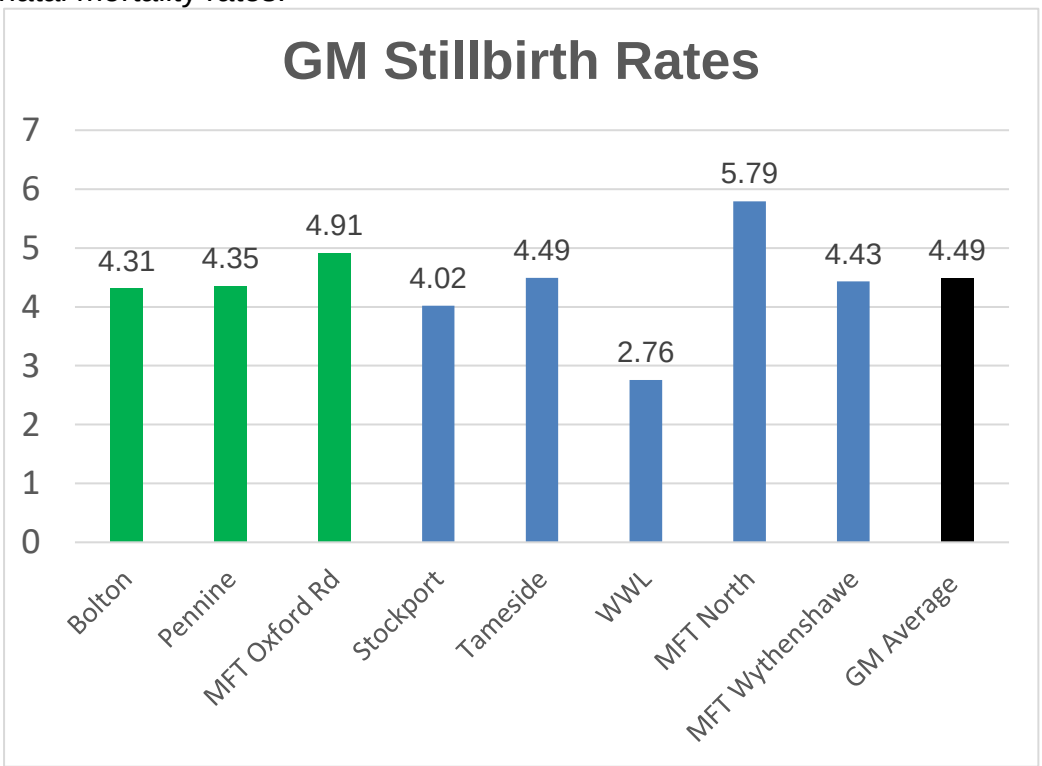
- Self-assessment against the seven immediate and essential actions (IEAs) outlined in the Ockenden 2020 interim report. An initial gap analysis was undertaken to identify current status and areas for improvement. Status at March 2022 was 90% compliance against the 41 standards. With actions in place to achieve full compliance by October 2022.
- Safety Champions meeting governance reviewed and revised
- Maternity Governance (Quality Forum) agenda reviewed to maintain focus and momentum
- Review of audit programme to ensure actions continue
- Ockenden one year on compliance submitted to Trust Board and Board of Governors

b) Strengthened Governance around CNST compliance

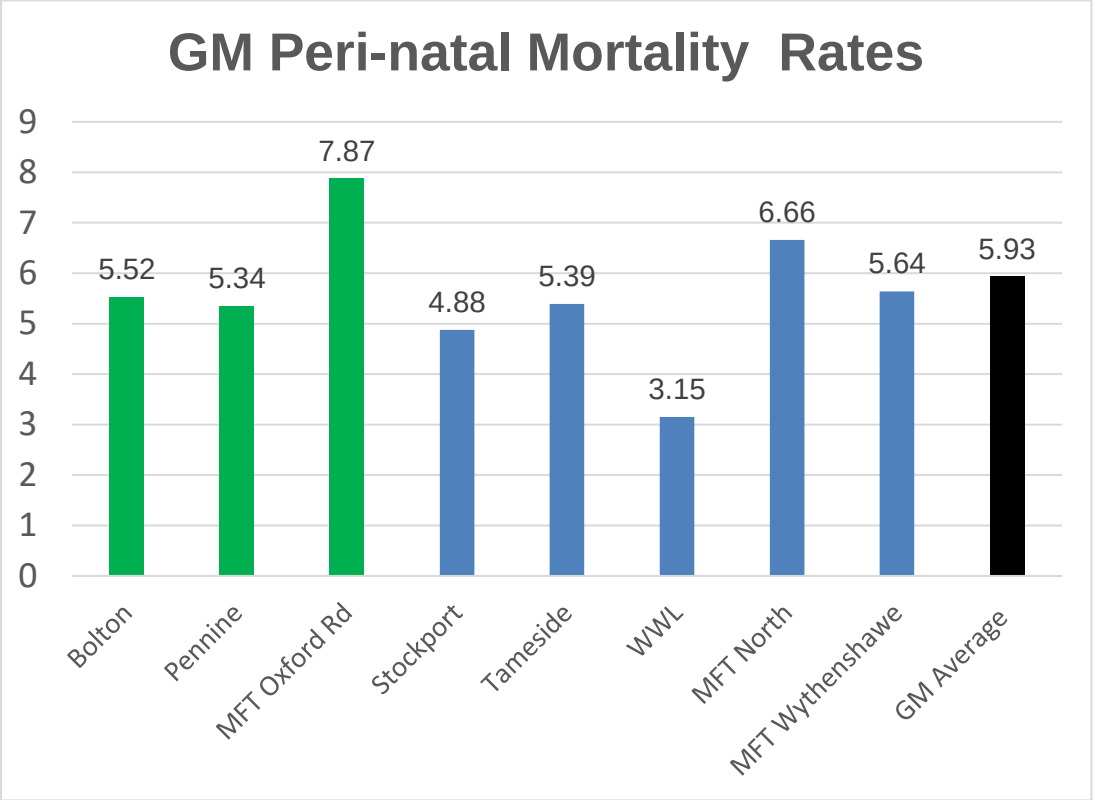
- Evidence for compliance with Year three - Ten safety actions presented to Trust Board and approved
- Plan for Year 4 – compliance criteria received with current submission date of June 2022
- Steering group established to monitor risks, gaps and actions

c) Best practice around perinatal mortality

The COVID pandemic has seen an increase in both stillbirth and perinatal mortality across the region - 75% of mothers who suffered a stillbirth had recently tested positive for COVID. However, the introduction of initiatives such as the rainbow clinic, continued concentration on the Saving Babies Lives bundle, means that we Bolton continues to benchmark well within the network and Q4 saw an overall fall in our perinatal mortality rates.



Data for full year 2021 shows Bolton with the best performance of the tertiary centres (indicated in green below), and third best performance overall for Greater Manchester for stillbirth rates

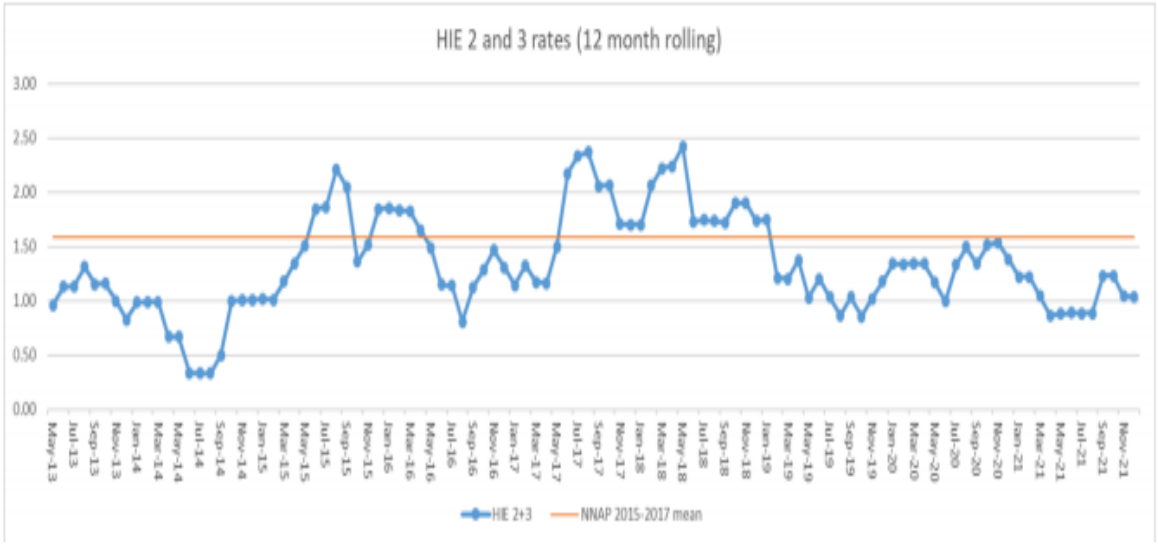


Improvement focussed in this area include:

- Clearer pathway guidance for booking midwifery team for women with multiple high risk issues and education with community teams regarding which pathway to allocate to women with multiple high risk needs
- Discussion and documenting with woman at each visit about COVID vaccination and sign posting of information and how to obtain vaccination.
- Re-writing of diabetes in pregnancy guideline to include clearer timings of scans and MDT diabetic review
- Continue to ensure adherence to saving babies lives pathway
- Investigation of stillbirth rate and peri-natal mortality rates by ethnicity to understand areas for improvements
- Pilot site for the implementation of Tommy's App – to prevent development of early onset pre-eclampsia and therefore delivery of extreme premature infants.

d) Best practice around Hypoxic-ischaemic encephalopathy

- Rates continue to be close to the target line with decline in rates noted since introduction of 24-hour consultant presence.
- Weekly MDT meetings to improve education on Cardiotocography (CTG) interpretation aimed at all doctors and midwives
- MDT training on understanding fetal physiology and fetal monitoring and CTG interpretation
- Audit to assess if rise in caesarean section rate linked to use of fetal physiology to interpret CTG



The data above show a maintained improvement in this area as a result of our training around cardiotocograph (CTG) interpretation and our learning from incidents.

e) Obsteric anal sphincter injury (OASI) best practice around 3rd and 4th degree tears

Data analysis noted higher rates of OASI following forceps delivery and from Q3 ventouse delivery. It is acknowledged that an improvement in training may have resulted in an increase in OASI detection rates.

The actions implemented to address this focussed on:

- Consultant presence for forceps delivery to observe practice, (ensuring correct technique and use of episcissors) and extended to ventouse deliveries from Q3.
- Senior review of all cases where diagnosis of OASI is uncertain following regional analgesia in theatre – ensuring appropriate diagnosis and management.
- Departmental OASI teaching
- Monthly audit of OASI by to identify any trends or training needs, with OASI rates monitored as a KPI locally and regionally.
- OASI leaflet included in the perineal guideline on staff intranet
- OASI training included on PROMPT training for midwives and obstetricians
- OASI discussed with women during 36-week antenatal appointment
- OASI discussed with women undergoing induction of labour
- Pilot site for the national OASI 2 bundle roll-out 2022/23 –including interventions and training and has demonstrated a reduction in OASI in the previous pilot sites

Next Steps:

This work will continue to be progressed at a divisional level and performance will be monitored via the divisional quality forum and IPM performance and via the Trust's Clinical Governance and Quality Assurance Committees. In addition to reporting progress to the national maternity QI initiatives below:

- Ockenden 2022 – benchmarking against the 15 immediate essential actions
- Saving babies Lives
- OASI 2
- Better Births and implementation of Maternity Continuity of Carer
- Spotlight on maternity
- Maternity and Neonatal Safety Collaborative
- Each baby counts
- MBBRACE UK
- CNST

Quality Account Improvement Priorities 2021/22 - National Early Warning Score (NEWS) – Improving the response to escalation

Following a review of governance themes and trends in 2020/21, the Anaesthetic and Surgical Services Division elected to focus their quality account improvement priority on Improving the response to escalation from clinical teams following a deterioration in a patients National Early Warning Score.

