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Bolton NHS Foundation Trust

Quality Account
2024/2025

Improving care,
transforming lives...for a better Bolton

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PART 1

Statement on the quality of services from the Chief Executive

Improving care,
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Statement on Quality from our Chief Executive

I am pleased to be able to share our annual Quality Account for the year 2024/25, a report that reflects our ongoing commitment to providing safe, effective and compassionate care for all those who need it.

This document outlines the progress we have made over the past year in improving the quality of our services, highlights the priorities we have set for the year ahead, and demonstrates how we are listening to and learning from patients, carers, staff, and partners across the health and care system.

A summary of achievements from all our 2024/25 quality account improvement priorities can be found in part two of this report. I would like to thank every single person across our organisation, who all play such a key role in the delivery of our quality and safety agenda. I look forward to the difference we can continue to make for our patients, their relatives and carers over the next 12 months and beyond.

The next twelve months promise to be incredibly challenging for the NHS, as the government has called for an urgent, national focus on the fundamental priorities of the NHS. As a provider of NHS services, this means we must continue to deliver against nationally set targets and challenges, whilst significantly reducing our costs to deliver better value for money for the tax-payer.

Quality and safety will continue to be our focus and our improvement priorities for 2025/26 are as follows:

- Recognising and response to the deteriorating patient
- Releasing time to care – phase one – a focus on documentation
- Communication – Involving our patient in their care and decision making

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.

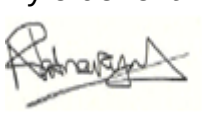
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality 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 2024/25* and supporting guidance *Detailed requirements for Quality Reports 2023/24*
- the content of the Quality Report is consistent with internal and external sources of information including:
    - board minutes and papers for the period April 2024 to the date of this statement
    - papers relating to quality reported to the board over the period April 2024 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 2024 national patient survey
    - the 2024 national staff survey
    - latest CQC inspection report
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board



