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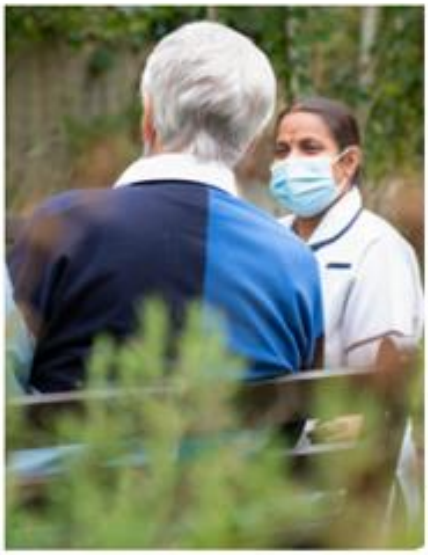
NHS
Bolton
NHS Foundation Trust

Bolton NHS Foundation Trust

Quality Account

2022/23





... 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 am pleased to be able to share our annual Quality Account, which highlights our achievements, successes and challenges throughout 2022/23. This Quality Account is a summary of the standards of care we have delivered during the last 12 months, and how we plan to maintain and improve care for our patients, their families and our service users.

Our aim is always to provide the best care possible for the people of Bolton and beyond and despite the impact of the COVID-19 pandemic lessening it has still been a challenging 12 months in Bolton. Pressures, at times, have meant we have had to focus on maintaining our essential services safely to allow us to care for people in the right place at the right time.

However, despite the difficult circumstances we have sometimes found ourselves in, I am so incredibly proud of, and humbled by, our staff. What they manage to achieve, every day, in the face of untold pressure is staggering, and I am in awe of how they rise to every situation. Thank you to all our workforce for their phenomenal efforts.

During the last year we have welcomed in colleagues from the Care Quality Commission, who inspected both our hospital services and our maternity services and found good levels of care given and highly skilled teams at work. While both reports found many areas in which we perform well, they also acknowledged the areas in which we know improvements need to be made, and we are well on our way to address these. Importantly, the CQC found how our staff focused on the needs of patients receiving their care, treating them with compassion and kindness and also providing emotional support for their families and carers.

Our urgent and emergency services remain rated as good overall, and we continue to be one of the busiest emergency departments in Greater Manchester, with more than 130,000 attendances during the last year. Our urgent care team work relentlessly to help those who need our care, and to treat them in the most appropriate places. This has included development of our Same Day Emergency Care unit to help alleviate some of the pressure and congestion in our emergency department.

Throughout our organisation our staff continue to develop how we work, and implement new ideas, to ensure the people we serve receive the treatment they need. The launch of our new Intravenous Access Team has not only freed up anaesthetists and theatre time to help with the surgical backlog, but it means that we are providing a better experience for our patients. The team had aimed to provide 150 patient line insertion a year, but in their first three months had inserted 79.

Providing quality care is something that is expected of the NHS, and the launch of our Quality Improvement Team this year shows how seriously we take the continued improvement of our services. Our Pressure Ulcer Collaborative met for the first time this year, with attendees from throughout the Bolton healthcare system. While bringing about change is often not immediate, by working together we can make meaningful differences to all of our patients. Our QI Team have exciting and ambitious plans to empower our teams and continuously improve the care we provide.

We are also utilising technology to make a difference for our patients. We have developed an app, called Medical Illustration Photography App (MIPA), which has allowed our district nurses to document pressure ulcer management in a vastly more efficient way. Previously, district nurses would take images of a patient's wound on a Trust camera, then travel to Medical Illustration, on the hospital site, to securely transfer the images (as the images are part of the patient's medical record), then go back to their district to carry on work and

redress the wound. The MIPA app allows this to happen securely while the nurse is still with the patient, reducing the amount of times the patient needs their wound redressing and improving efficiency. It is so effective that the equivalent of 0.8 whole time staff per month has been saved, compared to before its introduction.

A summary of achievements from all our 2022/23 quality account improvement priorities can be found in part two of this report, in addition to a summary of our aims for our 2023/24 improvement priorities, which are as follows:

- Pressure ulcer improvement
- Clostridium difficile infection reduction
- Enabling and empowering our staff through the development of quality improvement skills

We are always looking forwards, and it is good to reflect on our journey and how we will reach our goals and continue to ensure Bolton is both a great place to work and be cared in.

Staffing pressures remain an issue, although we always ensure we are safely running our sites. Our commitment to investing in our workforce continues and we were delighted to welcome more than 180 international nurses during the year. We are the exemplar site in the UK for international nursing recruitment partly due to our accommodation offer and we are the first organisation in the country to recruit two accommodation officers to support with the process. We also launched our Healthcare Assistant apprenticeship to help people step into a career in health, with so many applicants eager to join us, we had to close the advert early.

We launched our expanded staff networks this year, recognising the power of our differences and the value that diversity can bring not only for our staff, but for our patients and communities. Our six staff networks cover:

- Race, ethnicity, nationality and faith
- Sexuality and gender identity
- Gender equality
- Disability and health conditions
- Age and the diversity a multi-generational workforce brings
- Social backgrounds

This year also saw our Occupational Health team be highly accredited by the Safe Effective Quality Occupational Health Service, which has highlighted and recognised how well we meet the needs of our staff and the good practice we employ to do so. Our staff are our best asset and we need to ensure that they continue to be so well supported.

There is always more to be done, and our ambition is to be a truly inclusive organisation and to have a culture where all our staff thrive and feel safe, respected and included. We continue to listen to our staff about their experiences, then to action and make improvements for them.

Work continues on the Bolton College of Medical Sciences, which aims to support up to 3,000 learners each year and give prospective students a direct route into clinical healthcare employment. It is the single largest investment into healthcare and education in Bolton for decades, and I cannot wait for it to open in September 2024 and see the incredible difference it will make. The future of healthcare in Bolton is bright.

We still await news from the government on the outcome of our bid for new hospital buildings. If we are successful we will be 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 expected to hear of a decision during the last year, so while the wait continues we are hard at work modernising our estate to better provide for our patients.

Our new modular theatre build is well underway, with £19.6m funding secured for the two-storey building near to our maternity department. The four new theatres will significantly increase our theatre capacity for Bolton and Greater Manchester, which in turn will help to drive down waiting lists in the region. As part of this work we will also be creating a bespoke day case paediatric theatre hub by refurbishing Royal Bolton Hospital's existing day case theatres.

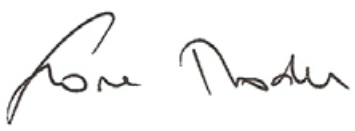
All of our work is ultimately to improve the lives of those we have the privilege to look after, and the integration of health and care services between sectors is key to this. I was delighted to be appointed to the role of place-based lead for health and care integration for Bolton last July, one of 10 place-based leads in Greater Manchester. Working in partnership has been a part of the way we deliver our services for such a long time now, and as we move towards an ever more integrated system, there will be increased opportunity for collaboration.

By working more closely with our partners, we will be able to bring our health and care services together to improve the offers and experiences of the people in our communities. We will be able to shift our focus from treating people to supporting them with their needs and helping them to live healthier lives. Integration in Bolton means doing things differently and creating improved ways of working and coming together to help the people of Bolton live better, healthier lives. I'm looking forward to what the future holds.

On a final note, the past year has seen some changes to our Board of Directors and I would like to take this opportunity to thank our previous Chair for all their support and dedication during their time with us at Bolton, and welcome their successor into the role. I am excited to see how we develop as an organisation and how we progress further on our integration journey.

I would also like to thank every single person in our organisation, who all play such a key role in the delivery of our quality and safety programme. I am delighted to work with them 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 an understanding of the focus we place and how important quality improvement, patient safety and experience are to us at Bolton NHS Foundation Trust.



Fiona Noden,
Chief Executive

Statement of directors' responsibilities in respect of the Quality Report

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

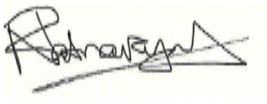
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality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

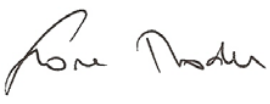
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation *trust annual reporting manual 2022/23* 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 2022 to (the date of this statement)
    - papers relating to quality reported to the board over the period April 2022 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 2022 national patient survey
    - the 2022 national staff survey
    - latest CQC inspection report dated 17/02/2023
- 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
28/06/2023

Chief Executive

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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 2022/23 and identifies the quality improvement priorities for 2023/24. Quality initiatives are chosen and prioritized based on quality, safety and experience data to ensure we focus improvement activities in the area of greatest need and that decisions are made based on robust data.

Key quality improvement priorities for 2023/24

Following consultation with our stakeholders we would like to highlight the following as our quality account improvement priorities for 2023/24:

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

Outline of aims and plans for the 2023/24 priorities are summarised on the following pages.

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

Quality Performance in 2022/23:

In our Quality Account for 2021/22 we set ourselves a series of key priorities for improvement for 2022/23, these were:

- 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)

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

Quality Account Improvement Priorities 2022/23 - Improving the response to escalation from clinical teams following a deterioration in a patients National Early Warning Score

Improving the response to escalation from clinical teams following a deterioration in a patient's National Early Warning Score has been a key focus of the Anaesthetic and Surgical Support Division since 2020. Following improvements and learning we decided to continue with this priority, but widening the scope to include the Acute Adult Care Division in 2022/2023.

This priority focusses on the primary escalation of concern and the response from the medical and surgical teams in order to prevent harm and reduce mortality, therefore highlighting areas for learning and training across these divisions. This work supports the planned trust wide standardisation of the initial response to patient deterioration through the introduction of the RRSAFER care bundle

<table>
<tr><td>AIM: The overarching outcome aim was to:</td><td>Outcome – Partially Achieved</td></tr>
<tr><td>Improve the following KPI metrics to achieve 95% and above
• Observations are carried out in line with trust policy
• There is documented evidence that a sepsis screening tool has been completed for any patient with a NEWS score of 5 or more
• There is documented evidence that the nurse has recognized the significance of the news score and actioned an appropriate response</td><td><table><tr><td>AACD</td><td>ASSD</td></tr><tr><td colspan="2">(22/23 average)</td></tr><tr><td>90%</td><td>91%</td></tr><tr><td>91%</td><td>86%</td></tr><tr><td>90%</td><td>97%</td></tr></table></td></tr>
<tr><td>Other measures we will monitor and report include:</td><td>Outcome – Achieved</td></tr>
<tr><td>• Deterioration and admission to critical care (Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions –as measured by CQUIN 22/23 target 60%</td><td>CQUIN 22/23 target 60%
• Q1 – 50%
• Q2 – 86%
• Q3 – 96%
• Q4- 92.3%</td></tr>
</table>

What we have done:
The key drivers and interventions and progress made in 2022/23 are summarised below:

a) Analyse the monthly KPI figures and patient safety incidents in relation to failure to escalate.

- Incident report meetings weekly are now embedded in divisions to show shared learning across the division.
- NEWS steering group established across both divisions and QI template agreed and ward manager's feedback findings each month.
- KPI's reviewed in both Divisions and actions carried forward into QI template for the next month.

b) Review and analyse escalation process within the divisions and make recommendations for improvement

- Ward round improvement group established and work streams identified in ASSD.
- NEWS group reviewing the process for escalation and embedding escalation from patient track and embedding policy

c) Improve education and training programme across divisions in NEWS score training.

- In addition to NEWS training there is wide offer of training for staff in order to improve the respond to the deteriorating patient.
- Face to face Sepsis Training sessions to support the early recognition and response to the patient with potential sepsis. These sessions are available to Medical, Nursing, Midwifery, Allied Health Professionals, Band 3 and Band 4 HCA/Nursing Associates who perform clinical observations, patient assessment and escalation.
- A full learning needs assessment (LNA) has been completed and outlines each staff member required and training in relation to the deteriorating patients for all clinical staff. The LNA signposts the clinical development of all staff responsible for taking, recording and calculating observations and NEWS score to improve recognition and response to the deteriorating patient. The education within the LNA reinforces a deeper understanding of common clinical manifestations of patient deterioration by building on frameworks to support an effective response to the deteriorating patient.

d) Response to the Acutely Unwell Patient and reduction in transfers to Critical care due to failure to escalate

- This driver is now part of the Deterioration and admission to critical care CQUIN – focusing on compliance with Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
- Compliance against recording of observations, escalation and response of Critical care team is captured within this data and reported via EPR and into the ICNARC data collection.
- Manual support alongside BI data is capturing the appropriate escalation and ability to plan Critical care admissions. Manual review provides feedback for referring teams.
- Achieved CQUIN target of above 60% - quarter 4 performance 92.3%

Next Steps:

This work will continue to be progressed at a divisional level via the AACD and ASSD divisional governance meetings and will feed into:

- Clinical Governance and Quality Committee
- Quality Assurance Committee

Key areas of focus being:

- Continue to drive sepsis screen via EPR work towards a single solution
- Continue to embed learning from incidents within both divisions
- Review data and decision to be made re Patient track recording of Sepsis screen.
- Critical Care Outreach Team link nurse role for the Deteriorating Patient to include sepsis and AKI to be embedded.

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 and complications of clostridium rates associated with inappropriate antibiotic use.

The areas of focus that stakeholders felt would lead to better patient outcomes and experience were:

- Objective 1: overall reduction in the use of antibiotics
- Objective 2: appropriate antibiotic in line with indication and trust guidance

AIM: *The overarching outcome aim was to:*	**Outcome – Partially Achieved**
• *10% increase in antibiotics stopped at the review date (72 hours from initiation of antibiotics on admission) by 31/03/23. Benchmark audit was 25% therefore overall aim of 35% increase in antibiotics being stopped at the review date.*	• *Re-audit not yet completed to confirm if aim of increase by 10% has been achieved. Planned for six months post implementation of antibiotic review kit on EPR.*
• *95% compliance or above with antibiotic prescribing standards by 31/03/23*	• *Compliance at 70% (excludes family care division).*
Other measures we will monitor and report include:	
• Antibiotic audits • Rate of clostridium infections associated with inappropriate antibiotic use	

What we have done:

We planned to meet the two objectives by:

- Objective 1 - implementation of ARK (antibiotic review kit) designed to support the reduction of antibiotic use through risk stratifying the probability when prescribing antibiotics into high or low, which has shown to encourage doctors reviewing antibiotics to stop at 72 hours.
- Objective 2 - introduction of order sets advising on the correct antibiotic to use as per guidance based on the indication rather than choosing the indication based on the antibiotic

The key drivers and interventions to progress these objectives are summarised below:

a) Understanding the barriers to delivering the standards

- Benchmark audits for objective 1 and objective 2 completed – no data available for objective 2 from family care division.
- MDT focus groups of antibiotic prescribers to understand the barriers to good practice complete
- Thematic analysis from prescribers – action plan pending
- Understanding and targeting areas for non-compliance with guidance – feedback through divisional governance structures. Data on individual consultant performance to be sent out again once QA completed

b) Education and training in prescribing standards

- Objective 1:
    - Benchmark data and intelligence regarding current education and awareness completed

    - Scoped implementation of ARK in EPR
    - Development of training package for ARK to be created once process approved and implemented in EPR
- Objective 2:
    - Testing and of the order sets and feedback to the EPMA team on going
    - Infographic informing clinical staff about Antimicrobial order sets created and published
    - Attendance at clinical staff departmental/lunchtime meetings to discuss the antimicrobial order sets
    - Inclusion of antimicrobial order sets in local inductions for next rotation – induction information package to be created in next 2 months prior to August changeover of doctors.
    - Ensure consultants are aware of the new process of prescribing using order sets
    - Increased awareness about antibiotic suitability based on indication rather than perceived efficacy of broader spectrum antibiotics

c) implementation and embedding proposed changes

- Objective 1 :
    - Process for ARK agreed – change request form submitted
    - Plan for ARK EPR implementation – agree design and implementation plan with stakeholders
- Objective 2:
    - Antibiotic prescribing order sets created in EPR
    - Process change shared as outlined above.

d) monitor compliance

- Divisional performance monitored and fed into antibiotic stewardship committee for oversight and support with improvement
- Scope the automation of audit data collection with Business Intelligence
- Re-audit in the next 6 months – once the EPR changes have been made
- Monitor percentage of antibiotics prescribed through order sets

e) identify and feedback on clostridium cases attributable to inappropriate antibiotic use

- Established feedback mechanism from root cause analysis and Harm Free Care panels related to antibiotic prescribing through divisional governance structures for learning and monitoring compliance.