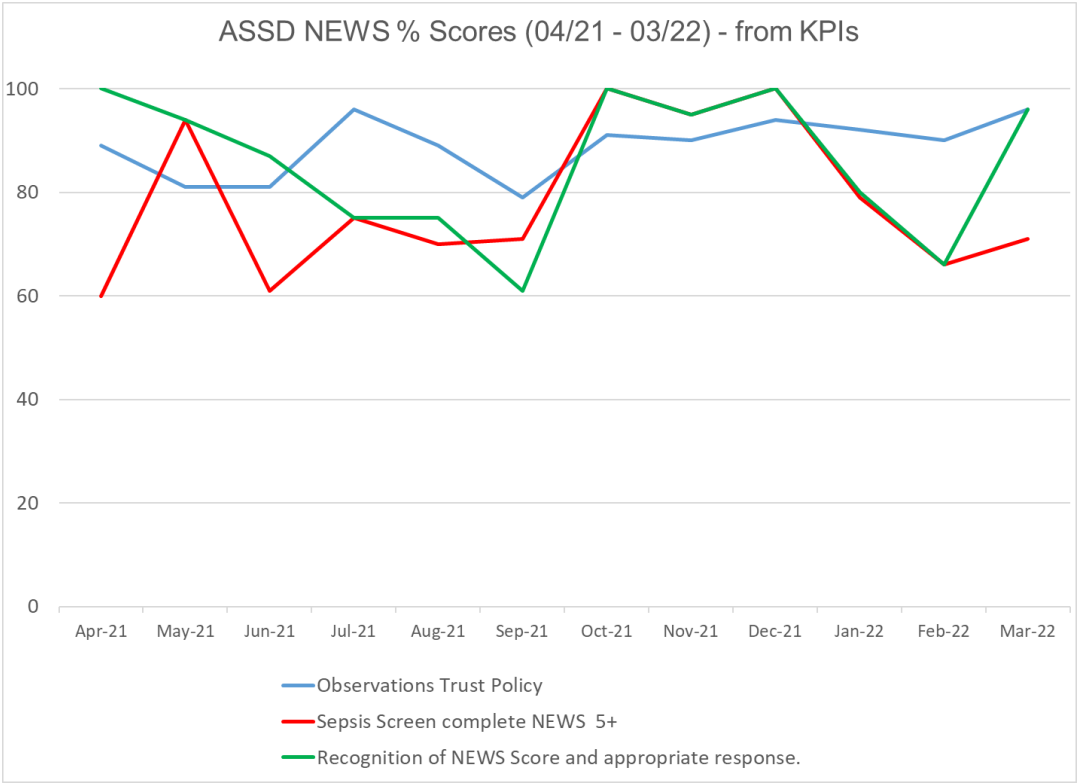
This piece of work focused on the primary escalation of concern and the response from the medical and surgical teams in order to prevent harm and reduce mortality; whilst highlighting areas for learning and training across the division.

AIM: The overarching outcome aim was to:

- Improve the NEWS related KPI metrics (ASSD) to achieve 95% and above

OUTCOME – PARTIAL ACHIEVEMENT

NEWS KPI metrics	Baseline 03/21	21/22 average
• Observations are carried out in line with trust policy	76%	89%
• There is documented evidence that a sepsis screening tool has been completed for any patient with a NEWS score of 5 or more	67%	79%
• There is documented evidence that the nurse has recognised the significance of the news score and actioned an appropriate response.	78%	86%



Although there is still improvement required to consistently achieve the 95% target across all three NEWS related KPIs, there has been an improvement in performance when comparing to baseline set in March 2021.

What we have done:

We had a comprehensive improvement work plan. The key drivers and interventions for 2021/22 are summarised below:

a) Analyse the monthly KPI figures and patient safety incidents in relation to failure to escalate
   - A review of safety incidents in 2020/21 relating to deterioration or treatment delays for benchmarking purposes and to direct improvement focus.
   - Thematic review and actions from divisional reviews
   - Weekly incident report meetings are now embedded in division
   - Targeted thematic reviews across urology and general surgery with correlation across complaints/incidents and SI reviews. MDT improvement plans collated from each speciality in response to themes.
   - KPI improvement plans at ward level with Matron oversight and feeding into divisional governance to demonstrate QI improvements and shared learning for division wide benefit
   - Triangulation of KPI (point prevalence audit) and E-observation data (continuous data) at ward level to feed into improvement plan.
   - Use of EPR data to understand why observations may be missed and actions targeted as appropriate.

b) Review and analyse escalation process within the division and make recommendations for improvement
   - Review of current SBAR and process undertaken
   - MDT working group established
   - Induction hand book for locums in general surgery piloted and shared for trust-wide use.
   - Review of surgical handover process: plan for observation and hot week outlined
   - Review and distribution process established in Divisional Peoples Committee for the oversight of exception reporting.
   - Escalation process shared with junior staff for operational support.

c) Improve education and training programme across division to achieve above 95% in response to NEWS score training.
   - Baseline review of training figures and training needs analysis for nursing workforce - priority for training in relation to upskilling band 6 leadership role in relation to deteriorating patient.
   - Funding for critical care training, AIMS and development of SAFER care programme.
   - 56% of our registered nurses, nursing associates, assistant practitioners and ODPs have completed the Royal College of Physicians NEWS2 e-learning package.
   - All newly qualified staff (joining the ASSD post September 2018) have completed face to face NEWS2 training during their preceptorship induction. The Care

Certificate programme includes a session on the recognition of a deteriorating patient.
- Registered staff are encouraged to complete the internationally recognised AIM (Acute Illness Management) course every three years and HCAs are welcomed onto the AIM for support workers course.
- Monthly focus on mandatory training in relation to NEWS per area led by Practice educator and ADND

d) Response to the Acutely Unwell Patient and reduction in transfers to critical care due to failure to escalate
   - Critical care medical staff commenced audit of patients referred to critical care, timing of observations and response times.
   - Consultant nurse for outreach and critical care working in collaboration with lead medical clinician to progress development of a SAFER EPR assessment document and policy complete to support this SAFER assessment care bundle
   - Safer Programme - Identification of cohort of band 6 Nurses, dates identified for three cohorts in 2022.

Next Steps – continuation of priority into 2022/23

As above demonstrates, a great deal of work has focused on understanding the issues and barriers to escalation and has highlighted areas for learning and training across the Anaesthetic and Surgical Support Division.

However, issues relating to recognising and responding to the deteriorating patient is not an issue solely for the Anaesthetic and Surgical Support division and so we propose to continue this priority into 22/23 - using the learning from 21/22 and widening the scope to all divisions, with ASSD taking the lead

AIM: *The overarching outcome aim is to:*
Improve the following KPI metrics to achieve 95% trust-wide by 31/03/23 1. Observations are carried out in line with trust policy 2. There is documented evidence that a sepsis screening tool has been completed for any patient with a NEWS score of 5 or more 3. There is documented evidence that the nurse has recognised the significance of the news score and actioned an appropriate response.
Other measures we will monitor and report include:
• E-observations – percentage of e-observations taken on time • Patient safety incidents in relation to the failure to escalate a deterioration in the patient's NEWS score • NEWS score training compliance

What we will do

We have a comprehensive improvement work plan. The key drivers and interventions for 2022/23 are summarised below:

a) Analyse the monthly KPI figures and patient safety incidents in relation to failure to escalate.
   - Review target areas within division in relation to data
   - Utilise the E-Observation data reports and link to SCR and thematic reviews across all divisions.

b) Review and analyse escalation process within the divisions and make recommendations for improvement
   - Establish a trust-wide working collaborative MDT group including the hospital at night team.
   - Review actions from divisional incidents. Audit and further develop a standard operating procedure for escalation process.
   - Monitor themes and trends in relation to response times for assessment- patient track audit

c) Improve education and training programme across divisions to achieve 95% in response to NEWS score training.
   - Practice education team to establish opportunity and access to training and assessment for NEWS compliance
   - Review and standardise the induction to trust in relation to NEWS escalation and response for all medical teams. Implement SSAFER programme

d) Response to the Acutely Unwell Patient and reduction in transfers to Critical care due to failure to escalate
   - Audit and review referrals into outreach and critical care with delay to escalation
   - Identify themes and shared learning for improving patient safety

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 improving consultant presence at handover are summarised below:

- NEWS Collaborative group
- Divisional Governance (each division)
- NEWS Escalation working group Clinical Governance and Quality Committee
- Quality Assurance Committee

Quality Account Improvement Priorities 2022/23: Antibiotic Prescribing Standards

The appropriate use of antimicrobial agents is crucial for patient safety and public health, particularly in view of increasing antimicrobial resistance. We measure appropriate use by the quarterly prescribing audits – based upon the Department of Health's Best Practice Guidance for Antimicrobial Stewardship in Hospitals and include the following standards:

- Standard 1: Compliance with Trust Antibiotic Guidelines (*including prescription in line with culture and sensitivity testing and/or microbiology recommendation).*
- Standard 2: Allergy status fully completed
- Standard 3: Stop or review date documented by 72 hours

- Standard 4: If stop/review performed - is the prescribed duration prescribed in line with guidelines / microbiology advice
- Standard 5: Saline flush prescribed and administered (if on IVs)

The outcome aim of this quality account improvement priority is to demonstrate compliance with the antibiotic prescribing standards, trust target being 95%

AIM: *The overarching outcome aim is to:*
To achieve 95% compliance or above with antibiotic prescribing standards by 31/03/23
Other measures we will monitor and report include:
• *The antibiotic audits* • *Compliance with prescribing of saline flush* • *Clostridium difficile cases*

What we will do

We have a comprehensive improvement work plan. The key drivers and interventions for 2022/23 are summarised below:

a) Root cause analysis to understand the multifactorial issues that are a barrier to delivering the standards - Understanding the problem is key to improvement
   - Divisional review of all antimicrobial prescribing to understand the issue
   - Review of ward areas with high usage of IV antibiotics
   - Appointment of antimicrobial champion
   - Investigate EPR as a method to overcome barriers

b) Education and training in prescribing standards
   - Review current training model for all prescribers
   - Investigate feedback to prescribers around standards
   - Develop awareness campaign around Bolton specific issues

c) Analysis of key parameters to understand compliance in some but not in others
   - The antibiotic audits require a review as standard 1, 2 and 5 are multifactorial

d) Clostridium difficile cases are consistently higher rates than similar organisations, the Trust will not achieve its trajectory this year
   - Review themes within clostridium difficile root cause analysis investigations to identify antibiotic prescribing concerns

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 improving consultant presence at handover are summarised below:

- Quality Account Antibiotic Prescribing Standards Task and Finish group
- Divisional Antibiotic Prescribing Standards Task and Finish group
- Divisional Board
- Divisional and Trust IPM
- Trust Antimicrobial Stewardship Group
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Quality Account Improvement Priorities 2022/23: Rheumatology

Rheumatology faces a continued deteriorating position in relation to management of newly referred and existing caseloads. This is reflected within both the PTL incomplete performance and overdue follow up waiting list which in itself currently totals 2,331 patients.

In association with the performance issues identified within the service, it is unable to deliver the care recommendations as advocated within "Rheumatoid Arthritis in over 16s NICE Quality Standard QS33". Therefore, there is a need to review systems and processes within the Rheumatology service, in order to prioritise the actions required to address the concerns that have been highlighted.

Previously, the specialty has focused on performance recovery through additional medical capacity requirement. Whilst this should not be discounted, there is a clear opportunity and inherent desire to focus on wider multidisciplinary team building and associated organizational development. With this focus in place, there is an expectation of developing a collaborative team vision and identity, which will harness the full potential and skills of the staff involved to deliver quality care to Rheumatology patients.