Chairman Chief Executive

25 June 2025

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PART 2

How quality initiatives are prioritised at the Trust

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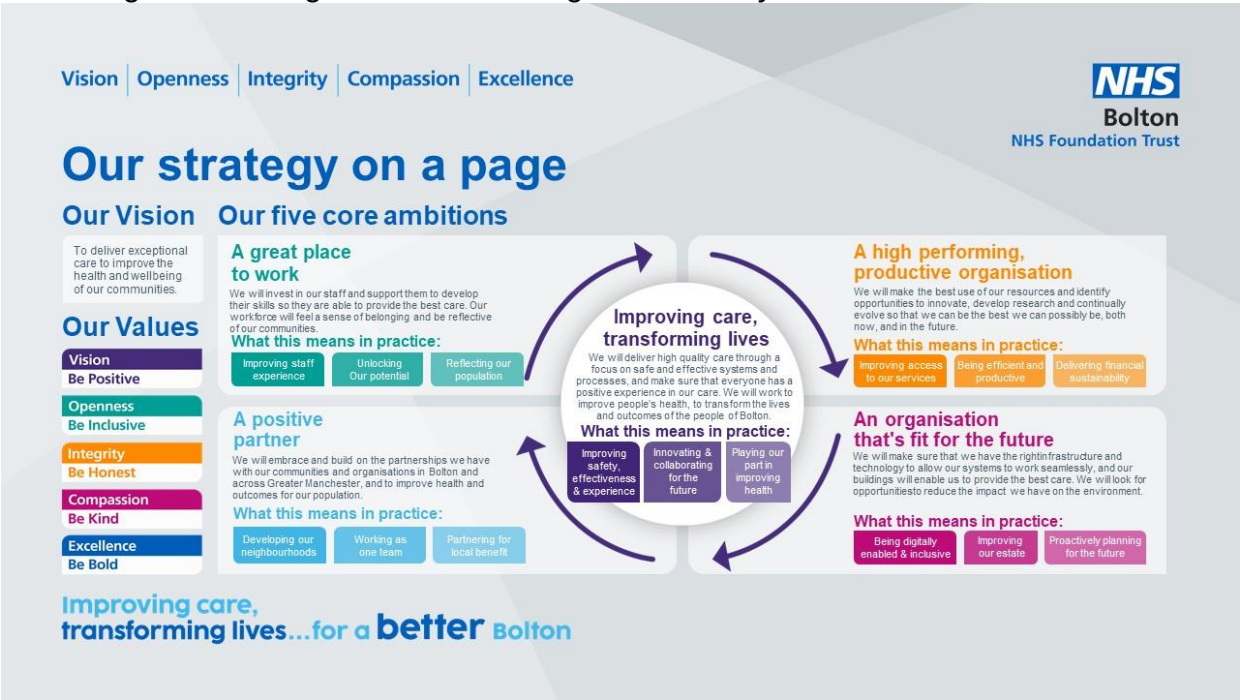
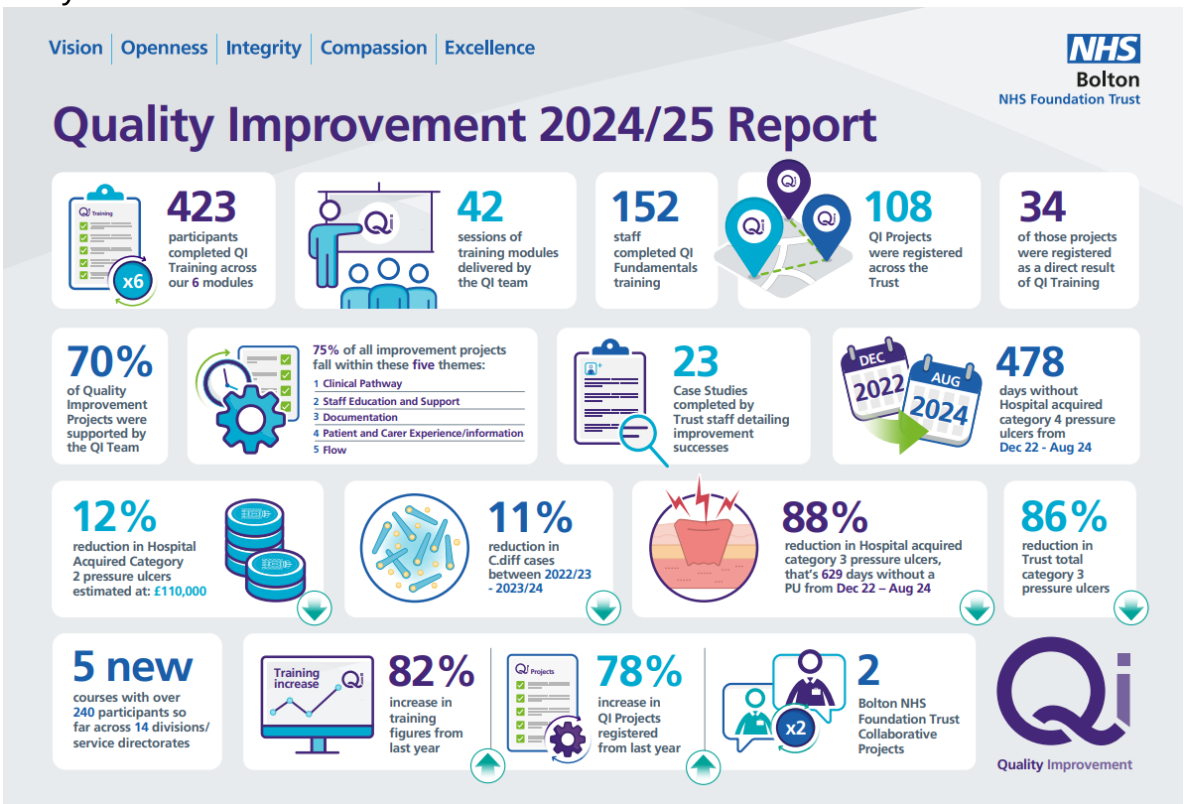
Enabling organisational strategy through the quality improvement (QI)

We are proud to be an integrated community and acute Trust, delivering services across Bolton. We know that for some, life is not easy with the cost of living on the rise, life expectancy in Bolton being lower than the England average and health outcomes differing greatly depending on postcode. Our strategy for 2024-29 demonstrates our commitment to addressing the challenges we face, through the delivery of our five core ambitions below:



Our overarching priority is to ensure everyone has a good experience of our services and the care we provide. If we deliver consistent and sustained improvements in the safety, effectiveness and experience of the care we provide, we will contribute to our goal of ***improving care, transforming lives***. Quality Improvement (QI) science is a key enabler of our organisational vision and strategy and this Quality Account report demonstrates how QI has supported progress towards the achievement of our strategic ambitions in 2024/25, a summary of which is shown below:



**Collaborative figures are accurate within the timescales of the respective collaborative projects.*

How quality initiatives are prioritised in the Trust
This Quality Report identifies the progress made against the quality and safety agendas in 2024/25 and identifies the quality improvement priorities for 2025/26. Quality initiatives are chosen and prioritised based on quality, safety and experience data to ensure we focus improvement activities around greatest need and decisions are made based on robust data.