Next Steps:

This work will continue to be progressed and monitored by divisional and Trust IPMs, the Trust Antimicrobial Stewardship Group, which will report into:

- Clinical Governance and Quality Committee
- Quality Assurance Committee
- This work will also form part of the Trust's Quality Account priorities for 2023/24 in relation to reduction in C-Difficile infections.

Quality Account Improvement Priorities 2022/23: Rheumatology

Rheumatology faced challenges in relation to management of newly referred and existing patients' caseloads. In association with this, the service was unable to deliver the care recommendations as advocated within "Rheumatoid Arthritis in over 16s NICE Quality Standard QS33". This therefore highlighted the need to review systems and processes within the Rheumatology service, to prioritise actions to address the concerns that have been highlighted.

There was a clear opportunity and desire to focus on wider multidisciplinary team building and associated organisational development; with an expectation of developing a collaborative team vision and identity, to harness the full potential and skills of the staff involved to deliver quality care to Rheumatology patients.

AIM: *The overarching outcome aim was to:*	**Outcome – Not Achieved**
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 by 31/03/23	See next steps section – which outlines plans to achieve in 23/24
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 have done:
We have a comprehensive improvement work plan. The key drivers and interventions for 2022/23 are summarised below:

a) Capacity enablement:

- Service redesign and transformation has been supported by the deployment of a Transformation manager to focus on the redesign of pathways to ensure patients are able to access the service quickly and appropriately.
- Review of previous and redesign of new "Directory of Services" to ensure appropriate patients are referred into the service or elsewhere as required i.e. EIA, GCA, Fibromyalgia, Osteoporosis
- "Straight to test" blood diagnostics prior to appointment to support timely treatment intervention.
- Clinic validation of new and follow up waiting lists

- Standardisation of PIFU pathways to ensure no medical vs non-medical discrepancy
- Rheumatology Physiotherapist undertaking steroid injection competencies which will release medical capacity
- Short and medium term capacity gains are being realised by focusing on leaner pathways and faster diagnosis / treatment:
    - Fibromyalgia educational pathway implementation
    - Increased Nurse follow up and Pharmacy outpatient capacity
    - Increased PIFU implementation.

b) Implementation of self-management strategies in patients with inflammatory arthritis

- Redesign of fibromyalgia pathway - transferring referred patients with a confirmed diagnosis of fibromyalgia onto therapy based, educational pathway as opposed to medical pathway
- Positive feedback from patients due to immediate access via the remote educational Fibromyalgia support.

c) Improve waiting list management

- Weekly ICSD escalation meeting in place, with focus on capacity, 52 week and forecasted 78 week breaches and actions to address - 78-week RTT potential breach potential for 23/24 (April – September) reduced by 70%
- Booking / escalation guidance in place for urgent demand.
- BI led capacity vs demand analysis completed
- Digital validation of new and follow up waiting lists
- Exploration of pathways that can be supported by advice and guidance as opposed to automatic referral

d) Expand and develop patient initiated follow up (PIFU) for stable patients.

- Medical roll out of PIFU implementation
- Full team PIFU meeting to emphasise PIFU pathways and standardised approach requirement.

Next Steps:

This work will continue to be progressed at a divisional level via the Integrated Community Services Divisional Governance meeting. Key areas of focus being:

- Straight to test “blanket/generic” blood diagnostic tests as a standard
- New hypermobility pathway - patients booked direct to AHP for assessment
- GP education to enable Fibromyalgia diagnosis within primary care setting.
- Job planning engagement with incoming consultant to incorporate a dedicated EIA clinic to fast track EIA referrals.
- One stop clinic for Consultant and Pharmacist as well as Therapist and Nurse, enabling less appointments and faster treatment.
- Criteria requirements for drug starts to reduce inappropriate internal referrals to Pharmacy
- Consideration of medical triage of medical referrals into the service to reduce risk averse decision making which will enhance capacity.
- Implementation of Rheumatology Advice and Guidance Service
- On-line portal for remote access to information, FAQs etc.

- Scope Denosumab patient self-administration

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

Information is an essential element of communication with patients, and lack of information has been noted to be a strong contributing factor in a number of complaints within the family care division. The CQC patient surveys, which make up a large part of the Caring section of their Insight report, also concentrates heavily on the amount of information given to patients and families throughout their admission and at discharge.

AIM: *The overarching outcome aim was to:*

We will improve scores on the information survey by 20% by 31/03/23

1. *On admission, did you know what was going to happen to you?*
2. *During the admission, were you always given the information you needed?*
3. *During admission, if you had a question was someone available to answer it?*
4. *During admission, were you ever left feeling uncertain about what was going on?*
5. *At discharge, did you know what would happen next?*

Outcome – Not Achieved

Baseline %		*Current*		
Maternity	*Paeds*	*Maternity*	*Paeds*	*Gynae*
89	*100*	*57*	97	67
85	*100*	*89*	93	93
100	*100*	*67*	93	100
64	*100*	*93*	97	87
100	*100*	*96*	93	100
N = 19	*N = 20*	*N = 45*	*N = 30*	*N = 16*

Other measures we will monitor and report include:

- *Friends and family test*
- *Complaints and PALS related to information and communication*
- *National patient survey*
- *National children and young peoples' survey*

What we have done:
The key drivers and interventions for 2022/23 are summarised below:

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

- Development of survey in maternity and acute paediatrics via face to face interview
- Baseline survey - initial results were generally positive whilst highlighting areas for improvement particular during the admission process
- Data collection expanded to Gynaecology

b) Set up on-going data monitoring

- Pilot study proved survey workable and collected some early benchmarking data confirming improvement opportunity in maternity.

c) Strengthen QI groups within clinical teams

- Engagement with clinical teams around the project
- Project lead appointed who will lead and monitor the progress.
- Leadership teams from each area support collation and monitoring of the data and co-design of PDSA cycles.
- Improvement group for Induction lead by Consultant Obstetrician and Ward manager (M2)
- Audit of wait times between induction and transfer to Central Delivery Suite
- Review of patient Information leaflet to explain possible waiting times
- Introduction of outpatient induction for low risk women

Next Steps:
It is to be noted that progress was affected by a change in the leadership teams and absence of project coordinator for the first two quarters of this project. In quarter 3 the project was relaunched with a new leadership team, a named project coordinator and strengthen ownership within each area. As such, this work will continue to be progressed at a divisional level via Family Care Divisional Governance Meeting and will report into:

- Clinical Governance and Quality Committee
- Quality Assurance Committee

Key areas of focus being:

- Updating women waiting for induction when delivery suite is busy.
- Aim for at least 10 responses per week from each area, which can then be plotted on SPC charts.
- Free text from the survey will allow us to get richer feedback that will also feed into the improvement work.

Quality Account Improvement Priorities 2022/23 - Accessible Information Standards

In August 2016, the Care Quality Commission (CQC) instructed that all providers of NHS care must meet the Accessible Information Standard (AIS). The AIS outlines what communication or information needs should be identified, recorded, flagged, shared and met for patients and includes additional needs caused by disability, impairment or sensory loss. The Trust as a whole is currently working toward achieving these standards and this project is led by the Equality, Diversity and Inclusion (EDI) team. Centralised Support Services (CSS) have recognised their position in supporting the Trust to work toward these standards and that Centralised Reception, Health Records and Access Booking and Choice (ABC) will play a key part in achieving the standards. The Diagnostics and Support Services Division is working closely with Trust Leads to support the Trust in meeting the standards, and a working group was established to drive this forward across the Trust, building on the work achieved within this Quality Account.

AIM: *The overarching outcome aim is to:*	**Outcome – Partially Achieved**
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	Co-ordinated working with the Trust's Equality , Diversity and Inclusion team has enabled the following: • GM wide single provider of Interpretation and Translation services – implementation in Q2 23/24

reminders and digital letters for outpatient and/or elective care(AIS) by 31/03/23.	• A review of provision against communication professional, communication support and written information required by patients with a disability, sensory impairment and sensory loss
	• Trust central budget for all interpretation and translation charges - swifter access to provision and timely payments
	• Review and ongoing audit of booking process:
	  • Communication prompt/flag in PAS to identify communication needs and advanced booking of provision.
	  • Patient information leaflets in a variety of formats.

What we have done:
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.

- Working with the Trust EDI Lead to carry out a gap analysis of available communication mediums across the Trust, and identify additional suppliers to meet current gaps. A communications card has been designed and will be rolled out once all AIS mediums are identified for offer.
- Multiple language options and audio options are available via digital letters service.
- Expansion of translation services between Language Line, DRC and DA Languages as new provider, and comprehensive services are offered to the Trust by RNIB/Action of hearing loss.
- The DSSD Division has implemented multiple written and audio translation options via the digital letter service; the use of yellow paper; large font; and opt out from digital letters, with blanket solutions for ophthalmology patients receiving appointment letters on yellow paper as standard and digital letters with a yellow background.

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

- Co-ordinated working with IT, ABC Manager, Records Manager and Receptions Manager to ensure implementation of consistent and most effective recording of communication needs, and define communication pathways within the IT system.

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.

- Stickers implemented to identify communication needs on patient hard copy records.
- Define reporting/progress measures
- Scope and progress towards the implementation of an electronic solution

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.

- Agree on where data needs to be shared and progress through AIS working group and integrated services model

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

- Gap analysis complete and all mediums implemented within current scope – digital letters with translation options, audio options with translation, yellow paper, large font, opt out of digital letters, etc.…
- All ophthalmology patients receiving appointment letters on yellow paper as standard and digital letters with a yellow background.
- AIS communications leaflet designed following consultation across GM
- EDI team leading on establishing future plans for additional service provision and contracting to fill gaps in services
- Implementation of digital solution for recording communication needs to ensure that all specialties follow the same approach to meeting patient AIS needs.
- Patient consultation to ensure collaboration around accessible information.

Next Steps:

This work will continue to be progressed and reported via the following groups:

- Clerical Support Services Governance Board Meeting
- Diagnostic and Support Services Divisional Governance Meeting
- Record Keeping Committee

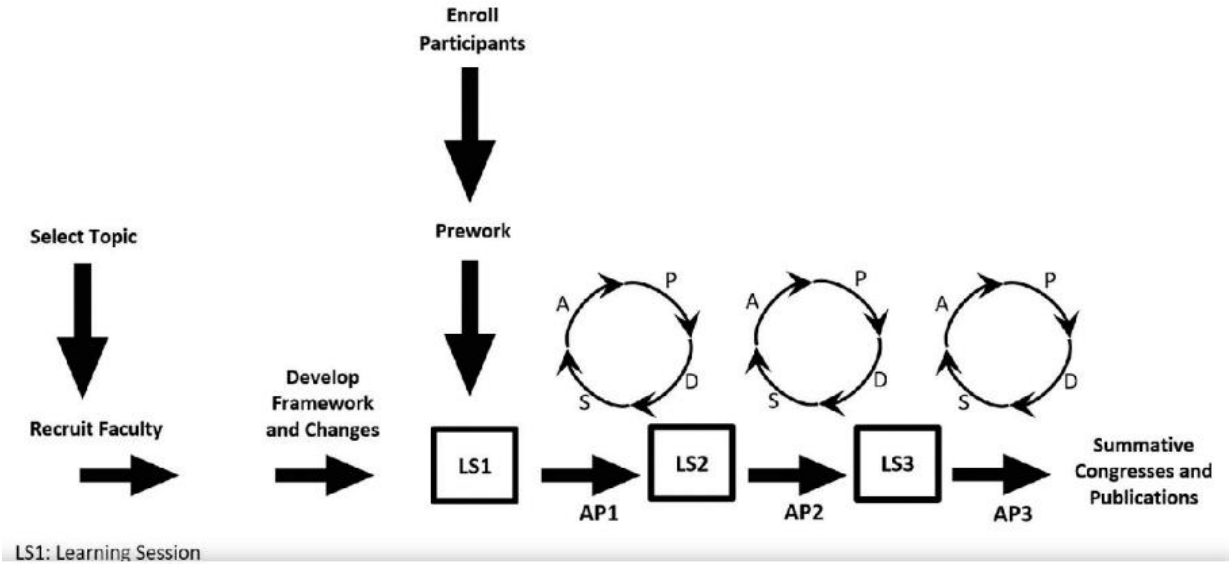
Quality Account Improvement Priorities 2023/24:

Following quality, safety and experience data review and stakeholder engagement, the chosen Quality Account Improvement Priorities for 2023/24 are:

1. Pressure Ulcer Improvement
2. Clostridium Difficile Infection Reduction
3. Enabling and empowering our staff through the development of quality improvement skills and knowledge

As Pressure Ulcers and C.*difficile* has significant impact on patient safety, outcomes and experience across the organization and system wide, we have decided to apply an Improvement Collaborative approach to the management and facilitation of these priorities.

An improvement collaborative is a short to medium-term (12-24 month) learning system that brings together teams to learn from each other and from recognised experts in topic areas where they want to make improvements. Over that period, change is tested and refined and if successful, a change package is created to be rolled out to the wider organisation/system.



The power of an improvement collaborative is:

- Staff empowerment – involving front line subject experts to define their own ideas for change and empowering them to influence improvement for the benefits of their patients and colleagues.
- Improved knowledge – learning from subject experts around best practice
- Improved QI skills and capacity - learning about QI, the framework and how to test change
- Networking and support – building organisation and system wide networks and support from peer group regarding implementing change
- Ability to prove (or disprove) if an idea works in practice – through the use of measurement strategies
- Culture change – shifting the perception around quality improvement and organisational change to engagement, empowerment and “the way we do things here”

Priority 1 - Pressure Ulcer Improvement

Pressure ulcers are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods. Pressure ulcers can affect any part of the body that is put under pressure. They are most common on bony parts of the body, such as the heels, elbows, hips and base of the spine. They often develop gradually, but can sometimes form in a few hours.

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

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

Why a Collaborative:
We have chosen to run an improvement collaborative on pressure ulcer improvement for the above reasons and there are a number of interventions, which have been proven to reduce pressure ulcers within care settings – a collaborative will help us to test and implement these changes and provide the potential and opportunity to make significant improvements.