AIM: *The overarching outcome aim is to:*
in line with " Rheumatoid Arthritis in over 16s NICE Quality Standard QS 33" we will offer (and maintain that offer) patients with suspected early inflammatory arthritis (EIA) a specialist assessment within 3 weeks of referral.
Other measures we will monitor and report include:
Caseload: • Overdue follow up waiting list   • Numbers and longest waiters • PTL incomplete performance • Patients triaged as suspected EIA • Numbers of discharges across the department • Number of patients added to PIFU list

What we will do

We have a comprehensive improvement work plan. The key drivers and interventions for 2022/23 are summarised below:

a) Capacity enablement
- Ensure provision of care is in line with service specification

- Develop non-medical workforce to deliver enhanced interventions with autonomy i.e. injections, assessments
- Reinforce Access Policy to ensure inappropriate patients are not retained unnecessarily
- Establish protected EIA clinic
- Establish a separate, identified EIA waiting list
- Consider capacity requirement to support NICE TA715 – moderate RA treatment

b) Implementation of self-management strategies in patients with inflammatory arthritis
   - Enhance patient education and resources to empower and support independence in line with EULAR recommendations
   - Enhance digital self-management offer e.g. video, app signposting (Orcha)

c) Improve waiting list management
   - Ensure correct first appointment allocation – working with the Choose and Book system
   - Trust PTL training & support to Rheumatology operational team
   - Protected, weekly PTL meeting for the Rheumatology operational team
   - Recruitment of deputy OBM role to support consultant led specialties including PTL oversight
   - Raise awareness to team of Access Policy

d) Expand and develop patient initiated follow up (PIFU) for stable patients.
   - Review / benchmark local PIFU implementation sites e.g. Neurology
   - Review / benchmark regional PIFU implementation sites
   - Create an identified PIFU patient data base / list
   - Assure capacity to support

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 improving consultant presence at handover are summarised below:

- Rheumatology Governance
- Rheumatology Steering Group
- ICSD Divisional Governance Meeting
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Quality Account Improvement Priorities 2022/23 - Improving Information to Patients

For the past few years the Family Care division has focused their quality account improvement priority on maternity services. In 2022/23 they wanted something which had a scope across all our services within the divisions, whilst also concentrating on the caring agenda.

Reviewing the CQC surveys the main element of the caring agenda they ask about is information giving. Specifically, they ask about admission at admission, during the stay, when procedures are planned, and at discharge.

When reviewing complaints, we have recognised that lack of communication of information is at the root of a lot of the issues.
We aim to set up a survey asking about information at 5 points:

- On admission, did you know what was going to happen to you?
- During the admission, were you always given the information you needed?
- During the admission, if you had a question was someone available to answer it?
- At discharge, did you know what happened next—in terms of treatment at home and follow up?

This survey will be used as the basis of a quality account improvement priority

AIM: *The overarching outcome aim is to:*
We will improve scores on the information survey by 20% by 31/03/23
Other measures we will monitor and report include:
• *Friends and family test* • *Complaints* • *National patient survey* • *National children and young peoples' survey*

What we will do

We have a comprehensive improvement work plan. The key drivers and interventions for 2022/23 are summarised below:

a) Set up survey as measurement and use as feedback mechanism

- Work with communications team to create Survey Monkey
- Scope ideas for mechanism for survey (e.g. QR codes)

b) Update teams on rationale for survey and roll out questionnaire in clinical areas

- Teams meetings with specialities
- Work with Deputy DDO, Matrons and communications to roll out survey
- Advertise survey in clinical areas

c) Culture change among staff highlighting importance of information to the caring agenda

- Initial meetings as above
- Feedback to teams of survey results
- QI workshops to discuss improvement strategies through PDSA methodology

d) Work on patient expectations around how they should be kept informed

- Posters
- Use of complaints to understand lack of information as a theme.

e) Feedback from National Children and Young Peoples survey highlighting the need for better communication and information to both children and parents/carers

- Engagement with staff on the ward to understand the importance of good communication.
- Posters and leaflets for parents and children.
- Monitoring FFT, compliments and complaints for improvement.

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 improving consultant presence at handover are summarised below:

- Family Care Divisional Governance Meeting
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Quality Account Improvement Priorities 2022/23 - Accessible Information Standards

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard (AIS). The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory. (PHE 2022). Although some steps have been made to date in line with this obligation many of our internal processes are not yet in keeping with the AIS standard.

Following an initial service level review, it has been identified that further work in conjunction with the Equality Diversity and Inclusion team to name but one is necessary to concertedly achieve compliance with the AIS and legislation (Equality Act 2021).

In addition to complying with AIS and legislation the steps outlined as part of this Quality Account are in direct conjunction with Bolton's Strategy and Values- ambition two, *to give every person the best treatment every time*, and the Patient Safety Strategy. Gaining such '*insight*' from this priority will ensure we '*involve*' and time '*improve*' care delivery.

AIM: *The overarching outcome aim is to:*
In line with legislation (Equality Act 2010 improve compliance with the Equality Diversity and Inclusion agenda by incorporating fundamental Accessible Information Standards in relation to Text reminders and digital letters for outpatient and/or elective care(AIS) by 31/03/23.

What we will do
We have a comprehensive improvement work plan. The key drivers and interventions for 2022/23 are summarised below:

a) Ask people if they have any information or communication needs, and find out how to meet their needs.

b) Record those needs clearly and in a set way.

c) Highlight or flag the person's file or notes so it is clear that they have information or communication needs and how to meet those needs.

d) Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.

e) Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

For each of the above we will:

- Gap analysis in collaboration with AIS/Equality Diversity & Inclusion Teams
- Work in conjunction with Trust EDI team to establish best practice
- Review start & end points what do patients receive now and what is required to comply with Accessible Information standards
- Develop a project management Plan and as part of that:
    - Determine communication & engagement plans
    - Establish Technical requirements
    - Configure
    - Extract
    - Test
- Monitor effectiveness and efficacy by measuring performance via Statistical Process Charts(SPC) charts (i.e. prospective monitoring)
- Measure performance against existing parameters in line with national bodies
- Look to reinstate checks at receptions & booking to record additional support needs
- Establish how to share information across NHS providers (with patients' permission)

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 improving consultant presence at handover are summarised below:

- Accessible Information Standard Task and Finish Group
- Clerical Support Services Governance Board Meeting
- Diagnostic and Surgical Support Divisional Governance Meeting
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Mortality Improvements:

Bolton's mortality data, as measured primarily by the metrics of Summary Hospital-level Mortality Indicator (SHMI) and Hospital standardised mortality ratio (HSMR), is higher when compared against local and national peers, after having been in expected range between July and December 2021. The determination of these metrics is complex and is driven by the collation of multiple pieces of data about our patients, which are then analysed using statistical tools that inform us about the number of patients who died within 30 days of being in hospital versus the number that would have been expected to die, given the information we know about them.

Our obligation is to ensure that we are delivering high quality patient care; in particular, we must be certain that we are not harming patients. To this end, we undertake ongoing review of the quality of our care, by the following mechanisms:

- Via Integrated Performance Management and Quality Assurance Committee
- Delivery of divisional and trust wide quality account improvement priorities
- Reporting to GIRFT and AQuA and internal audit
- Serious incident reports and recommendations
- Structured Judgement Reviews via the Learning from Deaths Committee
- Reports to Mortality Reduction Group

Through these routes, we are assured we are safe and effective. We know we can always make improvements and strive for better, but we are now certain that the main reason for our mortality indices sitting outside the expected range is not due to the care we deliver. Following extensive collaboration between our Business Intelligence, Coding, Quality Improvement, Clinical Effectiveness and clinical teams, we now understand that the key issue with our mortality figures is the quality of our data. The key problems we have identified are:

- On average, our patients are recorded as having less comorbidities than comparable patients in other trusts with a similar health demographic to Bolton
- Our current electronic patient record is not set up for easy and consistent recording of comorbidity data
- Administrative and flow systems inaccurately impact on which parts of the patient journey can be submitted to NHSE for analysis, affecting the diagnostic group into which the patient is entered, leading to a falsely low prediction of mortality
- Staffing within the coding department falling well below establishment at the end of 2021 into early 2022, affecting data submission completeness and having a profound impact on our recent mortality metrics, contributing significantly to them going outside expected range
- Fewer patients receiving specialist palliative care input compared to other organisations, which affects the HSMR
- Access to IT systems

Due to the way it is calculated (as a rolling average), there is a lag in seeing the improvements in the mortality indices from the actions being taken. To improve our mortality data, we have already:

- Raised awareness and delivered training for clinical and clerical staff on the importance of accurate and complete comorbidity and diagnosis recording and ADT input

- Increased the establishment in the Coding department, with an immediate improvement in the completeness of data submissions to NHSE
- Recognised the need to improve ward clerk staffing establishments and training with an appropriate action plan in place to address this
- Mandated the inputting of key conditions (Charlson comorbidities) that identify patients as being at a higher risk of death into the EPR
- Ordered additional IT equipment for all wards and clinical areas
- Recruited additional nurses to the Palliative Care team

AIM: *The overarching outcome aim is to:*

Be and then maintain the SHMI and HSMR within the expected range in the next 6-12 months.

To track our progress towards meeting our aim, we will monitor:

- The trend in the SHMI and HSMR with a trajectory to be within the expected national range in the next 6-12 months
- The number of "red alert" diagnostic groups (those that sit outside the expected range for that condition) that have had a clinical and coding review within one month of alerting
- Average comorbidities recorded per patient tracked against national and peer group averages
- The number of patients in whom their comorbidity scores vary significantly between admissions (an indicator of inconsistency of recording)
- Completeness of coding submissions to NHSE

What we will do

Our plan to improve our mortality data includes the following actions:

- Identify clinical champions within each department to drive the understanding and improvement at that level
- Improve the training package for staff using the EPR
- Improve standard operating procedures for clinicians and coders to create common rules for permanent codes for patients and acceptable standard language to ensure data is submissible
- Amend the EPR to automatically upload the Charlson comorbidities - to ensure they are visible and are able to auto-populate the current and future records
- Work with the GM care record team to produce a Charlson comorbidity area in the GP records, to easily identify those key conditions affecting a patient's mortality risk
- Maintain the focus on improving the quality of care, through initiatives to better recognise and respond to the deteriorating patient (through implementation of the RR-SAFER programme) and those with sepsis (with changes in the EPR to support clinical assessment and decision making)

For current mortality metrics, see page 57 and page 54 for more information on learning from deaths.

Statement of assurance from the board

Review of services
During 2021/22 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 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 100 % of the total income generated from the provision of relevant health services by the Bolton NHS Foundation Trust for 2021/22.