Key quality improvement priorities for 2025/26
Following consultation with our stakeholders we would like to highlight the following as our quality account improvement priorities for 2025/26:

1. Recognising and response to the deteriorating patient
2. Releasing time to care – phase one – a focus on documentation
3. Communication – Involving our patient in their care and decision making

Outline of aims and plans for the 2025/26 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 2024/25:
In our Quality Account for 2023/24 we set ourselves a series of key priorities for improvement for 2024/25, these were:

- C.*difficile* infection reduction
- Enabling and empowering staff through the development of quality improvement skills
- Recognising and response to the deteriorating patient

Progress against each priority is outlined on the following pages.

Quality Account Improvement Priorities 2024/25

Priority 1 - Clostridium Difficile Infection Reduction

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

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

AIM: *The overarching outcome aim was to:*
Reduce Healthcare associated C.*diff* Toxin (CDT) positive cases by 33% by 30/06/24, with a sustained reduction to the Greater Manchester peer mean (50%) by 31/12/2024
***OUTCOMES**: (to 31/03/25)*
• 11% decrease in Healthcare associated C.*diff* Toxin (CDT) positive cases from 2022/23 baseline N= 135 cases vs N= 120

Progress to date

- A C.*diff* improvement collaborative ran from May 2023 to January 2025 with four collaborative learning sessions and supported coaching to develop and share ideas for improvement around the following areas:
  - Bowel habits – regular monitoring and documentation of patients' bowel movements to identify and communicate changes and take action in a timely manner.
  - Diarrhoea Management Plan – staff awareness and compliance with the process to follow with new onset loose stools/diarrhoea – to ensure timely sampling and isolation to avoid cross contamination
  - Isolation within two hours of symptoms - timely action to isolate the patient, preferably into a single room with own dedicated toilet resources that remain in the isolation room.
  - Escalation – if isolation within two hours is not possible escalation to the Site Management Team must be completed and an isolation order set submitted on EPR to ensure hospital bed flow oversight and prioritisation of side room use where possible.
  - Hygiene, cleaning and assurance – staff awareness and compliance with *C. diff* cleaning protocols. Also that all patients, staff and visitors are aware of the importance of hand hygiene and the importance of washing their hands after toilet use and before/after meals.
- The ideas tested by collaborative teams have been consolidated into a trust-wide C.*diff* Change Package to be launched in June 2025.
- The following progress to reduce C.*diff* beyond the collaborative is summarised below:
  - Antibiotic use – audit against trust antibiotic prescribing standards
    - Prescription in line with the Trust policy for stated indication
    - Evidence of review at 48/72 hours
    - If the patient remains on intravenous antibiotics, is this in line with policy?
  - Testing of a short-term C.*diff* cohort area to release 'lost' side room capacity currently used for patients who already have CDI and acts as a blocker to new patients with loose stool being isolated.
  - Flow Office responsiveness to isolation requests, enabling isolation within two hours and/or escalation prior to the two hours should a plan not be agreed

Next Steps:

The C.*diff* Change Package will launch trust-wide in June 2025, including a reliability checklist for each of the five key principles above to enable the continual monitoring, improvement and sustainment of these standards.

C.*diff* reduction remains a priority for the organisation and an overarching CDI improvement plan is in place and reported to the Infection Prevention Control Committee.

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:

- Divisional Governance meetings
- Divisional and Trust IPM
- Infection Prevention Control Committee
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Priority 2 - Enabling and empowering our staff through the development of quality improvement (QI) skills and knowledge

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

AIM: *The aim for year two was:*

- 30% increase in staff trained in the fundamentals of QI from 23/24 baseline
- 30% of those trained in to run their own improvement project

***OUTCOMES**: (to 31/03/25)*

- 68% increase staff trained in the fundamentals of QI
- 82% increase in all QI training activities from 23/24
- 108 QI Projects were centrally registered – an increase of 78% from 23/24

Progress to date:
The key drivers and interventions for 2024/25 are summarised below:

QI Skills learning and development academy

- Expansion of QI skills capability building offering to now include:
- QI fundamentals
- Improvement Practitioner
- Introduction to Measurement
- Introduction to Lean
- Introduction to Well Organised Working Environment (WOWE)
- Improvement for Leaders (via Our Leaders Programme)
- QI modular learning – videos
- QI for doctors in training and student nurses/midwives/AHP etc.