AIM: *The overarching outcome aim is to:*
To reduce Hospital acquired category 2 pressure ulcers by 50% by 31/07/24 *To reduce Community acquired category 2 pressure ulcer by 30% by 31/07/24* *To eradicate category 3 and 4 pressure ulcers by 31/07/23*
Other measures we will monitor and report include:
• *Pressure ulcer count and rate for category 2s, 3s and 4s* • *Pressure Ulcer point prevalence* • *Pressure Ulcer risk assessment – Purpose T – completion within 6 hours of admission and ongoing review* • *% of Pressure Ulcers where wound assessment is completely correctly* • *Time to pressure relieving device* • *SSkin bundle*

What we will do
The primary drivers and interventions for the pressure ulcer improvement are summarised below:

- Data analysis and focussed tests of change
    - Use of measurement for improvement methodology e.g. SPC charts
    - Stratification of data to understand problems and their root cause:
        - Data split be category, site of body, location of acquisition, ward/dept/unit
    - Development of interactive pressure ulcer dashboard

- Pressure Ulcer Prevention:
    - PU risk assessment at admission –the use of Purpose T

    - Re-assessment of risk
    - Immediate access to pressure relieving devices
    - SSKIN Bundle - (Surface, Skin. Keep moving. Incontinence, Nutrition)

- Management of Pressure Ulcers:
    - Current best practice
    - National guidance
    - NICE guidance
    - EPUAP
    - Stage 3 and 4 = Never events
    - Learning from pressure ulcers, in line with PSIRF principles

- Leadership, staff and Patient Education and Ownership
    - Intentional rounding
    - Pressure Ulcer champions
    - Staff training and education
    - Patient education
    - Safety calendar

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 pressure ulcer improvements are summarised below:

- Pressure Ulcer Improvement Collaborative and Faculty
- Divisional Governance meetings
- Divisional and Trust IPM
- Patient Quality Group
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Priority 2 - Clostridium Difficile Infection Reduction

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

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

Why a Collaborative:
We have chosen to run an improvement collaborative on C.*diff* infection reduction for the above reasons and there are a number of interventions which have been proven C.*diff* – a collaborative will help us to test and implement these changes and provide the potential and opportunity to make significant improvements.

AIM: *The overarching outcome aim is to:*
Reduce Healthcare associated C.*diff* Toxin (CDT) positive cases by 33% by 30/06/24, with a sustained reduction to the Greater Manchester peer mean (50%) by 31/12/2024
Other measures we will monitor and report include:
• Total number of healthcare associated C.*diff* cases • Hand Hygiene and PPE spot checks by IPC • % CDT care plan completed • % Altered Bowel Habit Chart completed • Diarrhoea audit • Time from detection to sample being sent to lab • time from confirmation of a CDI to the start of treatment • Time from diagnosis to isolation • IPC mandatory training • Patient hand and environmental hygiene prior to meal times • % Antibiotic review within 72 hours

What we will do
The primary drivers and DRAFT interventions for C.*diff* infection reduction are summarised below*:*

- Data analysis and focussed tests of change
  - Use of measurement for improvement methodology e.g. SPC charts
  - Stratification of data to understand problems and their root cause:

- Documentation and communication

- Suspicion of infection and isolation
  - Escalation of loose stool between HCAs and registered nurses
  - Timely Sampling when patients have sign/symptoms
  - Isolation escalation of C.*diff* patients

- Antibiotic treatment
  - Prescription supported by diagnostic test
  - Compliance with Trust guidelines
  - Proportion of ward patients on abx

- Environment

- Staff education and practice
  - Harm Free Care case reviews – in line with PSIRF

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

The forums and governance committees which will provide progress, oversight and accountability for C.*diff* reduction are summarised below:

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

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

Quality Improvement – a definition
At Bolton we have adopted the National Quality Board's "Shared Single View of Quality", outlining systems should deliver care that is:
- Safe
- Effective
- Positive experience – responsive, personalised and caring
- Well-led
- Sustainably-resourced
- Quality care is also equitable

QI is the continual actions by staff and service users to improve outcomes (in line with the above key areas) for the benefits of our patients, whilst also engaging and empowering the workforce that supports those using systematic methods. Bolton NHS Foundation Trust has made a commitment to using quality improvement as THE method for all improvement and as a result are investing in our workforce, so our experts (our staff) are empowered and equipped with the knowledge, skills and permission to create tangible and sustained

improvements in their area of work.

AIM: *The overarching outcome aim is to:*
25% increase in Bolton NHS Foundation Trust Staff who have an awareness of the fundamentals of Quality Improvement by 31/03/24 (through QI fundamental training, improvement collaborative involvement, BoSCA QI involvement)
Other measures we will monitor and report include:
• *Contacts for QI assistance* • *Library of QI projects in the organisation* • *Hits on website* • *Contacts via social media*

What we will do

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

- Establishing the vision:
  - Development of QI Strategy with stakeholder engagement
  - Development of QI infrastructure – central team of QI expertise to support the organization

- QI Skills learning and development academy
  - QI Fundamentals
  - Test QI Improvement Advisor
  - Test QI coaching clinics
  - QI incorporated into leadership programmes – Bridging the Gap
  - Focus on our future workforce – QI for Doctors in training and student nurses/midwives etc.

- Incorporating QI into operational delivery
  - Trust/system wide improvement collaboratives
  - Divisional specific QI projects linked to quality and safety metrics in divisional IPM – test concept of improvement advisor
  - BoSCA
    - White to Silver – QI test of change with QI Team support
    - Gold Teams – test clinical microsystems (team based problem solving coaching) on a QI project up to 12 months

- Establishing the standards
  - Utilisation of trust system to track QI engagement – ESR
  - QI workbook
  - Creation on central library of QI activities for tracking and shared learning purposes
  - Registering your improvement project mechanism

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

- Signposting of QI opportunities both internal and external
- Case study development to share learning
- QI showcase events to celebrate and share learning

- Working with our partners/horizon scanning
  - National and local changes and strategies in relation to QI
  - Collaboration with the Bolton wide Quality Improvement Network

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

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

- Patient Quality Group
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Statement of assurance from the board

Review of services
During 2022/23 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 2022/23 represents 100 % of the total income generated from the provision of relevant health services by the Bolton NHS Foundation Trust for 2022/23.

Participation in Clinical Audits and Research Activity
The NHS published a list of 68 Quality Accounts (*of which several fall under the same programme of work) in 2022/23.

During that period Bolton NHS Foundation Trust participated in 50 out of 50 (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.

The Trust did not participate in the following audits:

Not Applicable

- Cleft Registry and Audit NEtwork (CRANE)
- Mental Health Clinical Outcome Review Programme
- Muscle Invasive bladder cancer
- National Audit of Cardiovascular Disease Prevention
- National Audit of Pulmonary Hypertension
- National Bariatric Surgery Registry
- National Congenital Heart Disease Audit

- National Audit Cardiac Surgery
- National Clinical Audit of Psychosis
- National Obesity Audit
- Neurosurgical National Audit Programme
- Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry
- Prescribing Observatory for Mental Health
- National Acute Kidney Injury Audit
- UK Cystic Fibrosis Registry
- National Audit of Percutaneous Coronary Intervention
- Paediatric Intensive Care Audit (PICANet)

Did not participate

- Fracture Liaison Service Database

The national clinical audits and national confidential enquiries that Bolton NHS Foundation Trust did participate in during 2022/23 are as follows:

	Project Name	Additional Information/Individual Studies/Data Range	No. of cases submitted
1	Breast and Cosmetic Implant Registry	Data Range: January 2022 to December 2022	11
2	Case Mix Programme (CMP) ICNARC	Data Range: 1st April - 30th September 2022	266
3	Elective Surgery National PROMs Programme	Data Range: April 2022 to February 2023 Hip Knee	 178 155
4 5 6 7	Royal College of Emergency Medicine QIPs	1. Infection Control 2. Pain in Children 3. Consultant Sign-Off Data Range: October 2021 – October 2022) 4.Mental Health self-harm Data Range: 3 October 2022 – 3 October 2024	273 160 74 0
8 9	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls National Hip Fracture Database Data Range: 2022/2023 continuous	6 420
10	Learning Disabilities Mortality Review Programme (LeDeR)	Please see narrative below	n/a
11	Medical and Surgical clinical outcome review programme (NCEPOD)	Please see narrative below	n/a
12	Maternal and New-born Infant Clinical Outcome Review Programme	Please see narrative below	n/a
13 14 15 16	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Children's Asthma Secondary Care COPD Adult Asthma Pulmonary Rehab Data Range: 2022/2023 continuous	177 301 84 45
17	National Audit of Breast Cancer in Older Patients (NABCOP)	Data Range: 2022/2023 continuous	351

18	National Audit of Cardiac Rehabilitation (NACR)	Data Range: 2022/2023 continuous	348
19	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) Published Nov 2022	Data Range: December 2019 and 30 November 2020	67
20	National Cardiac Arrest Audit (NCAA)	Data Range: 2022/2023 continuous	63
21 22 23	National Cardiac Audit Programme (NCAP)	Cardiac Rhythm Management Heart Failure MINAP Data Range: 2022/2023 continuous	273 461 215
24 25 26	National Diabetes Audit – Adults	NaDIA Harms Foot Care Inpatient Safety (Local data) Data Range: 2022/2023 continuous	23 226 115
27	National Emergency Laparotomy Audit (NELA)	Data Range: 2022/2023 continuous	135
28 29	National Gastro-intestinal Cancer Programme	National Bowel Cancer Audit National Oesophago-gastric Cancer Data Range: April 2022 – February 2023	210 56
30	National Joint Registry	Data Range: April 2022 – January 2023	259
31	National Lung Cancer Audit (NLCA)	Data Range: 2022/2023 continuous	151
32	National Maternity and Perinatal Audit	Data Range: 2022/2023 continuous	50
33	National Neonatal Audit Programme (NNAP)	Data Range: 2022/2023 continuous	52
34	National Paediatric Diabetes Audit (NPDA)	Data Range: 2022/2023 continuous	145
35	National Prostate Cancer Audit (NPCA)	Data Range: 2022/2023 continuous	207
36	National Vascular Registry	lower limb angioplasty Data Range: January 2022 – July 2022	10
37	Sentinel Stroke National Audit Programme (SSNAP)	Data Range: 2022/2023 continuous	207
38	Serious Hazards of Transfusion Scheme (SHOT) – Haemovigilance Scheme	Data Range: January 2022 - December 2022	32
39	The Trauma Audit & Research Network (TARN)	Data Range: 2022/2023 continuous	114
40	UK Renal Registry Chronic Kidney Disease Audit	*Note: Data for Royal Bolton Hospital is included within the Royal Salford Hospital submission as one of its satellites.*	17

42	Inflammatory Bowel Disease National Audit Project	IBD Registry Data Range: 2022/2023 continuous	45
42	National Early Inflammatory Arthritis Audit (NEIAA)	Data Range: 2022/2023 continuous	50
43	Society for Acute Medicine Benchmarking Audit (SAMBA)	Data Range: 23rd June 2022 - 19th August 2022	71
44 45	British Thoracic Society – Adult Respiratory BTS – Smoking cessation (Maternity & Mental Health) National Respiratory Support Audit is planned to begin on 1 February 2023. Tobacco Dependency/Smoking Cessation within Maternity and Mental Health Services Pilot Audit: Both pilots are on pause but are planned for later 2022/early 2023.	**Adult respiratory support Audit** Data Range: 1 February 2023- 31 March 2023 (national audit period) 1 February 2022- 31 January 2023 (local audit period) **Smoking cessation** **Maternity and MH service** Data Range: 1 September 2021- 31 August 2022 (Local Audit) 1 July 2021- 31 August 2021 (National Period)	0 (commenced Feb 2023) 0 0 84
46	National Audit of Care at the End of Life (NACEL)	Case reviews Staff Surveys Hospital Site overview Data Range: 6TH June to 7th October 2022	50 (100%) 24 1 (100%)
47	National Audit of Dementia (NAD)	Case note Reviews Patient Questionnaires Carer Questionnaires Organisational Proforma Data Range: 19 September – 14 October	58 32 4 1
48	National Ophthalmology Database	Adult Cataract Surgery Audit Data Range: 2022/2023 continuous	1703
49	Perioperative Quality Improvement Programme	Data Range: March 2022-February 2023	53
50	UK Parkinson Disease	Occupational therapy Physiotherapy	10 11

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

Testicular Torsion
Date Publication: Winter 2023

	Requested	Submitted
Case notes	6	6 (100%)
Organisational Proforma	1	1 (100%)
Clinical Questionnaire	6	4

Community Acquired Pneumonia
Date Publication: Winter 2023

	Requested	Submitted
Case notes	8	8 (100%)
Organisational Proforma	1	1 (100%)
Clinical Questionnaire	8	3

Crohns Disease
Date Publication: Spring 2023

	Requested	Submitted
Case notes	1	1 (100%)
Organisational Proforma	1	1(100%)
Clinical Questionnaire	6	1

Maternal, New born and Infant Programme (managed by MBRRACE UK)
Results of the October 2022 MBRRACE Report (based on 2020 data) are:

The results concern stillbirths and neonatal deaths among the 5,779 babies born within Bolton Hospital NHS Foundation Trust in 2020, EXCLUDING births before 24 weeks' gestational age and all terminations of pregnancy. Neonatal deaths are reported by place of birth irrespective of where death occurred.

Type of death	Number	Crude rate	Stabilised and adjusted rate	Comparison to the average for similar Trusts & Health Boards
Stillbirth	20	3.46	3.70 (2.84 to 4.75)	Up to 5% higher or up to 5% lower
Neonatal death	6	1.04	1.54 (0.99 to 2.38)	More than 5% and up to 15% lower
Extended perinatal	26	4.50	5.25 (4.25 to 6.72)	Up to 5% higher or up to 5% lower

The crude mortality rate is the observed rate for the Trust and is a snapshot of mortality for births in 2020. The stabilised & adjusted mortality rate gives a more reliable estimate of the underlying mortality rate taking into account key factors known to increase the risk of stillbirth and neonatal mortality as well as the effects of chance variation, particularly where the number of deaths was small.

While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within Bolton NHS Trust in 2020.
The stabilised & adjusted mortality rates for Bolton Hospital NHS Foundation Trust were similar to, or lower than, those seen across similar Trusts and Health Boards.

Comparing 2019/2020 data

Type of death	Crude rate 2019	Crude rate 2020	Stabilised and adjusted rate 2019	Stabilised and adjusted rate 2020
Stillbirth	4.04	3.46	4.01 (3.42 to 4.81)	3.70 (2.84 to 4.75)
Neonatal death	1.35	1.04	1.60 (1.02 to 2.55)	1.54 (0.99 to 2.38)
Extended	5.39	4.50	5.59 (4.84 to	5.25 (4.25 to 6.72)

perinatal			7.02)	

Comparison data 2019/2020 demonstrates an overall reduction in stillbirth, neonatal and extended perinatal death rates at Bolton Hospital NHS Foundation Trust during this period of time.