Participation in Clinical Audits and Research Activity
The NHS published a list of 49 Quality Accounts (*of which several fall under the same programme of work)

During that period Bolton NHS Foundation Trust participated in 32 out of 32 (100%) national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Bolton did not participate in the following audits:

Not Applicable

• Cleft Registry and Audit Network (CRANE)
• Mental Health Clinical Outcome Review Programme
• Neurosurgical National Audit Programme
• Paediatric Intensive Care Audit (PICANet)
• UK Cystic Fibrosis Registry
• Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry
• National Audit of Pulmonary Hypertension
• National Audit of Cardiovascular Disease Prevention
• National Clinical Audit of Psychosis
• Prescribing Observatory for Mental Health
• Urology Audits
  ○ Management of the Lower Ureter in Nephroureterectomy Audit
  ○ Cytoreductive Radical Nephrectomy Audit

Suspended due to COVID
• National Audit of Dementia (NAD) • 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery

The national clinical audits and national confidential enquiries that Bolton NHS Foundation Trust did participate in during 2021/22 are as follows:

	Project Name	Additional Information/Individual Studies/ Available or last published Data Range	No. of cases submitted
1	Case Mix Programme (CMP) ICNARC	01 April 2021 – 17 February 2022	577
2	Elective Surgery (National PROMs Programme) June 2021 – January 2022	Absolute numbers of scanned questionnaires by procedure Total Scanned Hip Total Scanned Knee	 127 130

3	Royal College of Emergency Medicine QIPs	Pain in Children Infection Prevention and Control *Data collection (4 Apr 2021 – 3 Oct 2022)* **Figures include initial data collection 2019*	511* 139*
4	Falls and Fragility Fracture Audit Programme (FFFAP) 1 Apr21- 21 Feb 22	Fracture Liaison Service Database National Audit of Inpatient Falls National Hip Fracture Database	139 13 364
5	Learning Disabilities Mortality Review Programme (LeDeR)	Please see narrative pg. 55	13
6	Maternal and New-born Infant Clinical Outcome Review Programme	Please see narrative pg. 36	N/A
7	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Children's Asthma (04/21 – 03/22) Secondary Care COPD (04/21 – 03/22) Adult Asthma Pulmonary Rehab	181 235 67 24
8	National Audit of Breast Cancer in Older Patients (NABCOP)	Apr 2021 – Mar 2022	339
9	National Audit of Cardiac Rehabilitation	Apr 2021 to Mar 2022	511
10	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	2019 / 20 cohort 79 children with 100% data completeness	79
11	National Cardiac Arrest Audit (NCAA)	April 21- June 21 July 21- Sept 21 Aug 21 – Dec 21 Jan 22 – March 22	18 19 21 15
12	National Cardiac Audit Programme (NCAP)	Cardiac Rhythm Management - 2021/22 Heart Failure – 2021/22 MINAP - 2021/22	344 485 303
13	National Diabetes Audit – Adults	NaDIA Harms - 01/04/2021 to 28/03/2022	25
14	National Emergency Laparotomy Audit (NELA)	01 April – 30 June 2021 01 July – 30 September 2021	36 41
15	National Gastro-intestinal Cancer Programme	National Bowel Cancer Audit National Oesophago-gastric Cancer	152 123
16	National Joint Registry	1 April 2020 – 31 March 2021 Hip Primary Hip Revision Knee Primary Knee Revision Elbow Primary Shoulder Primary	 21 < 5 9 6 5 5
17	National Lung Cancer Audit (NLCA)	Apr 2021 – January 2022	182
18	National Maternity and Perinatal Audit	Last data available – 2021 (Data between Octo 2020 - Sept 2021)	499
19	National Neonatal Audit Programme (NNAP)		117
20	National Paediatric Diabetes Audit (NPDA)		133
21	National Prostate Cancer Audit (NPCA)	Cancer Outcomes and Services Dataset Apr 2021 – Feb 2022	212
22	National Vascular Registry	2018-2020 NVR cases	212

23	Sentinel Stroke National Audit Programme (SSNAP)	Apr 2021 to Sept 2021	112
24	Serious Hazards of Transfusion Scheme (SHOT)	Jan 2021 – Dec 2021	10
25	The Trauma Audit & Research Network (TARN)		84
26	Chronic Kidney Disease Registry	2020 Data In-centre Haemodialysis (ICHD)	 108
27	National Comparative Audit of Blood Transfusion	2021 Audit of Patient Blood Management and NICE Guidelines	22
28	Inflammatory Bowel Disease National Clinical Audit Project	IBD Registry Biological Therapies	580 484
29	National Early Inflammatory Arthritis Audit (NEIAA)	2021-2022	7
30	Society for Acute Medicine Benchmarking Audit		68
31	British Thoracic Society	National Outpatient Management of Pulmonary Embolism National Smoking Cessation 2021 Audit	5 - 100% 100 - 100%
32	National Audit of Care at the End of Life (NACEL)	Case note retrieval Organisational Questionnaire	40 (100%) 100%

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

NCEPOD Studies were suspended due to COVID and there is currently a 6-month delay. However, below is a summary of the studies along with their current status.

Epilepsy study This NCEPOD study will investigate variation and remediable factors in the processes of care of patients presenting to hospital following an epileptic seizure.	Cases submitted 6/6 100% Organisational report submitted in full

Transition from child to adult health services This NCEPOD will explore the quality of care during transition from child to adult health services.	Organisational report submitted in full Data collection spreadsheet disseminated Feb/March 2022

Crohn's Disease This study will review the remediable factors in the quality of care provided to patients aged 16 and over with a diagnosis of Crohn's disease who underwent a surgical procedure.	Data collection spreadsheets disseminated Feb 22 Patient survey open Mar 2022

Previous Studies which have been reported in 2021/2022

In Hospital Management of Out of Hospital Cardiac Arrests – 'time maters'
The recommendations from this report were multidisciplinary and involved A&E, Critical Care, Cardiac Rehab and Neuro-rehab. The report was published in February 2021 and the aspect relating to Critical Care was discussed and presented at the Trust Audit Committee in November 2021. Gap Analysis and reporting were received from Palliative Care and A&E. Areas of improvement includes:

- Oxygen prescribing

- Introduction of saturation checklist
- TTM and oxygenation - update of policy

Dysphagia in Parkinson's Disease – 'Hard to swallow'
This study examined the review of the quality of dysphagia care provided to patients with Parkinson's disease aged 16 years and over who were admitted to hospital when acutely unwell.

Feedback received from the Community Parkinson Nurses Team. Recommendation:

- Notify the specialist Parkinson's disease service (hospital and/or community) when a patient with Parkinson's disease is admitted, if there is any indication from the notes, or following discussion with the patient of their relatives/carers, that there has been a deterioration or progression of their clinical state. Pathway required for notification to community nurse team when PD patients admitted to ED/ward.

Maternal, New Born and Infant Programme (managed by MBRRACE UK)

Results of the October 2021 MBRRACE Report (based on Jan-Dec 2019 data) are:

- stabilised and adjusted stillbirth rate: 4.01 per 1000 births (within 5% of expected for comparator group)
- stabilised and adjusted neonatal mortality rate: 1.60 per 1000 births (between 5 and 15% lower than the comparator group average)
- stabilised and adjusted extended perinatal mortality rate: 5.59 births (within 5% of expected for comparator group)

When congenital abnormalities are excluded:

- stabilised and adjusted stillbirth rate: 3.56 per 1000 births (within 5% of expected for comparator group)
- stabilised and adjusted neonatal mortality rate: 1.14 per 1000 births (between 5 and 15% lower than the comparator group average)
- stabilised & adjusted extended perinatal mortality rate: 4.68 births (within 5% of expected for stabilised group)

Therefore, in 2019 our performance in these areas was in line with that expected for a maternity service with a NICU.

The Family Care Division continues to deliver against all national maternity safety initiatives designed to meet the national ambition to reduce the number of stillbirths and neonatal deaths:

- Ockenden review – 15 essential actions
- Saving babies Lives
- OASI 2
- Better births
- Spotlight on maternity
- Maternity and Neonatal Safety Collaborative
- Each baby counts
- MBBRACE UK
- CNST

The Family Care Division also made perinatal mortality one of the main strands of its Quality Accounts improvement priorities for 2021/22 (Improving Safety in Maternity).

The Maternity department saw an increase in both stillbirths and Perinatal mortality through 2020 and 2021. However, this was during the COVID period and despite the increase, our figures continued to benchmark well against the rest of the GM network having lower than network average rates for both years.

The department continues to work on its improvement efforts. With the Tommy's app pilot planned for 2022.

National Clinical Audits: Actions to Improve

The reports of 26 national clinical audits were reviewed by the provider in 2021/22 and Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Project Name	Actions:
National PROMs Programme Applicable procedures: Hip replacement Knee replacement	The below data is from the Provisional Patient Reported Outcome Measures (PROMs) Score Comparison Tool Apr 20 to Mar 21, finalised data, published 11/02/22. 41 eligible hospital episodes and 47 pre-operative questionnaires returned – 114.6% participation rate (66.5% in England). 38 post-operative questionnaires sent out, 24 returned 63.2% response rate (59.5% in England). Eligible hospital procedures Hip Replacement – 12 Knee Replacement – 29 Total Hip Replacement EQ-5D Index Modelled records Improved Unchanged Worsened 4 4 (100.0%) 0 (0.0%) 0 (0.0%) Total Hip Replacement EQ VAS Modelled records Improved Unchanged Worsened 4 3 (75.0%) 1 (25.0%) 0 (0.0%) Total Hip Replacement Oxford Hip Score Modelled records Improved Unchanged Worsened 4 4 (100.0%) 0 (0.0%) 0 (0.0%) Total Knee Replacement EQ-5D Index Modelled records Improved Unchanged Worsened 12 12 (100.0%) 0 (0.0%) 0 (0.0%) Total Knee Replacement EQ VAS Modelled records Improved Unchanged Worsened 13 9 (69.2%) 1 (7.7%) 3 (23.1%) Total Knee Replacement Oxford Hip Score Modelled records Improved Unchanged Worsened 14 14 (100.0%) 0 (0.0%) 0 (0.0%) **Modelled records**: the number of questionnaire-pairs for which it has been possible to apply the casemix-adjustment model
Royal College of Emergency Medicine QIPs	Pain in Children - data collection (10/21 – 10/22)

	Infection Prevention and Control - data collection (10/21 – 10/22) The above audits are still ongoing per completion date above.
Falls and Fragility Fracture Audit Programme (FFFAP) – Inpatient Falls	Specific actions from this national audit include; • Ensure your trust or health board participates in NAIF by registering and providing audit data. • Do not use screening tools to identify people at high risk of falls. Instead, offer a multi-factorial falls risk assessment (MFRA) to over 65, and over 50 who may be at higher risk. • Assessment and provision of appropriate walking aids must be available for all newly admitted patients, 7 days a week • Ensure availability on all sites of equipment to safely move patients with suspected spinal injury/hip fracture from the floor. • Record inpatient hip fractures as 'severe harm' in national reporting and learning systems. • Ensure your trusts or health board has a patient safety group which: o includes falls prevention in its remit o is overseen by a member of the executive and non-executive team o regularly reviews data on falls, harm and deaths o assesses their practice against the trends in falls, harm and death rates from falls and reports and discusses these outcomes with the board. • Ensure training in the assessment, prevention and management of inpatient falls is provided for relevant staff groups. The Trust is compliant against all of the above recommendations.
Inflammatory Bowel Disease (IBD) Audit	IBD Registry - Biological Therapies – 09/21 report received. IBD Registry – 580 Patients submitted Biological Therapies - 484 Patients submitted Specific actions from this national audit include; • Record patient reviews and disease assessments (disease-specific score or Physician Global Assessment) at initiation, three months and twelve months after starting a biologic. KPI for national audit of biologic therapies highlighted 49.5% of patients had post induction review to improve our post induction follow up. All patients attending for infusions now complete IBD PROM (auditing this audit: 3976 use of IBD Control PROM to improve post induction follow up in biologic patients) • Consent is paused – but we continue recording and submitting records under the section 251 exemption from consent We are one of only a few trusts in the UK that is a pilot site for obtaining consent for the Registry. • Improve the characterisation of your IBD population by submitting disease characteristics for each patient. Data is now being collected regularly • Use the funnel plots in section 3.2 to assess your relative performance in the audit KPIs and to support your own internal quality improvement, as needed. As above this is being corrected.
Learning Disabilities Mortality Review Programme (LeDeR)	Specific actions from this national audit include; • Every LD death is allocated, reviewed and submitted to the national platform. • All LD patients are now subject to Structured Judgement Reviews See pg. 55 for more information

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	**1.Children's Asthma** Total paediatric medical emergencies 2020/21 is 1731. Total paediatric respiratory coded emergencies same period is 298. **2.Secondary Care COPD -** on-going national audit. Data collection process agreed, currently inputted 235 cases against possible 406 **3.Adult Asthma -** ongoing national audit Data entry commenced July 21 total of 64 cases entered to date **4.PR Audit** - ongoing national audit Data entry commenced July 21 with total of 24 cases entered against possible 74. There has been a delay due to the remote clinic, which does not fit all audit criteria.
National Audit of Breast Cancer in Older Patients (NABCOP)	The last report published 12/08/2021 had 11 recommendations, of which we were compliant against 9. The remaining recommendations have actions in place.
National Audit of Cardiac Rehabilitation	• Proforma to support data completeness/provide clinical input. • Face to face groups remain on hold - request approved, but alternative venue required. Bolton is an outlier in GM for recovery of CR programme • Functional capacity testing and assessment remains face to face to allow safe exercise prescription and remote follow up by physiotherapy. • NACR patient questionnaires reviewed - still variable response • Second assessment face to face clinic launched Feb 22 to support assessment and data collection • Piloting 100 heart manuals to support phase 3 CR delivery (although this would not be a replacement for traditional CR classes) if successful will be offered in addition to standard CR in line with current guidance. • Angina patients have previously not been inputted into NACR – but may consider using early and core. Will review in future. • Plan to work with clinical audit team to review data opt out process and include in SOP. Team introducing patient consent and document on audit proforma
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	2019 / 20 cohort - 79 children with 100% data completeness Similar age, but high deprivation compared to other trusts More 'uncertain' after initial assessment, less diagnosed with epilepsy after one year: According to national comparison improvements required: • arranging ECGs • appropriate first assessment • care planning agreement but not content • school healthcare plan Most seen within 6 – 8 weeks Slow to get EEG Drug use very similar to others Less valproate prescribed especially to girls Good for providing info re SUDEP Actions: • restart QOL clinics (nurse led virtual) • revamp transition clinics to include YP clinic • introduce epilepsy passport (care plan) • improve school IHP system • revisit BPT • further info re ECG / 1st paediatric assessment data

<table>
<tr><td>National Cardiac Arrest Audit (NCAA)</td><td>Available data shows all patients who had a true cardiac arrest were submitted to NCAA – national data not yet available

Local work RCA figures show:
<table>
<tr><th>Time period 2021/2022</th><th>Number of 2222 calls</th><th>% of RCAs completed</th><th>Number of Avoidable Arrests</th></tr>
<tr><td>Q1</td><td>18</td><td>100</td><td>2</td></tr>
<tr><td>Q2</td><td>19</td><td>100</td><td>1</td></tr>
<tr><td>Q3</td><td>21</td><td>100</td><td>2</td></tr>
<tr><td>Q4</td><td>15</td><td>57</td><td>0</td></tr>
</table></td></tr>
<tr><td>National Cardiac Audit Programme (NCAP)</td><td>1. Heart Failure
Gaps in compliance have been:
• Re-establishment of the exercise component of rehabilitation due to ban on group based activity with COVID. Restart approved, but original venue repurposed and alternative venue needs to be sought with financial implications. Mitigation in short term remains the use of the REACH HF programme and Heart Failure manuals-8-12 week home based programme delivered by a HFSN and physiotherapist with a combination of face to face and virtual support.
• Partially compliant with OP review 2 weeks' post-discharge full compliance limited at present by workload and ongoing need for staff to periodically isolate for COVID

2. MINAP
Target of 72 hrs to inpatient angiography is partially compliant due to ongoing COVID restrictions that limit ability to transfer COVID contacts. GM wide issue with some COVID contact angiography lists being established.

3. Cardiac Rhythm Management
Pacenet installed and data transferred allowing live data input
Trust compliant with MDTs on weekly basis and Operator and centre numbers. Quarterly reporting of compliance with indications for complex device implant-fully compliant</td></tr>
<tr><td>National Diabetes Audit – Adults</td><td>National Diabetes Foot Care Audit
Due to COVID, we have not received feedback from the national audit for 2 years. We have continued to input our data throughout this period.

National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms (NaDIA-Harms).
The NaDIA was put on hold in 2021, however, the audit has been reviewed and the evolution of the current, and on-going NaDIA-Harms collection was seen as the natural progression of the NaDIA programme.

Subsequently, the commissioners have reformed NaDIA into a new audit - the National Diabetes Inpatient Safety Audit (NDISA). The emphasis being on the importance of the safety aspects when managing diabetes care for hospital patients. Along with supporting the GIRFT recommendations for diabetic inpatient care, detecting and reducing avoidable harms in the diabetic inpatient community is seen as a key deliverable. The NDISA programme of work appears less burdensome, more automated and accurate way of detecting and reporting inpatient harms. Future newsletters will have more</td></tr>
</table>

	details of the change in processes before they occur. Until then, the current NaDIA-Harms collection is still ongoing, and the next report will be in 2022.
	
	During 2021, an in-house audit and patient questionnaire based on the national criteria was been developed and point prevalence audit took place in October 202, including 23 wards. 94 sets of notes and 48 patient questionnaires.
	
	Audit findings and actions to address is overseen by the Inpatient Quality and Safety governance group, Diabetes Governance group and Diabetes Steering group and findings are included in the trust quality account 2021/22.
	
	Recommendation 1: The MDiT1should meet regularly to discuss day-to-day errors and safety issues and report to a quarterly trust-level diabetes safety board. All hospital-acquired life-threatening episodes of hypoglycaemia, DKA and HHS should be recorded as serious incidents, submitted to NaDIA-Harms and root cause analysis undertaken.
	Partial Compliance - inpatient quality and safety committee meetings occur monthly and report to the diabetes steering group committee. Attendance can be poor and has been escalated through the chair's report and risk, on register (4998). Progress in Q3- attendance has improved
	
	Recommendation 2: Training should be provided for every healthcare professional that dispenses, prescribes and/or administers insulin, appropriate to their level of responsibility, including an assessment of competency. Electronic records and prescribing should be implemented in support.
	Compliant
	• Compliance target is 85% and monitored by divisions
	• Mandatory training packages for all clinical staff depending on your role – all staff with patient facing roles are expected to complete the relevant package and assessment:
	  • Bolton Diabetes for all trust employed HCAs
	  • Bolton Diabetes for all AHPs with patient contact
	  • Hypo recognition and treatment for community and non-ward based nurses
	  • Recognition and treatment for Hypoglycaemia for inpatient care
	  • Bolton Insulin Safety (For all nurses and medical staff)
	  • Diabetic Foot Treatment and Management for ward based staff (For all ward based nurses and medical staff)
	
	Recommendation 3: All trusts should have a dedicated multi-disciplinary team of specialist diabetes inpatient practitioners as indicated in the NHS Long Term Plan. Trusts should work towards providing base level specialist diabetes cover at weekends where this does not exist.
	• **Partial Compliance** an additional two DSN to be employed to start covering a seven-day service.
	
	Recommendation 4:

	All trusts should have a robust system to identify people with diabetes on admission to hospital, including emergencies and elective and non-elective surgery, and a triage system to identify those at risk and rapidly refer them to the diabetes team. This should be an electronic system, integrated with web-linked blood glucose meters, which provide an alert system for staff when any out-of-range reading is recorded. **Compliant** • Identification of inpatients via EPR, a tracking board system, generating a list of all patients with diabetes and a list of patients on insulin therapy • MDPAR scoring system via the in-patient Diabetes Care pathway to assess and triage referrals. The completion of the inpatient pathway is monitored monthly via KPIs • Web linked meters in use. Pin pointing hypos real time via meter upgrade within the next year. In addition, the next generation of glucometers with the interface will help tracking improve further. From the EPR data, audit additional dashboards produced by business intelligence will have logins for teams so they can pinpoint hypos in real time on demand. **Recommendation 5**: All hospital trusts should have clear, audited perioperative pathways from pre-assessment through to discharge. These should be broadly in line with NCEPOD recommendations. **Not compliant** • The trust has commenced work to potentially roll out the expansion of the IPD3 programme (improving the perioperative care of patients with diabetes) including the recruitment of a perioperative diabetes specialist nurse. This model has been successfully rolled out to 10 trusts, with improvements such as reduction in length of stay, care planning, improved would healing, improved satisfaction, improvement in HbA1c and reduced complications of note. Funding application is being sought through surgical elective care. **Recommendation 6**: All trusts should have and promote a self-management policy, which supports patients who want to self-manage their diabetes to safely do so while in hospital, as clinically appropriate and in line with wider NHS England and NHS Improvement policies on inpatient self-management. **Compliant** • Self-administration of insulin is part of the medicines policy. • The self–administration of insulin criteria has been included within the inpatient BOSCA to support the roll out • Pilot of the self-administration and management of insulin in hospital • EPR prompt message for those who are self-administrating their insulin. • An audit of the wards thus far confirms that the self-administration of insulin roll-out has been embedded into current practices.

<table>
<tr><td></td><td><u>National Diabetes Continuous Harms Data base (NDHARMS/ AUDIT 3749)</u>
• Monthly submission to NDHARMS ongoing
• Since the national audit commenced, 57 harms have been registered in total for the trust.
• In 2021, there were 22 harms of which 9 were inpatient DKA and 13 patients requiring hypoglycaemic rescue.</td></tr>
<tr><td>National Emergency Laparotomy Audit (NELA)</td><td>Sixth annual NELA report published 11/20 - sample results
• National case ascertainment - 84.5%
• Trust case ascertainment was 100%.
• CT Scan Preoperative National 90.5%, with the results reported before surgery: trust 68.1%, national 62.3%.
• Documented risk assessment before surgery, trust 99%, national 84%.
• Arrival to theatre in a timescale appropriate for the urgency of surgery, trust 88%, national 83%.
• Pre-op consultant input from an Anaesthetist, trust 100%, national 93.9%,
• Pre-op consultant input from a Surgeon, trust 100%, national 96.9%.
• A Pre-op input by a consultant intensivist, trust 76.8%, national 76.9%,
• A Consultants presence in Theatres, trust, a surgeon present 96% and an Anaesthetist 100%, - national 94.8% for a Surgeon and 92.3% for an anaesthetist.
• Post op critical care admission when risk of death ≥5%, trust 95%, national 85.2%.
• The 30-day mortality rate, trust 6.9%, national 9.31%.
Data was presented and discussed at AQuIL Committee</td></tr>
<tr><td>National Oesophago-Gastric Cancer Audit</td><td>In the last report published 12/2021 we submitted 123 records to the audit, 85 – 100 % case ascertainment rate, which is similar to other trusts in GM. The report published 10 recommendations, 7 were applicable, 100% compliant.</td></tr>
<tr><td>National Joint Registry</td><td>Hospital information is based on operation date, 01/20 – 12/20
Compliance is measured by comparing the proportion of all joint replacements entered into the registry, with those submitted to the Hospital Episode Statistics (HES).