Births at Bolton Hospital NHS Foundation Trust in 2020

- The proportion of mothers aged 35 years old or older is lower than that of the UK as a whole: 19.7% versus 23.8%.
- The mothers were more likely to live in areas of high deprivation than those giving birth across the UK as a whole.
- The proportion of babies of non-White ethnicity is higher than that of the UK as a whole: 30.5% versus 22.8%.
- 24 babies (0.4%) were born at 24 to 27 week's gestational age, similar to the 0.4% seen in the UK as a whole. The percentage of babies born at 28 to 31 weeks is also similar to the national average: 0.8% versus 0.8%. In addition, 101 babies (1.9%) were born post-term (42 weeks or greater), a lower percentage than the UK average of 1.9%.
- There were 5,779 births in the Trust at 24 week's gestational age or later, excluding terminations of pregnancy. The number of births puts Bolton in the highest third of all Trusts and Health Boards in the UK.

The overall stillbirth rates continue to benchmark well against regional (Greater Manchester & East Cheshire) rates.

Year	Bolton per 1000 births	GMEC per 1000 births
2020	4.50	4.55
2021	4.31	4.57
2022	3.46	4.38

The overall early neonatal death rates continue to benchmark well against regional (Greater Manchester & East Cheshire) rates.

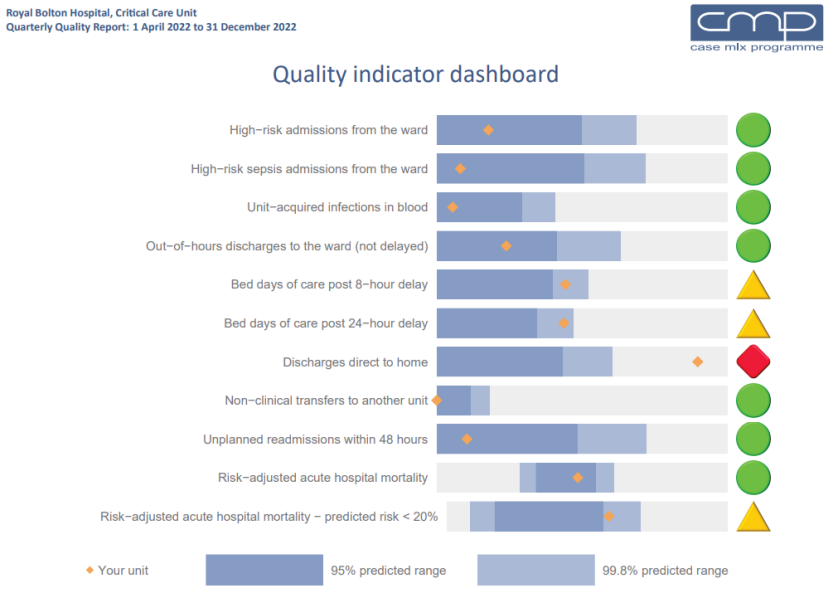
Year	Bolton per 1000 births	GMEC per 1000 births
2020	0.87	1.78
2021	1.21	1.63
2022	0.73	2.21

The Division continues with all of the national maternity quality and safety initiatives designed to meet the national ambition to reduce the number of stillbirths and neonatal deaths:

- Saving Babies Lives Care Bundle
- Ockenden repport
- NHS resolution maternity incentive scheme
- Maternity and Neonatal Safety collaborative
- Each Baby Counts
- Kirkup Report
- Improving Equity and Equality in maternity and neonatal care.
- Tommy's app

National Clinical Audits: Actions to Improve

The reports of 29 national clinical audits were reviewed by the provider in 2022/23 and Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Project Name	Actions
Case Mix Programme (CMP) ICNARC	This programme has 11 Quality indicators; the trust is within or below the 95% predicted range for 7 of the Quality indicators. For 3 of the Quality indicators the Trust is above the 95% predicted range but within the 99.8% predicted range. For 1 of them the Trust is above the 99.8% predicted range. 
Royal College of Emergency Medicine QIPs	There were 3 RCEM publications in 2022 for the following audits: **Infection Control (March 2022):** Compliant with all three standards, no action required. **Pain in Children (March 2022):** Compliant with all three standards, performing above national average – QI project followed and increased performance further. **Fractured Neck of Femur (June 2022):** Compliant with three of the four standards, slightly below compliance with the third standard: *Standard 3: Patients should have an X-ray at the earliest opportunity* Average time to x-ray104 minutes 48% within 90 minutes National average time 94 mins National average within 90 minutes 56% (43% in 120 minutes) Action required: Below the national average but not by much, crowding and radiology delays contribute to this. Nurses have been trained to order from triage hence improvements in the last 3 years Huge gains from 2017/2018 The audits below have recently closed QA 21/22; the national reports from RCEM are awaited: • **Infection Control** (October 2021 – October 2022) • **Pain in Children** (October 2021 – October 2022) • **Consultant Sign-Off** (October 2021 – October 2022) The audits below are ongoing/not yet started nationally:

	• **Assessing for cognitive impairment in older people** (April 2023 – October 2023 • **Mental Health self-harm** (3 October 2022 – 3 October 2024)
Falls and Fragility Fracture Audit Programme (FFFAP)	**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 those over 65, and others 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 or 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.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **- Children and young people asthma combined clinical and organisational audit**	Local Actions for this National Audit Include; • **Identify improved ways of sharing smoking cessation information and keeping this up to date.** The CURE Team review all smokers identified by Nurse or Doctor on admission/clerking document, and offer support to patients who want temporary abstinence from smoking which is established on first contact with patient. The team also discuss harm reduction if the patient declares they want to reduce the amount of cigarettes they smoke, ensure all smokers are offered and provided with Pharmacotherapy to help with nicotine withdrawal and or temporary abstinence. • **Feed back to the ward the need to improve sending patients home with personalised action plans and documentation around this**. The CURE Team ensure Nicotine Replacement Therapy is prescribed when they are inpatients, and are referred for support on discharge. • **Local work to improve asthma discharge bundle**. The CURE Team undertake a 4-week follow-up after the quit date via telephone, unable to facilitate NICE Guidance recommendation for

	the use of a carbon monoxide test post 4-week follow-up at the present. Child and Young Person Asthma 2021 Organisational Audit: Summary report published September 2022. Gap Analysis completed and received and shared with all relevant– ongoing local CYP asthma workshops to address particular points, pre-existing QI work for some points; discussion in Acute Paediatric Specialty Governance meeting.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **- Adult Asthma & COPD** **- Pulmonary Rehabilitation Audit**	**Adult Asthma & COPD Secondary Care:** The recommendations from the latest report (Adult asthma and COPD 2021 organisational audit report) are for both of the national audits. Gap analysis for the Adult asthma and COPD 2021 organisational audit report received on 15/03/2023 - of the seven recommendations in the report, four of the recommendations are applicable to the Trust and the Trust is compliant with these. Gap analysis attached to Safeguard as evidence of compliance. Recommendations: • R2: Make 7-day respiratory specialist advice available to all patients admitted with an asthma/COPD exacerbation. This recommendation is for service providers and clinical teams - COMPLIANT • R3: Have designated clinical leads in place for both asthma and COPD. This recommendation is for service providers - COMPLIANT • R6: All centres which accept transfers of care from paediatric services should put in place all five components of a transition service. This recommendation is for commissioners, service providers and clinical teams - COMPLIANT • R7: All services reviewing patients with severe asthma, and commissioners of these services, who are not already members of a regional network must develop referral pathways to a commissioned severe asthma service to ensure that all patients have access to a severe asthma MDT. Leadership for this should come from regional respiratory networks in England. In addition, the NHS Accelerated Access Collaborative consensus pathway in England is working to define clinical standards for pathways of care that span primary, secondary and tertiary care for patients with suspected severe asthma, as well as improving access to diagnostics for patients with suspected asthma. - COMPLIANT **Pulmonary Rehab:** Pulmonary Rehab has restarted after COVID, and the respiratory admin team are awaiting the audit forms that have been completed for the last few cohorts. This has been delayed due to sickness, but should be getting them across to input shortly. The National Asthma and COPD Audit Programme (NACAP) has published its latest report into pulmonary rehabilitation. There are 7 recommendations. A gap analysis was completed and returned o

	15/03/2023, the Trust's current compliance with the recommendations are detailed below: Recommendations: • R1: To drive improvement in care, NACAP urges commissioners, service providers and clinicians to review the way in which they provide pulmonary rehabilitation and work together to effect service-level change by implementing the individual recommendations highlighted in this report. - NOT COMPLIANT: Service not currently not meeting waiting time targets – plan to cleanse waiting list and increase assessment/class capacity. • R2: Provide PR to all people with a COPD self-reported exercise limitation (MRC grade 3–5) This recommendation is for service providers and clinical teams - COMPLIANT • R3: This recommendation is for service providers Service providers offering home-based pulmonary rehabilitation should ensure that the intervention is guided by the best available evidence and includes comprehensive initial and discharge assessments (including exercise capacity). For recent guidance on delivering PR, read the American Thoracic Society (ATS) paper Defining modern pulmonary rehabilitation - NOT COMPLIANT: Service currently only offering centre based rehabilitation due to current staffing resource. Future plans include offering homebased rehab option in addition to centre based rehab. Once staffing resource is available we would ensure that current evidence based guidelines are followed. • R4: If a 6MWT (6-minute walk test) is being used to measure exercise capacity, use a 30-metre course to adhere to technical standards This recommendation is for service providers and clinical teams - NOT APPLICABLE: We are using the ISWT. • R5: This recommendation is for service providers and clinical teams Include provision of a written exercise plan as a key element of discharge. To facilitate this: build designated time into discharge assessments for provision of an exercise plan develop a standardised exercise plan that can be customised for each person with COPD - COMPLIANT • R6: All service providers must ensure time for leadership activities is built into job plans for clinical leads, and work with commissioners to identify and assign additional resources where necessary to enable this. - NOT COMPLIANT: Meeting to review team structure and staffing planned for 16/03/23. • R7: Ensure all PR services have an agreed standard operating procedure (SOP) This recommendation is for service providers and clinical teams - COMPLIANT: SOP currently in draft form, aim to submit via clinical governance meeting next month.
National Pregnancy in Diabetes Audit	Local actions from National Recommendations <u>Pre-conception care</u> 1. Better utilization of the pre-conception clinics at BDC. 2. Better glycaemic control (HbA1c < 48 mmol/mol) before conceiving. 3. Better provision of contraceptives 4. Asking patients about their plan for pregnancy at every contact and directing them to appropriate services:

<table>
<tr><td></td><td>a. Primary care: Meeting due tomorrow.
b. Secondary care: EPR documentation already in place.
<u>Antenatal Care</u>
1. Deal with the rising number of pregnant women with Type 2 DM
2. Identify factors leading to LGA babies and address them earlier in pregnancy if possible</td></tr>
<tr><td>National Audit of Breast Cancer in Older Patients (NABCOP)</td><td>The Healthcare Quality Improvement Partnership Benchmarks results by key metrics. Out of the a total of 18 metrics the trust was higher than 90% of Trust in 9 metrics. The Trust was classed as Amber in three metrics when compared to other Trusts;
• Proportion of patients (non-screen detected) receiving a triple diagnostic assessment in a single visit [50-69 years]
• Percentage of patients with NABCOP Fitness Assessment Form data items recorded: Clinical Frailty Scale [70+ years]
• Percentage of patients with NABCOP Fitness Assessment Form data items recorded: Abbreviated Mental Test Score. [70+ years]
The Trust has an action plan in place to improve the three amber metrics.</td></tr>
<tr><td>National Audit of Cardiac Rehabilitation (NACR)</td><td>Assessment Breakdown Summary Report for Bolton QA 22/23 below-
Number Starting Core Rehab: 212
Number Valid Assessment 1 (before Rehab): 211
Percentage of Started with Assessment 1: 100%
Number Valid Assessment 2 (after Rehab): 164
Percentage of Started with Assessment 2: 77%

Following the publication of the NCP_CR 2022/23 report, Bolton's cardiac rehabilitation programme has been certified as Green and has been awarded National Certification. It will retain this status until the date of publication of the next (2023/24) NCP_CR results.</td></tr>
<tr><td>National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)</td><td>The last data published for Epilepsy12 was 2021and a summary of the Bolton issues and lessons learnt was received in February 2022.
Actions included:
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</td></tr>
<tr><td>National Cardiac Arrest Audit (NCAA)</td><td>Total number of team visits recorded for QA 22/23 is 63, please see breakdown of monthly denominator data below:

<table><tr><td>Quarter 1-
April 2022: 5
May 2022: 3
June 2022: 6</td><td>Quarter 2-
July 2022: 8
August 2022: 3
September 2022: 8</td></tr><tr><td>Quarter 3-
October 2022: 5</td><td>Quarter 4-
January 2023: 5</td></tr></table></td></tr>
</table>

	The November 2022: 8 December 2022: 7 February 2023: 5 March 2023: 1 number of team visits recorded also correlates with the total number of 2222 calls solely for cardiac arrest, which means that all team visits recorded were for cardiac arrests. Latest report data from NCAA (period of the latest report only covers 01/04/2022 - 30/09/2022, figures will be updated when more complete data is published) Reported number of admissions to your hospital: 37,262 Reported number of 2222 calls solely for cardiac arrest: 33 Number of team visits recorded: 33 Number of individuals: 33 Number of team visits to the ward recorded: 19 Number of individuals: 19 Number of potential non-arrests: 1 All 2222 calls that result in a patient having chest compressions has a RCA undertaken by the parent team as well as the incident itself being included in the NCAA. The RCA is then reviewed a panel of clinicians at a validation clinic. These findings are demonstrated above in the Annual Totals. The Monthly data is presented to the organisation via the Clinical Governance committee and also the Mortality Reduction Committee. Areas of concern are as follows and these have been identified following RBH Cardiac Arrest Data: Patients who in-spite of their complexity and multiple co morbidities were to be resuscitated, were for CPR And those whom had an appropriate DNA – CPR decision in place and were resuscitated / had chest compressions. The common theme is communication. • Reluctance to undertake DNA- CPR discussions • Lack of understanding of the DNA – CPR policy - Understanding this is a medical decision • Difficulty in identifying that patients are approaching end of life. • Poor communication within teams that patient in their care were not for CPR.
National Cardiac Audit Programme (NCAP) **-Myocardial Ischaemia National Audit Project (MINAP)**	For Quality Accounts 2022-23, the number of submissions entered via the NICOR portal is 215. QA 2022-23 is currently still open for submissions, the deadline for Quarter 3 (October-December) was 31 March 2023 and the deadline for Quarter 4 is 30 June 2023. There is a backlog of MINAP forms that need to be entered, going back to admissions in Sept 2022. An extension was requested from NICOR on behalf of cardiac rehab team on 27/01/2023; response received 30/01/2023 advising that an extension cannot be given, but

	encouraged to input missing data so that it will show next year. Cardiac rehab team have been informed. Management of Heart Attack 2022 Summary report [MINAP] was published with 9 recommendations. Gap analysis sent to Dr K Lipscomb. Gap analysis currently outstanding, latest reminder sent 16/03/2023. Recommendations from the summary report: 1. In the management of STEMI, staff in hospitals where Call-To-Balloon time standards are not being met should work with partner Ambulance Trusts, emergency departments, neighbouring non-interventional hospitals and cardiologists to better understand delays in provision of primary PCI. This may include making improvements to the hospital response to the arrival of a patient but may also focus on ways to improve pre-hospital Call-To-Door times. Since the end of the present annual audit cycle significant pressures on the ability of Ambulance Trusts to hand over care of patients upon arrival at hospital may further adversely affect this metric. 2. In the management of both STEMI and NSTEMI, staff in hospitals with lower rates of provision of an echocardiogram should undertake a review of data collection processes – to ensure that the reported rate accurately reflects practice – and then review the patient pathway to identify opportunities for echocardiography during the index admission. Consideration should be given to performing a limited 'bedside' echocardiogram if there are difficulties obtaining timely detailed 'departmental' studies. Where patients are discharged early to another hospital before an echocardiogram can be performed there must be a clear request to perform the test at the receiving hospital. 3. Those hospitals not reaching recommended levels for admitting patients with heart attack to a cardiac ward should review their systems and bed allocations to maximise access to cardiac care. This may require novel use of dedicated multi-specialty 'high care' beds and provision of cardiac outreach services to those nursed outside cardiac facilities. 4. Those hospitals with low rates of cardiology involvement in the care of patients with heart attack should undertake a review of their data collection processes – to ensure that the submitted data reflects practice. If it does, there should be consideration of improved provision of cardiac care during admissions. This might require increased staffing or more flexible use of members of the cardiology team – for example Nurse Specialists and Physician Associates. 5. Those hospitals with low rates of angiography in eligible NSTEMI patients should perform a review of their systems of data collection and submission, and their systems for managing acute coronary syndromes (ACS). 6. In those hospitals where the 72-hour quality standard for angiography following admission with NSTEMI is not met, commissioning groups, managerial and clinical leaders should engage

	in a process of system review, economic appraisal and quality improvement. This may require changes within hospitals, across referral networks and/or in the overall commissioning of services. There should be an emphasis on early reliable identification of suitable patients, streamlined referrals, and adequate capacity for transferring patients into (and out of) interventional hospitals; this may involve weekend angiography lists for such patients. Anecdotal reports suggest that since the end of the present annual audit cycle the improvements seen here have not been maintained. Any lessons regarding more timely care that have been learned during the pandemic should be incorporated within plans for post COVID recovery of services. 7. In the management of both STEMI and NSTEMI, staff in hospitals not meeting the standard for prescription of all secondary prevention medication prior to discharge should first explore data completeness and ensure that their data are a valid representation of practice. If suboptimal performance is confirmed quality improvement programmes should be implemented. These might include the use of discharge pro-forma or checklists, direct involvement of specialist cardiac pharmacists or 'ACS nurse specialists'. 8. Staff in those hospitals with lower rates of prescription of aldosterone antagonists should ensure that patients with impaired LV function are identified by echocardiography (or some other reliable assessment method) and that such patients are considered for appropriate treatment. This might require the use of discharge pro-forma or checklists and the direct involvement of specialist cardiac pharmacists, 'ACS nurse specialists' and specialist sonographers. 9. Hospitals not meeting the standards for referral of patients to cardiac rehabilitation following either STEMI or NSTEMI should review the provision of services and identify early patients who might benefit. This could include routine distribution of cardiac rehabilitation information/invitation leaflets to all patients admitted to cardiac facilities, and the inclusion of such information in discharge checklists. All hospitals should ensure equitable access to cardiac rehabilitation. Rehabilitation staff who were redeployed to ward-based duties during the pandemic should return to their original practices.
National Cardiac Audit Programme (NCAP) **-National Heart Failure Audit (HF)**	For Quality Accounts 2022-23, the number of submissions entered via the NICOR portal is 461. QA 2022-23 is currently still open for submissions, the deadline for Quarter 3 (October-December) was 31 March 2023 and the deadline for Quarter 4 is 8 June 2023. National Heart Failure Audit 2022 Summary report was published with 5 recommendations. Gap analysis sent to Dr K Lipscomb. Gap analysis currently outstanding, latest reminder sent 16/03/2023. Recommendations from the summary report: 1. Hospitals not achieving the recommended standard of the use of in-patient echocardiography for patients with acute heart failure should

	urgently review their clinical pathways and ensure that echocardiography is performed and ideally within the first 48 hrs of admission. 2. Hospitals should ensure that high-risk cardiac patients have access to a cardiology ward. Heart failure patients are often those in the highest risk groups. 3. Hospitals not achieving the standards for ensuring a patient with acute heart failure is managed on a cardiology ward or seen by a heart failure team should review their pathways of care and consider a quality improvement programme to improve on their current performance. Hospitals that do not have a clinical lead for Heart Failure should appoint one: ideally a consultant cardiologist with sub-specialty training in heart failure. Hospitals that do not have access to specialist heart failure nurses within their hospital team or in the community should urgently seek to appoint them. 4. Greater attention is needed to ensure all patients with HFrEF receive the disease-modifying drugs that they should be on unless there is a contraindication. This can be increased by patients being managed on cardiology wards or being seen by a HF specialist team, early during an admission. Those hospitals not meeting the expected standards should perform a clinical pathway review to investigate where improvements can be made. 5. More attention to follow-up arrangements is required so that patients are referred for Cardiology & Specialist Heart Failure Nurse follow-up, ideally leaving hospital with their first appointment. Hospitals should review their pathways for referral to cardiac rehabilitation to allow greater access and uptake for heart failure patients.
National Cardiac Audit Programme (NCAP) **-National Audit of Cardiac Rhythm Management (CRM)**	For Quality Accounts 2022-23, the number of submissions entered via the NICOR portal is 273. QA 2022-23 is currently still open for submissions, the deadline for Quarter 3 (October-December) was 31 March 2023 and the deadline for Quarter 4 is 30 June 2023. National Audit of Cardiac Rhythm Management 2022 Summary report was published with 1 recommendation. Gap analysis sent to Dr K Lipscomb. Gap analysis currently outstanding, latest reminder sent 16/03/2023. Recommendations from the summary report: 1-The fall in procedure numbers has been largely a result of the pandemic, and not within the control of specialists. However, doctors who have become de-skilled should consider undertaking procedures jointly with colleagues, especially for complex or high-risk cases. Those persistently undertaking very small volumes of procedures should examine whether this is sustainable, as should their hospitals. No new recommendations for catheter ablation procedures, the fall in implant rates has not been within the control of the hospitals. In recent

<table>
<tr><td></td><td>years, few NHS Adult hospitals have been significantly below the standards.</td></tr>
<tr><td>National Diabetes Audit – Adults</td><td>National Diabetes Continuous Harms database
Monthly submissions to NDHARMS
Since the Audit commenced there have been a totals of n77 harms. This figures were 57 2021/2022

There were 21 harms in 2021
There were 23 harms in 2022.
(Hypos – 19, Hhs – 2,) Dka -2

National Diabetes Foot care Audit (NDFA)
Monthly submissions to NDFA
226 new entries (i.e. new diabetic foot ulcers assessed by the diabetes podiatry team) between 01/04/2022 – 01/04/2023.</td></tr>
<tr><td>National Emergency Laparotomy Audit (NELA)</td><td>The Healthcare Quality Improvement Partnership Benchmarks results by key metrics. Out of the a total of 6 metrics the trust was higher than 85% of Trust in 3 metrics. The Trust was classed as Amber in 2 metrics when compared to other Trusts;
Crude proportion of high-risk cases (≥5% predicted mortality) with consultant surgeon and anaesthetist present in theatre AND admitted to critical care post-operatively
Crude proportion of patients aged 80 and over OR aged 65+ and frail (CFS>=5) who were assessed by a consultant geriatrician</td></tr>
<tr><td>National Gastro-intestinal Cancer Programme</td><td>The National Oesophago-Gastric Cancer Audit report published on in January 2023 made 7 recommendations. Of the 7 recommendations made 5 where applicable to the Trust.
<table>
<tr><th>n</th><th>Recommendation</th><th>Compliant</th><th>Comment</th></tr>
<tr><td>1</td><td>Review patients diagnosed with stage 4 disease to identify opportunities for earlier detection</td><td>Y</td><td>During the Surgical Multi-Disciplinary meetings (SMDT) previous investigations are always checked as part of our learning</td></tr>
<tr><td>2</td><td>Review patients diagnosed after emergency admission and undertake root cause analysis where appropriate to identify opportunities to reduce rates of emergency diagnosis.</td><td>Y</td><td>Reviews are a routine part of SMDT discussion</td></tr>
<tr><td>3</td><td>Review the oesophago-gastric cancer care pathway and identify ways to reduce the proportion of patients waiting more than 104 days from referral to first treatment.</td><td>Y</td><td>All 104 breachers go through detailed review with Trust Cancer Lead</td></tr>
<tr><td>6</td><td>In regions with high rates of surveillance or non-treatment, review whether patients with high grade dysplasia are being considered for endoscopic treatment, in line with current BSG recommendations.</td><td>Y</td><td>This is part of our SMDT</td></tr>
<tr><td>7</td><td>Review data collection practices for NOGCA and improve case ascertainment in regions where this is low.</td><td>Y</td><td>This is part of our AGM every 12 months</td></tr>
</table></td></tr>
<tr><td>National Joint Registry</td><td>The National Joint Registry Centre Website on the Surgeon and Hospital Profile page for the Trust highlights 5 Quality Measures. The Trust preformed 'Better than expected' in 2 measures and 'As Expected' in the remaining 3. The building of two new modular theatres will improve the experience for our patients, by cutting wait times & increase clinical capacity.</td></tr>
</table>

National Maternity and Perinatal Audit	Gap Analysis received 03/02/2022- Complaint with R1 - R4 Lead Responsibility Lisa Hall BI Senior analyst/Sharon Lord Digital Midwife Data items come from E3 Euroking Digital MIS (maternity information system) There is also some neonatal data items on BADGER NET. NIS (Neonatal information system) R1 Maternity service providers, NHSE&I and national organisations responsible for collating and managing maternity datasets in England should work together to identify how to support individual NHS trusts to meet the criteria for complete monthly data submissions to MSDS. R2 National organisations across England, Scotland and Wales that are responsible for collating and managing maternity datasets should work with NHSE&I, maternity information system suppliers and maternity services, as well as with organisations responsible for neonatal datasets, to improve capture and recording of maternal and neonatal data items. Where data sources have been insufficiently complete to report results, or where results suggest there may be data quality issues, maternity service providers, maternity information system suppliers, NHSE&I and those responsible for collating and managing maternity datasets should work together to improve completeness and accuracy of the data items required for these measures: - birth without intervention - smoking at booking and at the time of giving birth - breast milk at first feed, and at discharge - skin-to-skin contact at birth and for these data items used in the case-mix adjustment (English data only): - previous caesarean birth - BMI - smoking at booking and at the time of giving birth Organisations responsible for collating and managing maternity datasets in England (NHS Digital) and Scotland (Public Health Scotland Data and Intelligence) should use the 'NMPA Measures - Technical Specification for births from 1 April 2017' to align data items (to 0-500 ml, 500-1000ml, 1000-1500 ml, >1500 ml) for postpartum blood loss to enable measurement of the rate of major postpartum haemorrhage of over 1500 ml
National Neonatal Audit Programme (NNAP)	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. Update 19.10.2022 NNAP 2020 Report published 10.03.2022 What we have done in response to our NNAP 2020 data results: Improve our data entry on Badger: We have created a monthly focus on data entry into badger and have created an Optimisation multi-

	disciplinary team This has significantly improved our data and our figures for 2021 show above average results for most indicators (see our 2021 data displayed). We discuss the monthly badger data in our teaching sessions with trainee doctors, medical staff and ANNPs to ensure correct data entry A focus of Optimal cord management along with temperature control at delivery has improved the thermal support provided to preterm babies at birth so that their temperature on admission is within the normal range. Early breast milk feeding and improving breast feeding at discharge: A new quality improvement project lead by a band 7 on NNU along with breast feeding support team and mhas significantly improved our early breast milk feeding rates. Work is ongoing to sustain this through to baby's discharge from NICU. We have presented our work on breast feeding support to other units in the country through regional and national study days To optimise the respiratory support provided to preterm babies and improve the rates of BPD, we have introduced an alternate way of administering surfactant to preterm babies (Less Invasive Surfactant Administration – LISA) since March 2020 and we are looking into expand this into early use in delivery suite soon after baby's birth (something along these lines) Our current areas of quality improvement focus are: BPD QI project: Guideline on early respiratory management for babies <32 weeks in progress (in keeping with NICE guideline); October 2022 Delivery room CPAP along with LISA (Less Invasive Surfactant Administration – LISA) on delivery suite project to start in November 2022 Discussion on Postnatal steroids in grand rounds for babies ventilated in the second week of life Early breast milk feed project: Monthly dashboard to monitor progress 2 year follow up data: join the network meetings set up by NWODN to improve our 2 year follow up and data collection
National Paediatric Diabetes Audit (NPDA)	The latest report NPDA Parent and Patient Reported Experience Measures (PREMs) 2021 was published in September 2022. Fully compliant with all 8 recommendations. Paediatric Team have discussed the recommendation in their MDT away day and plan to present at the governance meeting. The outcomes were very good and generally above national and regional averages and also above our own data from 3 years ago. The Team have a poster produced and will try and put this up in outpatients. The only issue it has highlighted is a lack of awareness around who is present in MDT clinics and what support can be

	requested. The Team are making plans to have a board up in the initial nurse review room, in addition, also making plans to improve access to the survey next time as the numbers were quite low for our patients, whilst parents were adequate.
Perinatal Mortality Surveillance Report (PMSR)	New report published 2022. Report and gap analysis sent to Neeraja Singh to complete within the 3-month deadline A sample of Gap Analysis compliance results below: **Recommendation:** Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist. Trust Compliance: Partially compliant **Action:** Update guideline to include placental histology for all babies admitted to NNU. Updated guideline to be discussed at CDS staff huddles **Recommendation:** Explore local variation in post mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on the local population Trust Compliant: No **Action:** Add to 22/23 audit plan and complete audit **Recommendation:** Develop public health initiatives to address issues linked to high risk populations Trust Compliance: Yes **Comments:** The following are embedded in process - Smoking cessation services and BMI guideline in place. Vaccine administration, BCG complaint. Proposal to implement public health midwifery team to include: Bariatric clinic, Parent craft sessions, Alcohol drug service **Recommendation:** Ensure that healthcare providers have implemented national initiatives to reduce stillbirth and neonatal deaths and are monitoring their impact on reducing preterm birth. Trust compliance: Yes **Comments:** Saving Babies lives care bundle fully implemented and audited. Lead Consultant and Midwife for pre term prevention. Specialist pre term clinic in place **Recommendation:** Ensure that there is a multi-agency targeted approach affecting women living in areas of high socio- economic deprivation across all points of the reproductive, pregnancy and neonatal healthcare pathway. Trust Compliance: Yes – multiagency approach across all points of pathway as appropriate.