The trust completed 121 procedures
Consent Rate was 67%
The trust performed within expected range for the following
• Hips & Knees
• 90-day mortality
• Revision rate since 2011
• Revision rate since 2016

Hips - 08/11 – 08/21
<table><tr><th>Patient Outcomes Quality Measure</th><th>This Hospital</th><th>Patient Records Analysed</th><th>This Hospital Ratio</th><th>National Ratio</th></tr><tr><td>90 Day Mortality: Operations Aug16-Aug21</td><td>OK As Expected</td><td>566</td><td>0.65</td><td>1.00</td></tr></table></td></tr>
</table>

	Revision Rate: Operations Aug11-Aug21	OK As Expected	1669	0.70	1.00
	Revision Rate: Operations Aug16-Aug21	OK As Expected	684	0.48	1.00

Knees - 08/11 – 08/21

Patient Outcomes Quality Measure	This Hospital	Patient Records Analysed	This Hospital Ratio	National Ratio
90 Day Mortality: Operations Aug16-Aug21	OK As Expected	802	2.23	1.00
Revision Rate: Operations Aug11-Aug21	OK As Expected	1836	0.96	1.00
Revision Rate: Operations Aug16-Aug21	OK As Expected	815	0.92	1.00

National Lung Cancer Audit (NLCA)	The latest published report shows trust figures are not statistically different to the region or national averages. The results are presented at Clinical Governance and the outcome data present at peer review.
National Maternity and Perinatal Audit	Information taken from Gap Analysis 2021 - NMPA-BMI-Over-30-Report Recommendation: Audit local rates of missing data on BMI (or height and weight) before the end of the 2021/22, and commence local initiatives to improve electronic recording Compliant: No Action: IT Midwife to retrieve missing data on BMI Recommendation: Commence by the end of June 2023 the production of, or include in updates to existing documents, detailed guidance on the antenatal and intrapartum care offered to women who are suspected to have a large-for-gestational-age baby, including whether the guidance should differ for women with a BMI of 30 kg/m2 or above. Complaint: Yes- Guideline on Mx of LGA Action: n/a Recommendation: Support research and investigation into why women with a BMI of 30 kg/m2 or above have a higher risk of stillbirth, in order to inform clinical care which aims to reduce this risk. Compliant: Yes -through Stillbirth reviews and annual audit Action: N/A Recommendation: Identify common causes for readmission to the maternity unit following birth specifically for women with a BMI of

	40 kg/m2 or above, and commence local quality improvement initiatives to reduce the risk of readmission. Compliant: No Action: Add to Audit Plan 2022/2023 Recommendation: Offer all women breastfeeding information and support during pregnancy and again shortly after the birth. Women with a BMI of 30 kg/m2 or above may require support to be tailored to their specific needs and to be provided by a healthcare professional who is trained to adapt breastfeeding techniques for women with a higher BMI. Complaint: Yes Action: Recommence antenatal parent education programme suspended due to COVID. Recommence breastfeeding workshops for antenatal feeding preparation. Diabetes team are discussing antenatal collection harvesting with their clients. Mothers who are experiencing difficulties with breastfeeding in postnatal area can be referred to Infant Feeding Specialist Service as required
National Neonatal Audit Programme (NNAP)	A selection of the results from 2021/2022 reporting Mothers who delivered their babies between 23 and 33 weeks inclusive at Royal Bolton Hospital and received any dose of antenatal steroids. 85 (96.6%) Proportion of babies who had deferred cord clamping (≥ 1 minute) at Royal Bolton Hospital 26 (48.1%) Numbers of parents present on one or more ward rounds of babies with admissions of more than 24 hours 509 (99.2%) **Feedback and Assurance** The Team regularly discuss the key quality indicators from NNAP audit in their monthly neonatal Quality forum meetings and via dashboard at the iPM meetings. Within the department, this information is discussed at induction for trainee doctors and regular updates via emails and departmental teaching sessions to the medical and ANNPs colleagues. It was identified in early 2021 that parental communication within 24 hours by a senior was not being updated on Badger during the COVID period in 2020. A QI project was set up to improve the documentation on Badger with the help of ward clerks to ensure written communication from the medical notes was transcribed electronically to badger. The Team have made significant improvements to this figure and are performing above the national average for 2021/22. The team has identified that we are performing above the national average for most parameters. The BPD rated (bronchopulmonary dysplasia) rates are higher than the national average and we have noted this for the last 4 years. An audit of the NICE guidance for preterm respiratory care in 2019 showed that we were not offering LISA (Less invasive surfactant administration) which was a novel modality being practised in <30% units across the UK. We have successfully implemented this modality for babies >27 weeks' gestation and a multidisciplinary QI group has been established in

<table>
<tr><td></td><td>late 2021 to establish our current practice and plan for reducing our BPD rates.

Amongst the Teams notable successes for 2021/22, we had a preterm baby surviving and being discharged home after being born at 21+6 weeks' gestation, which is the earliest gestation to survive in the region to the best of our knowledge.</td></tr>
<tr><td>National Paediatric Diabetes Audit (NPDA)</td><td>The team are producing a Type 2 diabetes specific guideline, with sections on routine investigations, following national guidance. We are also producing an Insulin resistance guideline to guide general Paediatricians in management before referring into the diabetes service. Given current numbers we have not created a separate Type 2 clinic, but will continue to monitor this moving forward.</td></tr>
<tr><td>National Prostate Cancer Audit (NPCA)</td><td>Annual Report 2021 Data
<table><tr><th>Data Quality</th><th>Diagnosing Trust</th><th>Specialist MDT</th></tr><tr><td>No. of Cancer Registry records</td><td>171</td><td>563</td></tr><tr><td>Performance Status recorded</td><td>85%</td><td>91%</td></tr><tr><td>TNM completed</td><td>63%</td><td>69%</td></tr><tr><td>Stage variable assigned</td><td>80%</td><td>83%</td></tr></table>
<table><tr><th>Disease Presentation</th><th>Specialist MDT</th><th>National</th></tr><tr><td>No. of men with disease status determined</td><td>507</td><td>34801</td></tr><tr><td>Percentage of men diagnosed with metastatic disease</td><td>16%</td><td>13%</td></tr></table></td></tr>
<tr><td>National Vascular Registry</td><td>We only carry out lower limb angioplasty procedures.

The 2021 report shows we had 212 NVR cases 2018-2020, Day cases in 2020 91%. The readmission within 30 days 2020 2.0%, CLTI waiting times cases 2020 <10.

National NVR cases 2018-2020 was 15,126, Day cases 2020 58%, readmission within 30 days 2020 11.6% and CLTI waiting times cases 2020 1,776</td></tr>
<tr><td>Sentinel Stroke National Audit Programme (SSNAP)</td><td>Patient level scores which include the patient pathway including the HASUs.

Although case note ascertainment is good, the scores for audit compliance have been impacted with delays from Salford and Bolton due to staffing related to COVID.

Key Indictors scores 2021/2022
1. Thrombolysis (HASUs data not RBH) for the 4 quarters – BED
BED is the patient-centred score; our team-centred score is N/A as the team did not perform thrombolysis.
2. Case note ascertainment - AAA
3. Audit compliance - BDD
4. SNNAP combined indicator level - BCB.

Note: Each Key Indictors has various domains. Each domain is assigned a number of points based on compliance.
Those points are: A=100 B=80 C=60 D=40 E=20</td></tr>
<tr><td>Serious Hazards of Transfusion Scheme (SHOT)</td><td>With an improvement in 2021 figures, no concerns raised after the report has been disseminated and discussed - the trust is not an outlier regarding benchmarking statistics.</td></tr>
</table>

The Trauma Audit & Research Network (TARN)	According to TARN and HSE we estimate our number of cases p/a should be around 400, we are currently at 21% ascertainment for the Q1 21/22, we anticipate this improving when we have our fully trained dedicated TARN inputter – approx. August 2022. Lack of TARN data has been added to the 'at risk' register. Approval has been granted to develop a business case for a dedicated TARN data collector. An interim solution has enabled TARN data entry from Nov 2020 – April 2021.
National Audit of Care at the End of Life (NACEL) Round 3 Organisational Level Audit Case Note Review 40 consecutive patients in April and May 2021	Key Themes • Perform well in communicating with families and loved ones • Need to improve in documentation of discussions with patient and/or documenting why such discussions are not taking place e.g. capacity assessments. • Learning points in the area of advance care planning. • The trust is under resourced in terms of staffing in comparison to other teams nationally. • Staff feel well supported by the Specialist Palliative Care Team, but many had not received training specific to end of life care in the past 3 years. • Advance care planning training available across the locality. Specialist Palliative care education including recognising the dying patient provided to Foundation trainees, CMTs and GP trainees. Actions: • REAL plan - basic communication skills training package for ALL staff in how to communicate sensitively, break bad news and specific scenarios in end of life care. • Electronic Palliative Care Coordination System (EPaCCS) available on GMCR and rolled out across the Health Economy. Continued training required to encourage relevant staff to access this record and to keep records relevant and up to date. • The advance care planning (ACP) project board set up with workstreams to improve ACP across the Health Economy. • Record of Care for the Dying Person will be reviewed as part of the Advance Care Planning work stream and adapted for EPR. • The 'care of a loved one' leaflet reviewed and to go to print. • Business case submitted to improve staff resource in line with other organisations nationally. Improving staff resource will allow the team to reach more patients, improve advance care planning and our education offering. We have registered for round 4 of this audit. We will not be submitting to the Quality Survey for our Hospital and Community as there is already have a robust bereavement survey in place.
National Early Inflammatory Arthritis Audit (NEIAA)	• Rheumatology Team are continuing to recruit to the NEIA • Identified EIA/urgent slots (3 per substantive consultant post/week) since around Aug/Sept'21 new template set up to improve waiting time • Current waiting time for EIA appointment is 10 weeks as of 18 3 22 (national guideline - 3 weeks) • New Consultant business case for EIA service – ongoing: for updating and re-submitting for approval • At the close of current year of NEIAA recruitment April 22 a full national report and a local report will be forwarded to us by the BSR NEIAA team, this will be shared appropriately.

Local Clinical Audits

297 local clinical audits were registered by the Bolton Hospital NHS Foundation Trust in 2021/22. The breakdown is as follows:

Row Labels	N
Clinical Interest	63
Incidents/Inquests	13
CNST	10
Local Standard/Policy	32
Monitoring	21
National Regulations/CQC	26
Patient Satisfaction	2
Quality Improvement	70
Record Keeping/Documentation	6
Royal College/External Regulation	13
NICE	41
Grand Total	**297**

Local Clinical Audits, examples of learning and actions to improve

Below are some examples of the Trust's completed local audits which have taken place in 2021/22 with identified learning and actions.

Audit title	Aim	Learning/Actions
VTE Risk Assessment Audit	Pulmonary embolism is a leading direct cause of maternal death in the UK NICE estimates LMWH reduces VTE risk in medical and surgical patients by 60% and 70% respectively Admission to hospital during pregnancy is associated with an 18-fold increased risk of first VTE compared with time outside hospital; the risk remains increased after discharge, being six-fold higher in the 28 days after discharge	• if admitting people (usually from triage/ANDU) need to Px TEDs and clexane unless delivery imminent / or risk of bleeding • VTE risk to be included on midwifery SBAR admission sheet/huddles • Document VTE risk calculation on admission to CDS. • Document VTE risk score on doctors' ward rounds • VTE score documented at each antenatal clinic appointment alongside BP/urine checks to prompt commencement of LMWH if VTE 3 or more • Ensure patient's weight is known before Px postnatal clexane
Screening of Gestational Diabetes during COVID	Diabetes occurs in 2-5% of all UK pregnancies with prevalence increasing. 40 years ago, the majority of women with DM attending antenatal clinic had type 1, but today the majority of women have type 2 or gestational DM. the prevalence of type 2 DM is predicted to increase due to current trends in obesity	• Continue with current practice of GDM screening no evidence of increased maternal or fetal poor outcomes • Gain local data for GTT screening in previous years for comparison • Re-audit in 1 year (cases

	and physical inactivity	from Mar-April 21—present June22) with comparison of previous years' cases screened by OGTT. • Consider FPG ≥ 5.3 mmol/L to improve detection rate if resources and capacity allow, as there is a potential for increased number of women accessing services with a diagnosis of GDM. • Clinicians will need to be aware that while the specificity of the above HbA1c and FPG thresholds are high (i.e. low false positive rate) for diagnosing GDM, the detection rate is low
Gestational Diabetes Risk Assessment Audit	The identification of women with Type 1 and Type 2 diabetes and those at risk of developing Gestational Diabetes will lead to appropriate management during pregnancy. Establishing and maintaining good blood glucose control will contribute to reduction in the risks associated with diabetes including miscarriage, congenital malformation, stillbirth, neonatal death, congenital abnormality, heart disease, stroke, retinopathy, blindness and kidney failure.	• All women should have a risk assessment for Gestational Diabetes performed and appropriate referral for OGTT • Ensure generally that midwives are aware of the risk factors for gestational diabetes and are referring accurately for OGTT • To continue to audit 6 monthly to ensure women are being appropriately screened for GDM and learning from audit has been embedded
2229 Management of Sepsis in Children NICE NG51	Audit of management of sepsis in children covering compliance with national CQUIN in more detail than is currently gathered, compliance with NICE guideline and Quality Standards also covering use of Sepsis 6, compliance with current paperwork/PEWS scoring and looking forward to introducing new screening tools and stratification in line with NICE.	• Aim for 90% compliance across all areas of the audit • To improve delivery of IVABX where clinically indicated • For new sepsis screening tool to be implemented across all Paediatric areas • Sepsis information leaflet to be distributed within the Paediatric Emergency Department • Sepsis in children leaflet on discharge to all patients who have been treated for sepsis. • Implementation of sepsis screening tool
3474 Check compliance with NICE guidelines for UTI in children <16 years of age	Evidence of compliance with NICE guidelines	• Documenting dipstick results using the 'Point of Care Testing' aspect of EPR's Flowsheets tab • Documenting on WR/discharge the category of a UTI to ensure no follow-up is missed