	Recommendations: Identify the specific needs of Black and Asian populations and ensure that these are addressed as part of their reproductive and pregnancy healthcare provision. Trust Compliance: Yes **Comments:** Cultural Liaison Midwife in post
Sentinel Stroke National Audit Programme (SSNAP)	National Average Overall Audit Compliance Band: A National Average Overall Audit Compliance Score: 92.8 From the Sentinel Stroke Audit Programme Annual Report 2022, which uses recommendations from NICE NG128 (Stroke and transient ischaemic attack in over 16s: diagnosis and initial management), the Trust is compliant with all recommendations as per the completed baseline assessment tool provided by Dr G Halstead. This also includes the updated guidance for NG128 regarding the new recommendations related to hypertension management, which we follow and are also being incorporated in the new guidelines for stroke prescribing.
The Trauma Audit & Research Network (TARN)	Data quality report for Quality Accounts 2022-23: Case ascertainment percentage for this time period: 24 - 29% Number of cases submitted: 110 Data completeness is the percentage of cases submitted to TARN compared to the expected number derived from the HES dataset. Accreditation percentage for this time period: 74.5% Patients with chest wall injuries- Number of patients: 33 Number of >3 Rib Fractures: 5 (15.2%) Number of Operations: 0 (0.0%) Number of chest wall fixations: 0 (0.0%) Number of Over 65s: 23 (69.7%) Seen by pain team: 0 (0.0%) Risk 4836 update: TARN staff member having to support with 12-hour breach analysis so this will remain as a risk until the new breach process is in place. TARN staff member needs to undertake training from TARN courses, awaiting new TARN course dates. Risk target completion date is 01/03/2023, currently flagging as overdue on the risk register.
Inflammatory Bowel Disease National Clinical Audit Project	The latest quarterly report (published October 2022) shows that 87% of patients whose disease activity was assessed as severe at the start of their biologic treatment had improved at three months, whereas smaller proportions of patients whose disease was less severe showed improvement (71% and 50% respectively for those with moderate and mild activity). Audit Summary 2019 - 2022 for Royal Bolton Hospital KPI trends from the report published on 20/04/2023, below- (% = Performance) KPI 1: Was the patient screened before starting on a biological therapy? (For KPI 1, only biologic naïve patients are reported, so the numbers represent a subset of all biologics starters)

	2019: Bolton 98% - National Average 69% 2020: Bolton 99% - National Average 71% 2021: Bolton 99% - National Average 74.2% 2022: Bolton 99.1 - National Average 76.7% KPI 2: Was a formal assessment of disease activity recorded at the point the decision was made to commence a biological therapy? (Physician Global Assessment - PGA - not included) 2019: Bolton 40% - National Average 40% 2020: Bolton 55% - National Average 40% 2021: Bolton 58.5% - National Average 37.4% 2022: Bolton 58% - National Average 36% KPI 3: Was a formal assessment of disease activity recorded at the point the decision was made to commence a biological therapy? (PGA included) 2019: Bolton 96% - National Average 64% 2020: Bolton 98% - National Average 67% 2021: Bolton 93.2% - National Average 63.1% 2022: Bolton 91.5% - National Average 61.9% KPI 4: Did a post induction review take place? 2019: Bolton 43% - National Average 39% 2020: Bolton 47% - National Average 41% 2021: Bolton 49.5% - National Average 41% 2022: Bolton 49.8% - National Average 41.6% KPI 5(a): Was a formal assessment of disease activity recorded at the post-induction review? (PGA not included) 2019: Bolton 83% - National Average 42% 2020: Bolton 87% - National Average 40% 2021: Bolton 87.1% - National Average 38.7% 2022: Bolton 88.2% - National Average 38.3% KPI 5(b): Was a formal assessment of disease activity recorded at the post-induction review? (PGA included) 2019: Bolton 96% - National Average 63% 2020: Bolton 96% - National Average 64% 2021: Bolton 96% - National Average 62.3% 2022: Bolton 96.4% - National Average 61.6% KPI 6: Did a 12-month review take place? 2019: Bolton 62% - National Average 34% 2020: Bolton 65% - National Average 36% 2021: Bolton 61.9% - National Average 35.2% 2022: Bolton 57.7% - National Average 34% KPI 7(a): Was a formal assessment of disease activity recorded at the 12-month review? (PGA not included) 2019: Bolton 83% - National Average 46% 2020: Bolton 84% - National Average 46% 2021: Bolton 77.1% - National Average 40.1% 2022: Bolton 77.3% - National Average 38.8%

	KPI 7(b): Was a formal assessment of disease activity recorded at the 12-month review? (PGA included) 2019: Bolton 91% - National Average 65% 2020: Bolton 92% - National Average 67% 2021: Bolton 84.3% - National Average 60.8% 2022: Bolton 83.5% - National Average 59.4%
National Early Inflammatory Arthritis Audit (NEIAA)	Bolton NHS trust have been listed as an outlier for the National Inflammatory Arthritis Audit for NICE Quality Standard 2 which is that 'the patients with suspected inflammatory arthritis need to be seen within 3 weeks of referral via the GP'. There is improvement work within Rheumatology of which EIA is part and is currently on the risk register. •The Rheumatology Team are continuing to recruit to the NEIA - Medical clinicians are recruiting suitable patients in clinic if/when time permits. The time constraint in clinic has been highlighted in Rheumatology meetings, and enquiry & response re potential support from Clinical Audit is pending. MP to meet with Rheumatology Steering Group to discuss (November 2022). •Identified EIA/urgent slots (3 per substantive consultant post/week) Since around Aug/Sept'21 new template set up to improve waiting time - Protected EIA slots in place within medical job plans, but currently insufficient capacity (October 2022) •Current waiting time for EIA appointment is 10 weeks as of 18/3/22 (National guideline - 3 weeks) - As of 19/10/2022, length of wait has increased to 14 weeks. •New Consultant business case for EIA service –- ICSD is currently working with BI to undertake an in depth capacity vs demand analysis for Rheumatology to highlight establishment shortfalls if any (medical, nursing etc.) to support the identification of true staffing requirements. Separately, as part of the Rheumatology QAC steering group, work is being undertaken by team stakeholders that will review current service provision and potentials for increasing existing medical capacity through redesign. Request made to clinical lead October 2022 to consider increasing overall capacity as well as swapping existing routine capacity for additional EIA capacity.
Society for Acute Medicine Benchmarking Audit (SAMBA)	SAMBA22 data collection started 23rd June 2022 and ended on 19th August 2022. Bolton submitted 71 cases total for this national audit. Bolton's report was produced on 17 October 2022 and is attached to Safeguard. It shows that Bolton's service is compliant with the national average. Report findings below- PATIENT POPULATION: Percentage of unplanned admissions with NEWS2 score of 3 or more: Average: 29% Bolton: 32%

	Percentage of unplanned admissions aged 70 years or older: Average: 50% Bolton: 44% Referral source for unplanned admissions: Average percentage GP referrals: 20% Bolton: 22% Percentage of unplanned admissions who had been in hospital in prior 30 days: Average: 20% Bolton: 22% EARLY WARNING SCORES: Percentage of unplanned admissions with Early Warning Score recorded within 30 minutes of hospital arrival Median unit performance: 75% Bolton: 86% Performance depending on initial assessment location (by any clinician) in your unit: Initial assessment in ED: 80% Initial assessment in AMU: 100% Initial assessment in SDEC: 100% FIRST CLINICIAN REVIEW: Percentage of unplanned admissions reviewed by a competent clinical decision maker within 4 hours of hospital arrival Median unit performance: 82% Bolton: 81% Performance depending on initial assessment location (by any clinician) in your unit: Initial assessment in ED: 73% Initial assessment in AMU: 100% Initial assessment in SDEC: 100% Percentage of unplanned admissions with consultant review (if required) within the target time Median unit performance: 52% Bolton: 50% Performance depending on initial assessment location (by any clinician) in your unit: Initial assessment in ED: 38% Initial assessment in AMU: 100% Initial assessment in SDEC: 100% Percentage of unplanned admissions arriving during the daytime (08:00-20:00) with consultant review within the target time (6 hours) Median unit performance: 41% Bolton: 47% Percentage of unplanned admissions arriving overnight (20:00-08:00) with consultant review within the target time (14 hours) Median unit performance: 80% Bolton: 57% Percentage of unplanned admissions discharged without overnight admission Median unit performance: 28% Bolton: 41%

British Thoracic Society	National Improvement Objectives: 1. A validated risk stratification score should be recorded in the notes of all patients managed on an OP PE pathway. Target 90% Each centre should ensure a validated risk score (most commonly PESI or sPESI) is mandated in their PE management guideline. PESI/sPESI should be easily accessible and visible within EDs/AMUs, and the scoring system should be added, where possible, to clerking proformas. 2. Initial anticoagulation should be administered within 1 hour of clinical suspicion of PE, unless diagnostic investigations occur within the first hour. Target 90% Each centre should ensure that this timescale is mandated in their PE management guideline. Electronic radiology requesting systems should include guidance to administer initial anticoagulation unless imaging will be performed within the hour. 3. All patients should receive written information including emergency contact details and follow-up within 7 days of going home. Target 90%. Each centre should ensure that easily accessible printed patient information including emergency contact details is available. Follow-up (face to face or remote) within 7 days of going home should be booked. Timeline: 18 months from report publication - February 2024.
National Audit of Care at the End of Life (NACEL)	Fourth round of the audit (2022/23) bespoke dashboard was received in February 2023. Action Development of a business case to add 8a to the team to move from advice/liaison service to a proactive decision making service and see these patients early and role model AC – **Completed recruitment underway March 2023** Lack of complete holistic individualised assessments - Re-develop an electronic record of Care
National Audit of Dementia (NAD)	This national audit (Round 5) has now been completed, as of 06/02/2023. It is on the QA 2023-24 list and is due to recommence (as Round 6) in August 2023. Details from Round 5 below- Case-note Audit Part 1: There were 58 patients submitted for the auditing period 19th Sept 2022-14th Oct 2022. Case-note Audit Part 2: information about assessment and planning was completed ahead of the deadline of 3 January 2023. The annual dementia statement has also been completed, which also had the same deadline. Case-note Audit Part 3: details of the patient's discharge date/date of death, the deadline was 24 March 2023, this has been completed on 06/02/2023. Carer Questionnaires: 4 questionnaires were completed by carers who posted them back to the Royal College of Psychiatrists.

	Patient Feedback Questionnaires: 32 total questionnaires submitted to the NAD Patient Feedback Tool.

Local Clinical Audits

216 local clinical audits were registered and reviewed by the provider in 2022/23 and Bolton NHS Foundation. The breakdown is as follows:

Topic	Count of Request Date
Clinical Interest	14
Clinical Outcome Reviews	4
CQC	3
External Audit	1
Incident (Divisional Review)	3
Incident (SI Review)	11
Inquest	1
Local Standard	18
Monitoring	10
National Regulations	16
NICE Clinical Guidelines (CG)	9
NICE Guidance (NG)	9
NICE Quality Standards (QS)	1
Patient Satisfaction	4
Quality Account Requirement	27
Quality Improvement	58
Record Keeping/Documentation/L	5
Royal College	11
Trust Policy	11
Grand Total	**216**

Local Clinical Audits, examples of learning and actions to improve

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

Audit title	Learning/Actions
Perinatal mental health	PMH problems carry significant health and social burden for the UK society and timely identification and treatment of these can help reduce the long-term human and economic cost associated with PMH. This fact should constitute an important focus point for policy makers, commissioners, and health care providers. Locally, more attention should be paid to PMH with more resources channeled to provide adequate care for at risk women especially in the current COVID-19 climate associated with worsening PMH indices. Healthcare professionals who work with pregnant women should ensure the promotion of physical and emotional wellbeing of these women in perinatal period.

Ongoing vision care in hearing aided children	**Actions include:** The current questionnaire needs to be amended to obtain more information about vision -Discuss with Regional Audit group re amending the form 2 children not referred for O testing after diagnosis due to Covid-related disruption in clinic -Refer those not tested and those with possible Ophthalmology issues a/c questionnaire
Risk assessment at each Ante natal appointment	The majority of women had a full risk assessment undertaken at booking, however some improvements need to be made particularly around anesthetic assessment, manual handling assessment. **Actions include:** • Findings to be shared with the AN matron, ANC manager, team leaders to be disseminated to midwives • Intended place of birth to be included in E3 antenatal contact section • Formal risk assessment to be included in E3 antenatal contact section
Consultant attendance at difficult births	The audit has identified that consultant attendance in all of the RCOG recommended scenarios is not in line with RCOG recommendations. • Overall there were 2 cases where HDU care was required and both had consultant presence. • 5/7 (71%) of cases of caesarean births <28 weeks' gestation had consultant presence. • 9/10 (90%) of cases of PPH >2 litres had consultant presence. • All cases of twins <30 weeks had consultant presence. There were no cases of: caesarean section for major placenta praevia/abnormally invasive placenta, BMI >50, 4th degree tear, unexpected intrapartum stillbirth or eclampsia in the audit period of time. Whilst evidence was found that in all cases consultant discussion took place, improvement in attendance in C/S<28 weeks and PPH>2 litres is required in order to ensure that optimal clinical standards are provided and to be compliant with RCOG recommendations.
Do we meet the NICE quality standards for a diagnosis and management of headaches in young people <12yrs?	The audit looks at our compliance with NICE guidelines for headaches in the over 12s. Due to numbers, this also included some patients under 10.The main areas that need improvement, highlighted in the initial audit, are documentation around analgesia over-use and documenting the use of the (very good) headache leaflet.
Use of IBD Control PROM to improve post induction follow	The IBD Control results gave a quick PROM result on day of infusions highlighting to staff need for further investigations/review.

up in biologic patients	Results show a good correlation with already established DAS Using the IBD Control highlights patients struggling early, we were able to quickly intervene and switch/optimise treatment quickly. Implementation of the IBD-Control Questionnaire proved feasible and acceptable to patients and staff, with high rates of response and completeness. Using adverse scores to trigger ad hoc reviews allowed treatment interventions that would otherwise have been delayed until clinic follow-up.
Royal Bolton Hospital Trust compliance to NICE and Trust guidance on assessment of stroke/bleeding risk and the choice of anticoagulation newly diagnosed non-valvular Atrial Fibrillation	Edoxaban is now the 1st line recommendation for DOAC in new NVAF (within clinical context) Improvements needed for inpatient documentation regarding: Management strategy- RATE VS RHYTHM CHADSVASC and ORBIT/HASBLED Be careful of UNDERdosing with Apixaban (need two of the outlined criteria) Communication with primary care needs improvement: CHADSVASC/ORBIT AF registry Use opportunities to offer lifestyle advice to AF patients- e.g. lots of documentation of 'high BMI' but no explanations given to the patient as to the implications of this Planning to present it to the acute medical team (date tbc)- see attached summary of data. We will re-audit in December/January.
Dermatology toolkit for Advanced Clinical Practitioners working on ambulatory care unit	55% of these patients were female and 45% were male. Age and gender are important contributions to skin health due to the hormonal status affecting the skin function and structure; after menopause female skin becomes noticeably thinner (Mvitzrovitz er al.,2016). Approximately 94% of the patients referred to dermatology required a follow-up appointment. We can identify positive downward trends in waiting times for appointments pre and post-intervention and although this may be multi-faceted it hopefully reinforces that the referral was required and appropriate.
Improving Headache Assessment on the Ambulatory Care Unit	• Reduction in proportion of females in post-intervention audit reflects a fall in suspected idiopathic intracranial hypertension referrals over Christmas period. This, together with fall in GP and rise in A&E referrals during same period, are potential confounding factors. • Good baseline neurology and red flag assessment. Fundoscopy, however, undertaken infrequently by ACPs and others clerking. COVID, and need to avoid unnecessary close contact, may have been a factor. Further work required to explore issue and improve use. • 8 Significant findings out of 59 patients with red flags suggests good pre-test probability assessment and a reminder that some

	headache presentations may point towards a serious underlying pathology. • 11 red-flag negative patients underwent neuroimaging, with no significant findings – suggesting headroom for greater adherence to guidelines and reduction in non-indicated neuroimaging. • Educational and guideline tool aimed at ACPs was associated with improved knowledge and confidence in headache assessment, indications for neuroimaging and reduced length of stay.
Audit on quality of discharge summaries post percutaneous coronary intervention in patients with acute coronary syndrome	• Among 56 discharge summary, 70 % (n=39) had detail ECG findings and ECG findings were missing in 30% (n=17) of discharge letters. • Results of Trop I were mentioned in 77% (n=43) of discharge letters whereas 23% (n=13) discharge letters didn't have Trop I results. • Echo findings in detail were described in 84% (n=47) of discharge letters and 16% (n=9) of letters were missing Echo Results. • Angiogram findings in detail were written in 86% (n=48) of discharge summary, whereas 14% (n=8) of letters were missing that information. • Out of 57 patients, 79% had PCI and PCI was not indicated in 21% (n=12) people. However, description of PCI was written in 59% (n=33) of letters, whereas 20% (n=11) letters were missing that information. • DVLA advice was given in only 11% (n=6) of people and 89% (n=50) of discharge letters did not include that important information. • Among 57 patients 96% received Dual Anti-Platelets Therapy (DAPT) on discharge. However, DAPT regime was mentioned in 73% (N=41) of letters and 23% (n=13) letters were missing that information. DAPT were not indicated for 4% (n=2) of people. • Only 4% (n=2) people received written advice on secondary prevention and there was no mention of secondary prevention in 49% (n=26). However, 39% (n=21) of people were advised to register on IHD register and 4% (N=2) people were referred to secondary prevention clinic. Secondary prevention was not relevant/applicable in 4% (n=5) of people. • Further stage procedures were mentioned in 7% (n=4) discharge letters and no mention of further stage procedure in 4% (n=2) letters. This is because further stage procedure was not indicated in 89% (n=50) of patients.