		• Encouragement to search for previous samples on 'LabCentre', to not miss recurrent cases • Re-audit 1 year
3874 Audit of Paediatric Audiology paper based records	Evidence that Paediatric Audiology paper based records are meeting trust documentation standards	• Only entries in the preceding 12 months should be audited • Clinic letter template amended to include clinic and typed date • Ensure allergies are recorded on front cover of records • Where there is a delay in reviewing a child from the recommended timescale, the reason, if known e.g. COVID, should be recorded • Demographics sheets to be filed in all records • As nursery/school not in demographics sheet, to document this either on front of records or demographics sheet • Purchase stamp re demographics and consent for GF19
3924 Bedside Transfusion Practice	To assess compliance with current transfusion guidelines on bedside practice and the correct completion of transfusion documentation	Improvements required: • Documentation of transfusion activities. Action plans put in place to improvement awareness and re-audit 100% compliance for: • Correct use of wristbands and identifiers for a patient having a transfusion.
3399 An audit to evaluate the need of prescribing weak opioids as independent prescribing physiotherapist working in first contact roles	The use of non-steroidal anti-inflammatory drugs (NSAIDS) in the management of acute moderate musculoskeletal pain is well documented and recommended in both local and national guidelines. However, the use of NSAIDS has become more constrained due to an aging population and contraindications to its use. This audit will examine how often First Contact Physiotherapist with independent prescribing qualification encounter the need to prescribe codeine (co-codamol) for pain management in patients to allow improved function and movement and thus address the health and wellbeing needs of patients and possibly supporting a return to work	This is particularly appropriate for FCP working in areas of deprivation. Despite the low prescription rate, post graduate independent prescribing module remains a valuable educational possession to support FCP in the medicine optimisation of patients presenting with pain. Current restrictions by HCPC in opioid prescribing rights by physiotherapist working in a first contact role, in primary care causes, delay, inconvenience and disruption for health care professionals, the patient and FCP.
3609 Advice on the safe	The audit will identify if all aspects of safe practice for prescribing isotretinoin, for female patients is being followed correctly.	PHQ9 forms are used to measure and document mood in patients that are on Isotretinoin,

introduction and continued use of isotretinoin in acne in the UK	Ensuring compliance British Association of Dermatologists guidelines	some patients have these, other have mood documented in the notes. A standard approach to be applied
3962 ICU Handover Audit	To monitor morning and evening handovers	• Issues with standardisation of data collection • Overall, most aspects of handover are done fairly well. • Area for potential improvement would be to avoid interruptions/bleeps during handover. • Particularly switchboard bleeps could be avoided – scope the possibility to arrange for a change in the time of the emergency bleep checks
3312 Adults NICE CG 103 In Emergency Department	To assess adherence to NICE Clinical Guideline 103: Delirium quality statement "Adults newly admitted to hospital or long-term care who are at risk of delirium are assessed for recent changes in behavior, including cognition, perception, physical function and social behavior" in a busy Emergency Department.	• Following discussions with the frailly team; there is working on-going around this topic. • Need formal discussions around delirium assessments
3809 Management of Dental Abscess	Since March 2020 Dental presentations to Emergency Departments have increased by 800%. Staff knowledge and management suspected to be inadequate.	• Guidelines already exist, • Inform/ sign post clinicians to the guidelines on the NICE website, to improve antibiotic stewardship and patients would be informed of self-care advice.
3538 VTE prophylaxis and regular medicines charting in acute general surgical admissions: are we compliant?	To examine whether VTE prophylaxis and charting of regular medicines in patients admitted under the acute general surgical take complies with recommendations from trust guidelines.	• Use of Graphnet and GP Summary Care Records to obtain a list of patients' regular medications at the time of admission • Junior doctors verbally communicating to nursing staff any critical medicines that need prompt administration • Distribution of an email detailing findings to current and new staff to enact change • Re-audit following above intervention
4032 IV Fluid Prescribing for General Surgical Patients	Currently NICE suggests adult patients requiring maintenance fluids receive: 25-30ml/kg of water, approximately 1mmol/kg/day of each Potassium, Sodium and Chloride. Assess and improve trust compliance with	• Poor compliance with NICE guidance relating to IV maintenance fluid prescriptions during audit period. • Improve compliance through junior doctor IVF prescribing

	NICE guidelines for maintenance intravenous fluid prescriptions for general surgical patients. Use inpatient data to assess current practice.	teaching and increase access to NICE guidance relating to maintenance fluid prescriptions on surgical wards.
Smoking in pregnancy	To look at the impact that smoking in pregnancy has on the outcome for mother and baby	• Increase education to ensure data inputting for smoking statistics is accurate and new tobacco control plan to be introduced • Lead midwife to attend team meetings and increase visibility on CDS • Review guidelines in line with new NICE and update if appropriate.
3829 Audit of Perinatal Mental Health Referrals in Royal Bolton Hospital	To improve care and service delivery for women with perinatal mental health concerns- improving referral pathway and system. • Determine indications for PMH referrals • Determine compliance with timescale of referral response • Proportion of referrals seen at the PNMH ANC at 28 weeks • Proportion of referrals with documented care plan by 32 weeks • Percentage of women who had PMH enquiring at every visit- antenatal and postnatal	• All red category referrals should be triaged/action plan within 14 days • Women in the red category should have PMH ANC referral and review by 28 weeks • Women in the red category should have documented care plan on E3 by 32 weeks • Referrals should be appropriate • PCMHT and safeguarding referrals where indicated
3746 Virtual Keratoconus monitoring Clinic	To see how effective, the new Keratoconus monitoring clinic is running with the new virtual service and face to face appointments compared to previous face to face only appointment	• Improvements needed in questionnaire responses. • Small number of patients booked into virtual clinic incorrectly/not suitable for the patient and small no of patients had inconclusive scans due to poor quality of scans/wearing cls for scans • Ensure patients are booked on correct pathway and appropriate recall for monitoring • Able to increase capacity for EJKCL Clinic • Reduce chair/contact time during COVID by offering virtual clinic • Ensure patients are attending the most appropriate clinic • The Optometry team have been able to set up a service to address waiting times following lockdown ensuring patients are seen in good time to help limit preventable sight loss

Participation in Clinical Research
45 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 2021/22. 2502 patients receiving relevant health services provided or sub-contracted by Bolton NHS Foundation Trust were recruited to participate in research during that period.

Goals agreed with Commissioners: use of the CQUIN payment framework

In accordance with the revised arrangement for NHS contracting and payment during the COVID pandemic (Publications approval reference: 001559), Bolton NHS Foundation Trust was paid for all activity via block payments in 2021/22 and 2020/21. These blocks were deemed to include payment for Commissioning for Quality and Innovation (CQUIN).

The operation of CQUIN for Trusts was suspended in 2021/22 and 2020/21; the Trust therefore did not to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data.

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 2021/22.

Bolton NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Bolton NHS Foundation Trust was inspected by CQC in December 2018 and reported in April 2019 and achieved an overall rating of "**GOOD**", with some key areas of outstanding practice and rated as "**OUTSTANDING"** for being well led at every level. Please see below CQC ratings grid:

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Data Quality
Bolton NHS Foundation Trust submitted records during 2021/22 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:**
  - *99.9 %* for admitted patient care;
  - *99.9 %* for outpatient care; and
  - *99.7 %* for accident and emergency care.

- **which included the patient's valid General Medical Practice Code was:**
    - *94.4 %* for admitted patient care;
    - *99.6 %* for outpatient care; and
    - *99.2 %* for accident and emergency care.

Action to Improve Data Quality

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

- 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. This also includes ethnicity to ensure our services meet the needs of the population we serve
- The Data Quality team continues to provide advice and guidance to other users
- The Data Quality team are involved in discussions regarding how activity should be recorded in line with the National definitions
- 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 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 have recently been reviewed by the team and updated as and where necessary
- The RTT validation team is now under the management of the Deputy Head of Business Intelligence (Data Quality). There is now an RTT data lead in post who delivers RTT awareness sessions not only within our own team but across the wider organization.
- The team support numerous projects across the organisation to ensure that data is recorded correctly and in line with national definitions
- In addition to this we receive assurance on the accuracy of our data quality through an annual report on non-financial data from our internal auditors, a review of metrics included in this report performed as part of the audit conducted by our external auditors and other external audit reports as appropriate
- The data quality strategy is now embedded within the Informatics strategy. This will assist the team in moving forward and by raising the importance of quality data will ultimately lead to improvements

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 2021/22 by the Audit Commission.

Learning from Deaths -

During 2021/22 1333* of Bolton NHS Foundation Trust patients died in hospital. **excluding AE, Babies and community*

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

- 302 in the first quarter;
- 323 in the second quarter;
- 360 in the third quarter;
- 348 in the fourth quarter.

In 2021/22, 194 structured judgement case record reviews and 69 cardiac arrest root cause analysis investigations (where the patient did not survive) have been carried out in relation to 1333* of the deaths included above.

Out of 194 Structured judgement cases recorded, in 5 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:

- 70 Case record reviews in the first quarter; Investigations = 1
- 53 Case record reviews in the second quarter; Investigations = 1
- 64 Case record reviews in the third quarter; Investigations = 1
- 7 Case records reviews in the fourth quarter; Investigations = 2

0.83% (11/1333 x 100) (4 avoidable cardiac arrests, 7 deaths audited by Structured Judgement Review) of the patient deaths 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.

In relation to each quarter, this consisted of:

- 4 representing 1.3 % (4/302 x 100) for the first quarter; (2 SJR and 2 avoidable CA_
- 4 representing 1.2 % (4/323 x 100) for the second quarter; (3 SJR and 1 avoidable CA)
- 2 representing 0.6 % (2/360 x 100) for the third quarter; (1 SJR 1 avoidable CA)
- 1 representing 0.3 % (1/348 x 100) for the fourth quarter. (1 SJR)

These numbers have been estimated using the data provided within the cardiac arrest root cause analysis reports and adult 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 Trust has received 13 ‘in scope’ death notifications between April 2021 and March 2022 (to date), one person was confirmed to be COVID positive at time of death (7.7%). Leading cause of death was pneumonia, 30.7%, followed by cardiac issues, cancers and sepsis, all at 15.3%. The average age of LD deaths notified for the Bolton area was 60.8 years of age. In total, since we began the process in March 2017, we have had 84 learning disability deaths notified via the LeDeR system.

Of note, 100% of all local death notifications for the 2021/22 period were deaths, which occurred in acute settings. This may indicate an ongoing issue around the lack of community notifications, which requires further consideration.

The support from NHS England and the GM Partnership has continued and we have been able to allocate a significant number of reviews to an external reviewer team which has helped ensure we remain up to date with allocation and completion of local reviews.

Of the 13 reviews for the 2021/22 period, 3 are fully complete, 8 in progress and 2 yet to be

allocated to a reviewer. We have made progress with the outstanding multi-agency reviews required, all of which have now been completed with additional learning identified.

In July 2022 the process will move to a regional model where all reviews will be completed by external reviewers, however, the learning from reviews will remain our responsibility. We have recently appointed a health improvement project nurse to the community learning disability team. This will ensure that learning from deaths remains a clear focus and we will continue to produce an annual report, the next report being due in June 2022.

We have maintained a local multi-agency steering group which provides an oversight and challenge role and provides executive leadership.

Seven day services
Seven day services review was put on hold for the duration of the COVID pandemic as per NHS Improvement's request - so there is no audit data and resulting action plan available for 2021/22.

Raising Concerns
Following the recommendations of Sir Robert Francis QC's Freedom to Speak Up (FTSU) report, it was recommended that all NHS organisations should have a FTSU Guardian in place, to support workers to speak up about anything that gets in the way of providing quality patient care or staff safety and well-being. In October 2018, the Trust appointed a FTSU Guardian working 0.6WTE. The Guardian is supported by FTSU Champions who reflect the diversity of our workforce. Although the FTSU Champions are unable to manage individual cases- they are able to promote speaking up and support/ signpost workers appropriately.

The Guardian takes 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 Guardian works in partnership with the communications team in utilising different methods of promoting the freedom to speak up approach. The Guardian meets regularly with the CEO, Executive Director of People and the Non-Executive Lead for FTSU to discuss concerns raised by workers whilst protecting staff confidentiality. The Guardian requests feedback from every individual that speaks 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 Divisions and an annual report delivered by the Guardian to the Trust Board. Due to the increased numbers of workers using the FTSU approach, the Executive Team agreed to increase the provision of FTSU Guardians in March 2022 to create an additional part time post. The additional staffing capacity will help further embed the FTSU approach across the organisational and provide a much more robust service delivery model.

Guardian of Safeworking
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. The guardian is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The GOSW identifies and either resolve or escalate problems, and acts as a champion of safe working hours for junior doctors. The guardian provides assurance to the Workforce Assurance Committee (quarterly) and to the Trust Board (annually), that issues of compliance with safe working hours are addressed, as they arise. The guardian reports to the Executive Medical Director and is accountable to the Trust Board.

Reporting against core indicators – *latest published data to 22/04/22*

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 time 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	2021/22	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2020/21	2019/2020
Mortality: The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for (12/20 to 11/21) latest published data available	SHMI value = 1.1533 (12/20 to 11/21) Band 1	SHMI value = 1.00	SHMI Value = 0.7161 Chelsea and Westminster Hospital NHS Foundation Trust Band 3	SHMI Value = 1.1949 Norfolk and Norwich University Hospitals NHS Foundation Trust Band 1	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 = 1.1030 Band 2	SHMI value = 1.1722 Band 1
The percentage patients' deaths with palliative care coded at either diagnosis or specialty level for the period (12/20 to 11/21) Latest published data	34% (12/20 to 11/21)	39%	64% Yeovil District Hospital NHS Foundation Trust	11% 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	31 %	27.0%
Patient reported outcome scores for groin hernia surgery	Measures not mandated – no benchmarking data available						
Patient reported outcome scores for varicose vein surgery							

Indicator	2021/22	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2020/21	2019/2020
Patient reported outcome scores for hip replacement surgery (April 2020 to March 2021) latest data available	Insufficient data	46% *20/21*	57% Royal Devon and Exeter NHS Foundation Trust *20/21*	39% Luton and Dunstable University NHS Foundation trust *20/21*	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 the adjusted health gains, therefore not published nationally. However, national clinical audit section outlines findings from the records submitted, with actions to address – see pg. 37	n/a	56%
Patient reported outcome scores for knee replacement surgery (April 2020 to March 2021) latest data available	Insufficient data	31% *20/21*	40% Woodland Hospital *20/21*	17% The Princess Alexandra hospital NHS Trust *20/21*		N/a	60%
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 9.8% for discharges in February 2022 *(based on PBR national guidance, exclusions apply)*						
28 day readmission rate for patients aged 16 or over *							
Responsiveness to inpatients personal needs – measured by Overall experience whilst in hospital: Adult Inpatient survey 2020	8.2 (2020)	8.4 (2020)	9.5 (2020, as per CQC)	7.5 (2020, as per CQC)	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The methodology follows exactly the detailed guidelines determined by the Survey Co-ordination Centre for the overall National Adult Inpatient Survey programme. Due to a national change in questions and methodology results for the Adult Inpatient 2020 survey are not comparable with results from previous years. Therefore, no historic performance included. Overall experience used as closet measure to responsiveness. Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • Review and refining of the Concerns and complaints policy • Receipt of real time patient stories and analysis • Always Events • Lived Experience Panel • Development of Local Surveys • Carer Involvement • Patient Safety Plan		
Percentage of staff who would recommend the provider to friends or family needing care – Friends and Family Test	No staff FFT 21/22 or 20/21 due to covid-19 (most recent published data is Q2 19/20)						85% (19/20)

Indicator	2021/22	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2020/21	2019/2020
The percentage of admitted patients risk-assessed for Venous Thromboembolism (Mar-22)	97.19% (03/22)	VTE national submission and reporting is still suspended, therefore comparative data is not available			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 campaign • RCA of patients developing clots for continuous learning and improvement	97.34 %	96.38%
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*	23.8 (20/21)	17.7	5.5 Ashford and St Peters Hospital	44.5 Wye Valley	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 published September each year. Therefore, latest available published data is 2020/21 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. • Collaborative working across the health economy. • Revised guidance and policy. • IPC link nurse development programme.	18.7 (19/20)	12 (18/19)
Number/Rate of patient safety incidents per 1000 bed days (04/2020 to 03/2021) latest data available (NRLS)	64.9 per 1,000 bed days N = 10,882	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) National data published September each year. Therefore, latest available published data is 2020/21 Bolton NHS Foundation Trust Risk & Assurance team have undertaken:	60.4 per 1,000 bed days N = 6,224	61.2 per 1,000 bed days N = 6,127 04/19 – 09/20

Indicator	2021/22	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2020/21	2019/2020
Number of above patient safety incidents that resulted in severe harm or death 04/2020–03/2021 latest data available (NRLS)	N = 24 8 deaths 16 Severe harms	n/a	n/a	n/a	• Preparation for the Implementation of new national Learning from Patient Safety Events Service, replacing NRLS • Local risk management system suppliers (i.e. Safeguard) rolling out a programme of upgrades to products compatible and compliant with the new system, • The Risk and Assurance team worked in collaboration with supplier of Safeguard to understand the work being undertaken and the impact on national incident reporting to support the transition from NRLS and StEIS over to the new system • It is anticipated the Learning From Patient Safety Events Service (LFPSE) will 'go live' in July 2022 (delayed from Spring 2022)	. N= 10 3 deaths 7 Severe harms	N= 10 0 deaths* 10 Severe harms *Please note that there were 3 incidents with actual impact of 5 – death attributable to the PSI, however these were sent to the NRLS after their deadline and are therefore not included in their figures
Inpatient Friends and Family Test (Feb-22)	96.1%	95.9%	100% Royal Berkshire NHS Foundation Trust	77.4% Ashford and St Peter's Hospital 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	96.6%	97%
Accident and Emergency Friends and Family Test (Feb-22)	85.0%	85.4%	100% Homerton University Hospital NHS Foundation Trust	25.6% The Rotheram NHS Foundation Trust		89.7%	90%

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Performance against Trust selected metrics

... for a better Bolton

Performance against Trust selected metrics

This section of the report is provided to give an overview of the quality of care 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	**2021/22**	**2020/21**	**2019/20**
Patient Safety Outcomes	Mortality - SHMI	See page 57		
	C.Diff – number of cases	See page 64		
	Pressure ulcers by category: • Cat 2 • Cat 3 • Cat 4 *Data source – Bolton NHS Foundation Trust's incident reporting system*	248 50 3 (04/21 – 03/22	210 46 3	158 42 6
Patient Experience	Friends and Family Test inpatients • Response rates • Recommendation rates *Data source – captured locally, submitted nationally and published by NHS England*	21.7% 95.7% (Mar-22)	31.2% 96.6%	26.6% 96.9%
	Lessons Learnt	See below		
	Dementia Training* * *HEE Tier 1 Dementia Awareness* *Data source – captured via local training and development system (Moodle and ESR)*	*Suspended and not reinstated*	90.8%	91.04%
Effectiveness	Sickness rates *Data source – captured via local attendance management system (E-roster and ESR), submitted nationally and published by NHS Digital*	5.1% (Mar 22)	4.1% (Mar 21)	5.22% (Mar 20)
	Appraisal rates *Data source – captured via local ESR and reported locally for Board report*	78% (Mar 22)	78.4% (Mar 21)	82.4% (Mar 20)
	Mandatory Training compliance *Data source – captured via local training and development system (Moodle and ESR)*	85.4% (Mar 22)	91.8% (Mar 21)	91.6% (Mar 20)

The above data is reflective of 2021/22 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 2021/22 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. In the period 1st April 2021 – 31st March 2022, 12 SBARS were published. In addition to this learning intelligence was shared in a variety of formats at the Clinical Governance and Quality Committee from the Governance Team for distribution across divisions.

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 meet 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 21-Mar 22**	**Target**	**Achieved**	**Apr 20-Mar 21**	**Apr 19 -Mar 20**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway (as at 31/03/2022)	65.4%	92%		62.2%	76.7%
A&E: Maximum waiting time of four from arrival to admission, transfer or discharge (average for the year)	66.84%	95%		80.0%	79.0%
All cancers: 62-day wait for first treatment from:					
• Urgent GP referral for suspected cancer (04/21 – 03/22)	85.35%	85%		83.47%	76.7%
• NHS Cancer Screening Service referral (04/21 – 03/22)	77.28%	90%		74.45%	79.0%
Clostridium difficile - meeting the C. difficile objective *National data published September each year. Therefore latest available published data is 2020/21*	40 (2020/21)	19		38 (2019/20)	24 (2018/19)
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 31/03/2022)	66.9%	99%		61.8%	93.4%
Venous thromboembolism (VTE) risk assessment included in "**Reporting against core indicators section"** 97.19%					

Bolton NHS Foundation Trust Quality Account 2021/22 – Statement from NHS Bolton Clinical Commission Group

The CCG would like to share the sentiments of Fiona Noden and convey our gratitude once again to staff at Bolton NHS Foundation Trust for their continued commitment during the Pandemic. We also acknowledge how staff have readily adapted to working differently and how this provides a basis on which future new ways of working can be explored and implemented to improve patient care.

The CCG continues to work closely with Bolton FT to gain assurance the Trust provides safe, effective and patient focused services. Performance and quality continues to be monitored via a collaborative and clinically led process and the content of this account is consistent with the information presented in year. As we move in to 22/23 it is encouraging to see that many services have restarted and not only are many elective services and diagnostics now working above pre-pandemic levels but CAU is also supporting A&E's continued high demand.

We acknowledge the current pressures on recruitment throughout the NHS and it is encouraging to see the Trust investing in several staff development opportunities and leadership programmes. The CCG welcomes the new Chief Nurse who will be integral to continuing the 'outstanding leadership' noted by the CQC. The CCG also welcomes the vision to expand and improve the Trust's estate and to invest in digital solutions for both staff and patients.

The CCG notes the section on performance against the 21/22 priorities which are consistent with the updates we receive via membership of the Trust's Quality Assurance Committee. We note the full achievement of priorities relating to Diabetes and the partial achievement for those relating to pneumonia, radiology, maternity safety and NEWS, with the latter priority of NEWS being carried forward to 22/23 in order to meet the required improvement. The additional priorities for 22/23 not only provide a mix covering a broad range of Trust services but they also have clear goals which can be easily measured in year.

The CCG also welcomes the additional sections on mortality and maternity which reflect the challenges and work undertaken in both these areas and the work that is to be continued into 22/23. We are optimistic the Trust will achieve the challenging ambition of being within expected range for mortality rates within 6-12 months.

The CCG is pleased with the performance of the Trust in what has been another year of unprecedented challenges. We look forward to continuing to work together throughout 22/23 to address not only the significant challenges ahead, including those caused by the Pandemic, but to also ensure a smooth transition from Bolton CCG to the Greater Manchester Integrated Care System, while maintaining the provision of safe, effective and patient focused care.

Dr Jane Bradford - Clinical Director for Governance and Safety
Michael Robinson - Associate Director of Governance and Safety