A&E Cauda Equina Referrals	Out of 108 referrals from A&E there was 6 confirmed cases which is 5.6% positive rate for Cauda Equina Out of the 108 referrals all the patients had their scan performed and reported within 24 hours All patients were scanned and had report available within 24 hours No breaches Low positive rate of CES Takes approximately 30 mins to scan 51 hours a year scanning where CES was not present A more thorough physical examination is required from referring consultants A study conducted by zusman et al, (2022) concluded a combination of physical examination findings of lower sacral function is an effective means of ruling out CES and with further study, may eliminate the need for MRI is many patients reporting back pain or bladder dysfunction. Offering a 24/7 service for certain types of emergency scan (CES and MSCC) Including bank holidays Implication: Tele-radiologist service will be required Offering a on-call service Needing more MR trained staff Re-audit yearly Audit all routes of referrals for Cauda Equina Syndrome Audit on if physical examination is carried out prior to referral for MRI Follow a standardise referral procedure for MRI CES scans which specifically mentions information about physical examinations that needs to be carried out in clinic. Continue to achieve a 100% standard in scanning all A&E? cauda equina scan within 24 hours as according to the local policies. Re-audit in a year to see the standard is being kept up of scanning all ? cauda equina within 24 hours. In the next audit try to include all ? cauda equina from across the hospital instead of just one area of the hospital.
dignity and care after death	Where we can improve • 88% of patients appeared clean and washed as no distinctive body odour was detected and/or food debris identified. 6/52 patients were identified to have a distinctive body odour. • 23% of patients were a delayed transfer to the mortuary. • Patients hair not combed, 14 Patients were identified to have had their hair combed. 60% had not had their combed. Good practice • 96% of patients were transferred to the mortuary wearing either their own clothes or shroud as per trust policy. • 100% of plastic split sheets were used correctly on our deceased patients.

	• 90% of patients had their arms by their side. • 96% of patients were identified correctly with wrist bands in situ. • 98% of patients were transferred to the mortuary with the appropriate slide sheet in place (orange). • 96% of patients were identified as having no leakage from the cannula site. • 98% of patients had the Notice of Death form completed appropriately. • All of the patients audited across all specialities were checked and identified if they had a pacemaker or ICD. The findings of this report will be fed back and shared at the End of Life Steering Group and discussed with the End of Life Care Educator with how to move forward with training of Care after death and continue to support staff. Share results with ward managers and matrons and Bereavement Ambassadors Mortuary staff will contact the ward/department directly, if the patient appears to have not had care after death completed as per hospital policy or if any concerns are identified i.e. no orange slide sheet in place. The mortuary staff will then inform the bereavement nurse who can offer further training and support if required to the staff and/or ward area. An incident form to be completed for all patients transferred to the mortuary not achieving the standard of the policy. Care after Death training sessions will continue. Discussions with EOLC Steering Group executives to ensure Care after Death stays on the Care Certificate Training Programme.
Abdominal Radiographs : Learning by our practice	Improvements could be made to our practice as radiographers. This could be achieved by: -Simply asking patients if they are able to transfer to the table for imaging due to higher doses associated with images taken on trolleys (free detector). -By achieving better centred 1st images, ideally including Symphysis Pubis to avoid re-radiation over this sensitive area. -CPD given in the form of a presentation/ email slides to radiographers to help understand where we could do better, particularly of the need to palpate patients when centring. -A poster on abdominal technique within the department demonstrating essential image criteria. Further work 1.A re-audit in a year to see if there has been a significant change in the quality of images/ greater compliance to DRL's, addressing some of the limitations of this audit. 2.For example, a separation of data for ?Perforation /?

	Obstruction where an erect chest is also performed, look at the effect this has on the data for image analysis. 3.Further audit of LMP documentation to see if the results found in this audit are representative. Standard 1: Results within National Dose Reference Levels -70.9% of examinations were within the National DRL of 250uGycm2. -Of the 29.1% above the standard, 56% had a BMI >25 or evident excessive soft tissue on imaging reinforcing the relationship between patient BMI and dose. -Overall average dose has improved on previous years. The average dose for this sample in 2022 was 218.80 uGycm2 as oppose to 214.98uGycm2 (2020) and 266.91 uGycm2 (2021). -Reasons for examinations being above the National DRL include patients imaged on trolleys, rather than on the x-ray examination table, poor centring and cutting off anatomy and subsequent repeats. Standard 2: Image Analysis • Only 2/117 (1.7%) fulfilled all image criteria on 1 film, both of these were within the local DRL. • Looking as standalone images, 14 of the 117 (11.97%) patients completely fulfilled all image criteria • 23% non-compliance for LMP form scanned onto CRIS. • 101/117 images were of adequate exposure • 4 over exposed, 11 under exposed, 1 examination (2 images was a combination of adequate and over exposed) • And only 4/117 had patient artefact. This is positive due to patients attending fully clothed, especially from A&E, and the placement on metal fastenings on hospital pyjamas. • 65% demonstrated the Symphysis Pubis, although less successful demonstrating lateral margins and diaphragm. However, a discussion could be had about how vital these are. For example, if the request is for ? Perforation ? Obstruction, the diaphragm would be included on the accompanying chest film. This is a limitation to the study in terms of image analysis and would be addressed in further audit. • Another example, requests for KUB, or Stents, if the image is diagnostic and Kidneys or Stents can be visualised, is there a need to include the lateral margins of the abdomen or the diaphragm? Standard 2: Image Analysis • Only 2/117 (1.7%) fulfilled all image criteria on 1 film, both of these were within the local DRL. • Looking as standalone images, 14 of the 117 (11.97%) patients completely fulfilled all image criteria • 23% non-compliance for LMP form scanned onto CRIS. • 101/117 images were of adequate exposure • 4 over exposed, 11 under exposed, 1 examination (2 images

	was a combination of adequate and over exposed) • And only 4/117 had patient artefact. This is positive due to patients attending fully clothed, especially from A&E, and the placement on metal fastenings on hospital PJs. • 65% demonstrated the Symphysis Pubis, although less successful demonstrating lateral margins and diaphragm. However, a discussion could be had about how vital these are. For example, if the request is for ? Perforation ? Obstruction, the diaphragm would be included on the accompanying chest film. This is a limitation to the study in terms of image analysis and would be addressed in further audit. • Another example, requests for KUB, or Stents, if the image is diagnostic and Kidneys or Stents can be visualised, is there a need to include the lateral margins of the abdomen or the diaphragm?
Are we compliant with our Lateral Lumbar Spine DRL's?	Radiographers are not compliant with the national DRL when AECs are used. This can be seen on both AP and Lateral projections. However, compliancy is met when AECs have not been used (on both projections). To deliver CPD sessions to revisit optimum imaging techniques with regards to lumbar spine examinations. This can be done over a lunch break as it will act as a revision session and so should not take too long. This CPD session can held as soon as possible to ensure immediate learning can take place. To re-audit in 12 months to re-assess compliance as this will demonstrate if effective learning has taken place.
Adequacy of images for Skeletal Survey Imaging for Suspected Physical Abuse in Children	It is felt that engagement with our Paediatric colleagues will improve our image quality and reduce the amount of artefact caused by holders anatomy. The production of a departmental guide to skeletal survey imaging may benefit staff and raise awareness of the importance of the image quality for such examinations. Re-iteration of the need to aim for excellent quality imaging regardless of examination length time. Generally, image quality has improved for skeletal survey examinations. However, we failed to meet the target of 80% in 3 of the 4 areas of assessment, and of 75% for overall image quality.
An evaluation into the voice and upper airway profiles of those living with Long COVID	The complexities of SLT needs described highlights the essential requirement of embedded multi-disciplinary working not only to provide the best care for patients, but to critically support the professionals working with individuals with post-COVID voice, swallowing, communication, and upper airway symptoms. The clinical complexities also call for appropriate staffing provision, skill, and training to fulfil the needs of this population. It is acknowledged that nationally there are inconsistencies and inequalities regarding the access and service provision of Long COVID services. It is therefore essential that speech and language therapy is recognised within Long COVID commissioning guidelines that guide service managers and clinicians of the multi-faceted nature of voice, swallowing, communication, and upper airway symptoms.

An evaluation into the voice and upper airway profiles of those living with Long COVID	The complexities of SLT needs described highlights the essential requirement of embedded multi-disciplinary working not only to provide the best care for patients, but to critically support the professionals working with individuals with post-COVID voice, swallowing, communication, and upper airway symptoms. The clinical complexities also call for appropriate staffing provision, skill, and training to fulfil the needs of this population. It is acknowledged that nationally there are inconsistencies and inequalities regarding the access and service provision of Long COVID services. It is therefore essential that speech and language therapy is recognised within Long COVID commissioning guidelines that guide service managers and clinicians of the multi-faceted nature of voice, swallowing, communication, and upper airway symptoms.
Audit of the MAGSEED system in localizing non-palpable breast lesions at Royal Bolton Hospital	Three patients who needed re-excision Two had Magseed placed within tumour or adjacent One had Magseed placed >5mm away from tumour All were IDC with associated DCIS • 100% of impalpable lesions identified at first operation (ABS) • 93.8% of lesions removed completely (6.2% re-excision rate) • 92% of Magseeds placed within/adjacent to tumour • Magseed localization appears to be used safely and effectively in Bolton
Obstetric analgesia response times	Response times overall are good Overnight sometimes there was a solo anaesthetist which occasionally delayed response to requests where they were in theatres or busy with another patient. Documentation in some instances was not accurate
Trial of Magtrace®. in Royal Bolton Hospital as an alternative method to radioactive isotope in sentinel node biopsy in axillary breast cancer surgery.	• Magtrace worked well in small inner tumour more dissection than isotope and needed to be close for signal. However, 2 hot and blue nodes. Need more babcock/thinner retractors/smaller probe • Magtrace provided an alternate option in case where radio isotope was not available (patient DNA, High BP) but was unsuccessful • Lack of focal signal until very close to node, mainly guided by blue dye. • There is a steep learning curve it was acknowledged that the number of cases performed was small and that greater numbers needed to be performed by those clinicians not familiar with the technique before any conclusions could be reached. Mr Pardo suggested that the learning curve for the technique is quite steep and offered to provide support in theatre.
Retrospective Review of Naevus Clinic since it started in Feb 2021	• Standardised care and follow up now undertaken for all patients with a naevus. • More patients being discharged to the care of their own Optometrist with copies of their images as they are low risk and do not need to be reviewed in the HES.

	• Clinicians gaining more experience so fewer low risk naevi being sent for opinions to Liverpool. • Inform High Street Optometrists of the new guidelines so they can monitor more patients and only refer in the ones with MOLES scores of 1 or over for assessment. (Already completed) • Organise meeting with the Chair of Bolton Local Optical Committee to discuss the new guidelines and the possibility of organising a training session next year.
Compliance and Effectiveness of the Tinnitus Handicap Inventory	1We are maintaining high compliance. Continue active monitoring, on-going scores guide treatment and management plans, this will however be carried forward to next audit to ensure compliance and treatment plans booked as appropriate. Post THI not completed. Implementing Evaluation form or when audit base is upgraded implementing TFI (tinnitus functional index to capture date) 2Over the last three months there have been 5 patient's DNA tinnitus follow-up appointments, these patients had not received a letter and were subsequently re-appointed, however there had been no phone call prior to the appointment which was agreed to be implemented in a previous audit. Tinnitus staff to mirror follow-up appointment in the rota prior to appointment to ring patient to remind. 3Capacity for appointment to be increased MA to devise fitting symbol for tinnitus fitting. Implement In-house training for interested Audiology staff in tinnitus THI conclusion We are maintain high compliance with initial THI to implement effective management plan No measure of effectiveness at follow-up. THI part 2 being completed, no measure of data to ensure we are delivering an effective service not capturing Actions Evaluation to be created to be given at follow -up to monitor any changes needed for service delivery Re-audit for effectiveness 2023 DNA Conclusion to many DNA impacting on capacity and cost Actions Audiologist when booking follow-up appointments in the department to improve DNA rate, put shadow alert 3 days prior to ring patient to confirm attendance Re-audit 2023 Good compliance with severe/catastrophic being appointed within 2 weeks Actions Severe/Catastrophic to continue to be given an appointment within 2 weeks to issue hearing aid/combination device. MA to create new tinnitus symbol for capacity with tinnitus staff, role out staff training in house identify audiologist who wish to

	deliver a more formal tinnitus service peer review/appraisal Beaumont patient to have triage appointment within a week a receiving referral letter On staff meeting for office staff. LK to monitor fitting waiting list Re-Audit 2023

Participation in Clinical Research

52 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 2022/23. 2004 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

A proportion of Bolton NHS Foundation Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between Bolton NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2022/23 Bolton NHS Foundation Trust received £3.2m of its CQUIN target agreed with commissioners

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

Further details of the agreed goals for 2022/23 and for the following 12-month period are available on request

Care Quality Commission Registration

Bolton NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions". The Care Quality Commission has not taken enforcement action against the Bolton NHS Foundation Trust during 2022/23.

Bolton NHS Foundation Trust participated in an unannounced visit to the urgent care centre and medical wards and an announced inspection of maternity services in December 2022.

The CQC inspection report for the unannounced visit to the urgent care and the medical wards was published on 17 February 2023. This report contained three 'Must Do' actions and five 'Should Do' actions.

The Trust has also received the inspection report for maternity services. The report contained six 'Must Do' recommendations.

A trust wide CQC improvement plan has been developed to monitor a number of recommendations and actions following the CQC inspection visits and the internal quality and safety assessment sand the improvement sprints. All recommendations and are included in one trust wide improvement plan that is overseen and monitored at Clinical Governance and Quality Committee on a monthly basis. As at 31/03/23 all actions were either complete or in progress. No actions are overdue.

Data Quality
Bolton NHS Foundation Trust submitted records during 2022/23, at the Month 11 inclusion date 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
  - *95.5 %* for accident and emergency care. (ECDS dataset 1 April 2022 to 11 April 2023)

- **which included the patient's valid General Medical Practice Code was:**
  - *100.0 %* for admitted patient care;
  - *100.0 %* for outpatient care; and
  - *98.2 %* for accident and emergency care. (ECDS dataset 1 April 2022 to 11 April 2023)

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, and continue to be created as necessary, to identify DQ issues as early as possible so that they can be rectified before activity is reported on or submitted to national bodies
- Users are signposted to the relevant training
- All training manuals have recently been reviewed by the team and updated as and where necessary
- The RTT validation team is under the management of the Deputy Head of Business Intelligence (Data Quality). There is now an RTT data lead in post who delivers face to face RTT awareness sessions not only within our own team but across the wider organisation.
- Face to face training has been, and continues to be, delivered to Ward Clerks to ensure the accuracy of inpatient data
- The team support numerous projects across the organisation to ensure that data is recorded correctly and in line with national definitions
- We undertake regular internal audits, carried out by the Validation Team Leader focusing on known or suspected data quality issues
- Data Quality is a standard item on various Trust group agendas
- Senior managers from within the organisation have sat with the DQ validation team to gain more of an understating of the role the Data Quality team play in ensuring accurate data

- 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 2022/23 by the Audit Commission.

Learning from Deaths
During 2022/23 1628 of Bolton NHS Foundation Trust patients died in hospital.

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

- 344 in the first quarter;
- 405 in the second quarter;
- 453 in the third quarter;
- 426 in the fourth quarter.

In 2022/23, 187 structured judgement case record reviews and 60 cardiac arrest root cause analysis investigations (where the patient did not survive) have been carried out in relation to 1628 of the deaths included above.

Out of 187 Structured judgement cases recorded, in 3 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 92 Case record reviews in the first quarter; Investigations = 2
- 48 Case record reviews in the second quarter; Investigations = 0
- 33 Case record reviews in the third quarter; Investigations = 0
- 14 Case records reviews in the fourth quarter; Investigations = 1

27% (6 avoidable cardiac arrests, 187 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:

- 19 representing 5% for the first quarter;
- 20 representing 5 % for the second quarter;
- 7 representing 2 % for the third quarter;
- 6 representing 1 % for the fourth quarter.

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

All Divisional Reviews and Serious Investigations which are generated via an avoidable cardiac arrest are identified timely by using the cardiac arrest validation clinic and have

specific individual actions generated which remain the responsibility of the Division. Learning from deaths is disseminated through specialty mortality and morbidity meetings and individual feedback to the clinicians concerned.

Learning Disabilities Mortality Review (LeDeR)

There have been significant changes to the LeDeR process in the past 12 – 18 months. Since January 2022, the programme has changed to Learning from Lives and Deaths; People with a Learning Disability and Autistic People (LeDeR) and notifications should now be made for people aged 4+ with a learning disability and for autistic people. Across Greater Manchester, the reviews are now completed by a regional review team, however, the learning and action from reviews remains the responsibility of each locality. The external review arrangements help to ensure reviews are completed objectively and within the required timescales.

From April 2022 to date, there have been 10 Bolton death notifications made to the LeDeR platform, all previously known to specialist learning disability services. We have a cause of death recorded for 7 as some reviews are still in progress. Of the 7 who do have a recorded cause of death, 57.1% (four people) had pneumonia listed as primary issue. One person died of cancer, one pulmonary embolism and one as a result of surgical complications. The average age of death is 58.4 years of age and 90% died in hospital with one person dying at home.

There is continued concern about notifications to the LeDeR platform; only one of the notifications has been made by a GP, all the others were alerted by LD specialist staff. This is a continuing trend and raises concern that we are not notified of the deaths of people who are not in receipt of specialist learning disability services. Of additional concern, is a lack of any child death notifications, whilst these would be subject to the CDOP process, the death should still be alerted to the LeDeR platform for collation of data. There are also no notifications for adults with autism only, despite the change to the process in January.

The Bolton locality continues to deliver a multi-agency LeDeR steering group to ensure appropriate governance and any learning from deaths is reported and actioned across all relevant organisations.

Seven day services

Seven day services review was put on hold for the duration of the COVID pandemic as per NHS Improvement's request – the recommencement of the audit is currently being reviewed.

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 and this was increased in July 2022 to 1.2 WTE. The Guardians are supported by a Network of 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 Guardians take the lead in supporting workers to speak up safely, to thank them for speaking up, to listen to their concerns and to help resolve issues satisfactorily and fairly at the earliest stage possible ensuring workers receive regular feedback and support. Importantly, the role is independent and impartial. The Guardians work in partnership with the communications team in utilising different methods of promoting the freedom to speak up approach. The Guardians meet 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 Guardians request 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 people Committee and Divisions and an annual report delivered by the Guardians to the Trust Board. The Guardians also provide quarterly data to the National Guardian Office.

Guardian of Safeworking – NHS Doctors in Training

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

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

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

Reporting against core indicators – *latest published data to 20/04/23*

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	2022/23	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2021/22	2020/21
Mortality: The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for (12/21 – 11/22) latest published data available	SHMI Value = 1.0817 (12/21 – 11/22 Band 2 (As expected)	SHMI value = 1.00	SHMI Value = 0.7173 Chelsea and Westminster Hospital NHS Foundation Trust Band 3	SHMI Value = 1.2219 Norfolk and Norwich Hospital 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 = 1.1533 (12/20 to 11/21) Band 1	SHMI value = 1.1030 Band 2
The percentage patients' deaths with palliative care coded at either diagnosis or specialty level for the period (12/21 – 11/22) Latest published data	33% (12/21 – 11/22	40%	66% Isle of Wight NHS Trust	13% 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	34% (12/20 to 11/21)	31 %
Patient reported outcome scores for hip replacement surgery	In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMS-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at the present time. This has resulted in a pause in the current publication reporting series for PROMs at this time.						
Patient reported outcome scores for knee replacement surgery							

Indicator	2022/23	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2021/22	2020/21
28 day readmission rate for patients aged 0 – 15 *	*The latest available published national data for 28-day readmission rate provided for these measures is for 2011/12. Local data for Bolton NHS Foundation Trust readmission rate is 9.4% for discharges in February 2023 *(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 2021	8.0 (2021) (Best and worst performer included for reference as calculated by CQC) Most up to date available is 2021 Adult Inpatient Survey.	8.1 (2021)	9.4 (2021)	7.4 (2021)	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 • Lived Experience Panel • Development of Local Surveys • Carer Involvement • Patient Safety Plan	8.2 (2020)	
National Quarterly Pulse Survey – staff engagement score	6.99 (Quarter 4 2022/23)	6.99 (Quarter 4 2022/23)	7.49 (Quarter 4 2022/23) University College London Hospitals NHS Foundation Trust	4.54 (Quarter 4 2022/23) North Bristol NHS Trust	The National Quarterly Pulse Survey (NQPS) provides a consistent and standardised approach, nationally and locally, to listening to staff at more regular intervals with a robust data set. NQPS focuses on the core set of nine questions which make up the engagement theme from the NHS Staff Survey that provide insight into motivation, involvement and advocacy.	The Staff FFT collection was suspended during Covid and not reinstated Results for the National Pulse Survey by Trust started in Quarter 4 2022/23 so no previous data is available.	

Indicator	2022/23	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2021/22	2020/21
The percentage of admitted patients risk-assessed for Venous Thromboembolism (Mar-23)	96.94% (04/22 to 03/23)	n/a	n/a	n/a	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • VTE Nurse Champion • Nurse-led DVT Clinic • VTE database • Staff Awareness campaign • RCA of patients developing clots for continuous learning and improvement	97.19%	97.34%
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*	32.7	18.3	59.0 Wye Valley NHS Trust	5.6 East Cheshire	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. • C'diff Improvement Collaborative • Revised guidance and policy. • IPC link nurse development programme.	23.8 (20/21)	18.7 (19/20)
Number/Rate of patient safety incidents per 1000 bed days Apr/21 to Mar/22 latest data available (NRLS)	61.5 per 1,000 bed days N = 12,420 Apr/21 to Mar/22	n/a	n/a	n/a	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the National Reporting and Learning System (NRLS) National data published September each year. Therefore, latest available published data is 2021/22 Bolton NHS Foundation Trust Risk & Assurance team have	64.9 per 1,000 bed days N = 10,882 20/21	60.4 per 1,000 bed days N = 6,224 19/20

Indicator	2022/23	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2021/22	2020/21
Number of above patient safety incidents that resulted in severe harm or death Apr/21 to Mar/22 latest data available (NRLS)	N = 33 10 deaths 23 Severe harms Apr/21 to Mar/22	n/a	n/a	n/a	undertaken: • Preparation for the Implementation of new national Learning from Patient Safety Events Service, replacing NRLS • Preparation for the Implementation of new national Patient Safety Incident Response Framework (PSIRF)	N = 24 8 deaths 16 Severe harms 20/21	. N= 10 3 deaths 7 Severe harms 19/20
Inpatient Friends and Family Test (Feb-23)	96.4% (Feb-23)	95.03%	100% The Royal Orthopaedic Hospital NHS Foundation Trust	66.07% 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	96.1%	96.6%
Accident and Emergency Friends and Family Test (Feb-23)	87.1% (Feb-23)	79.2%	94.74% Torbay and South Devon NHS Foundation Trust	37.5% University Hospital Southampon NHS foundation Trust		85.0%	89.7%

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Part 3

Performance against Trust selected metrics

... for a better Bolton

Performance against Trust selected metrics

This section of the report 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	**2022/23**	**2021/22**	**2020/21**
Patient Safety Outcomes	Mortality - SHMI	See page 64		
	C.Diff – number of cases	See page 66		
	Pressure ulcers by category: • Cat 2 • Cat 3 • Cat 4 *Data source – Bolton NHS Foundation Trust's incident reporting system*	304 16 1	248 50 3	210 46 3
Patient Experience	Friends and Family Test inpatients • Response rates • Recommendation rates *Data source – captured locally, submitted nationally and published by NHS England*	25.6% 96.2% (Mar-23)	21.7% 95.7%	31.2% 96.6%
	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	Suspended	90.8%
Effectiveness	Sickness rates *Data source – captured via local attendance management system (E-roster and ESR), submitted nationally and published by NHS Digital*	4.6% (Mar-23)	5.1%	4.1%
	Appraisal rates *Data source – captured via local ESR and reported locally for Board report*	84.1% (Mar-23)	78%	78.4%
	Mandatory Training compliance *Data source – captured via local training and development system (Moodle and ESR)*	85.3% (Mar-23)	85.4%	91.8%

The above data is reflective of 2022/23 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 2022/23 used a variety of methods to ensure that learning is captured, shared and embedded in a timely manner.

Capture: Incidents, complaints, claims, audits and Inquests provide us with the opportunity to reflect when our practice could have been better, the Governance Team are central to ensuring that the intelligence gleaned from such events is accurate and focused on learning.

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

Embedded: SBARS, once published are monitored in terms of demonstrating embeddedness via a measure in BoSCA (our in-house ward and departmental accreditation scheme) which ensures that staff in clinical settings have been made aware of the SBAR. Furthermore, the Governance Team 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 22-Mar 23**	**Target**	**Achieved**	**Apr 21-Mar 22**	**Apr 20-Mar 21**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway (as at 31/03/2023)	60.29%	92%	✗	65.4%	62.2%
A&E: Maximum waiting time of four from arrival to admission, transfer or discharge (average for the year)	59.48%	95%	✗	66.84%	80.0%
All cancers: 62-day wait for first treatment from:					
• Urgent GP referral for suspected cancer (04/22 – 03/23)	81.72%	85%	✗	85.35%	83.47%
• NHS Cancer Screening Service referral (04/22 – 03/23)	82.91%	90%	✗	77.28%	74.45%
Clostridium difficile - meeting the C. difficile objective *National data published September each year. Therefore latest available published data is 2021/22*	66	N/A	✗	40 (2020/21)	38 (2019/20)
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)	86.1%	99%	✗	66.9%	61.8%
Venous thromboembolism (VTE) risk assessment included in "**Reporting against core indicators section"**					

Bolton NHS Foundation Trust Quality Account 2022/23 – Statement from Greater Manchester Integrated Care Board

The Greater Manchester Integrated Care Board (NHS GM) would like to thank Bolton NHS Foundation Trust for the opportunity to respond to the Quality Account and convey our gratitude once again to staff at Bolton NHS Foundation Trust for their continued commitment to recover from the impact of the pandemic and ensure those patients that need the services receive them as
soon as possible.

NHS GM 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. NHS GM continues to work closely with Bolton NHS Foundation Trust to gain assurance the Trust provides safe, effective, and patient focused services. Performance and quality continue 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 2023/24 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 the Same Day Emergency Care Unit is also supporting Accident and Emergency's (A&E's) continued high demand.

We acknowledge the current pressures on recruitment throughout the NHS and it is encouraging to see the Trust is investing in several staff development opportunities and leadership programmes.

NHS GM also welcomes the continued investment in seeking digital solutions for both staff and patients.

NHS GM notes the section on performance against the 2022/23 priorities. As well as observing the improvement pathways and the partial achievement for those relating to Rheumatology, Pneumonia, Radiology, Maternity safety and the National Early Warning Score (NEWS). NHS GM welcome updates via our membership at the Bolton NHS Foundation Trust Quality Assurance Committee for the following areas:

- Improving the response to escalation from clinical teams following a deterioration in a patients' NEWS, which is a continuation from 2021/22.
- Antibiotic prescribing standards
- Rheumatology
- Improving information for patients
- Accessible Information Standards (AIS)

NHS GM welcomes the improvement work in relation to reducing harms caused by pressure ulcers and the commitment to reducing infections caused by clostridium difficile. It is good to see the application of the improvement collaborative approach in the management of priorities and participation in such a large number of both national and local clinical audits to help improve better quality of care for the local population.

Delivering maternity services are not without challenges however the ongoing commitment to improve the quality of maternity care delivered, in line with national maternity quality and safety designed to meet the national ambition to reduce the number of stillbirths and neonatal deaths is welcomed, including but not exclusively:

- Saving Babies Lives Care Bundle
- Maternity and Neonatal Safety collaborative

- Each Baby Counts
- Improving Equity and Equality in maternity and neonatal care.
- Implementation of Tommy's app

NHS GM 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 2023/24 to address not only the significant challenges ahead, but also to ensure the services we provide, together will meet the needs of the local population, while maintaining the provision of safe, effective, and patient focused care.

Mark Fisher
Chief Executive
NHS Greater Manchester