Share and Celebrate "Central library of QI" mechanism:

- 160 QI project registrations on "Central library of QI" accompanied by case studies for sharing and learning purposes.
- Inaugural National QI Week – "QI is for everyone"
- Chief Nursing Officer annual conference – introduction to Lean methodology, Value and

Waste – understanding improvement to release time to care
- QI Junior Doctor Showcase
- QI new starter induction literature

Vision - launch of QI Plan 2024 – 2028

Incorporating QI into operational delivery and standards – through the Bolton Scheme of Care Accreditation (BoSCA).
- **BoSCA – QI –** 45 teams closed/complete, 12 in progress, 13 teams currently scoping their improvement project/test of change.

Next Steps:

QI Skills learning and development academy
- Continuation of offering as above
- Bespoke QI skills development – e.g. Proud2bOPs – QI development programme for operational staff.

Share and learn and celebrate:
- Continuation of offering as above
- QI showcase events to celebrate and share learning

Incorporating QI into operational delivery and standards
- BoSCA – Platinum accreditation
- Roll-out of ward/department based Improvement Boards – making every day improvement visible

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

The forums and governance committees which will provide progress, oversight and accountability for Enabling and empowering our staff through the development of quality improvement skills are summarised below:
- Clinical Governance and Quality Committee
- Quality Assurance Committee
- Clinical Effectiveness Group
- Patient Safety Group
- Quality and Patient Experience Group

Priority 3 - Recognising and response to the deteriorating patient

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

Over the past few years there has been a great deal of work focussing on recognition and response to deterioration in patients with conditions such as sepsis, Acute Kidney Injury (AKI). However, there are commonalities in the ability to detect and respond to deterioration across these conditions and so work has been brought together to understand these and share learning.

Progress to date:

Deteriorating Patient Quality Improvement (QI) Collaborative
In 2024, the organisation commissioned an Improvement Collaborative to test improvement ideas on the identification and escalation of deterioration across various specialties, acute and community settings, different identification pathways and patient groups and demographics. This will be a multiple year improvement priority and a change package detailing recommended service changes will be released following the end of the first phase in February 2026.

The Collaborative commenced in February 2025, with the following innovation teams selected based on their influence within identification and escalation of deterioration:

- Gastroenterology
- Respiratory
- General Surgery
- Orthopaedics
- Maternity
- Paediatrics
- Admission Avoidance
- Community Learning Disability Team
- Hospital at Night,
- Critical Care Outreach,
- Laboratory Medicine
- Digital EP

Due to the diverse nature of deterioration amongst our collaborative teams, it was decided that the high level outcome aim that demonstrated the most severe result of deterioration would be:

AIM:

To reduce the number of cardiac arrests across inpatient and community sites by 20% by 28th February 2026 and by a further 30% by 31st March 2028.*

Cardiac arrests are measured by:

- **Avoidable*
- *Should not have been for resuscitation (DNACPR)*
- *Non-avoidable*

However, each collaborative team will have their own main measure of deterioration. For example, in Maternity the focus may be on preventing pre-eclampsia while in Paediatrics, the focus may be on respiratory arrests. Therefore we will also track the following:

- Sepsis 6 Standards – e.g. screening for sepsis
- AKI Standards – e.g. risk assessment, time to treatment
- NEWS2 / MEWS / PEWS
- 2222 calls
- Peri-arrests
- HSMR
- Crude mortality
- Incidents – avoidable deaths
- Martha's Rule calls
- Admission rates

The collaborative teams are working on tests of change across four primary drivers:

- Reliable recognition and response
- Communication
- Knowledge and skills
- Leadership

Details of current change ideas and project focus can be found in the next steps section.

Martha's Rule

Bolton was a pilot sites for the national Worry and Concern Improvement Collaborative aimed to test reliable methods for patients and their families to raise concerns about clinical deterioration related to acute illness. This collaborative formed the foundation for the introduction of Martha's Rule, made up of the following components:

- Patients will be asked daily how they are feeling, whether they are getting better or worse, and this information will be reviewed in a structured way.
- All staff can request a clinical review from another team if they are concerned about deterioration that is not being addressed.
- Patients, families and carers will always have access to an escalation route, which will be clearly advertised across the hospital.

In May 2024 Bolton was selected as one of 143 national pilot sites to implement and test the delivery of Martha's Rule, where we:

- Submit monthly data to support national reporting and measure our progress.
- Capture qualitative feedback from patients and staff to understand the impact of Martha's Rule
- Piloted the Patient Wellness Questionnaire in key inpatient areas
- Worked with local organisations to capture their views for co-design work
- Integrated the documentation into the Electronic Patient Record (EPR) and built further documents within the system to support the role out.
- Delivered education and awareness campaigns for staff, patients, and families

Additional work to improve recognition and response to the deteriorating patient:

Staff awareness and education

- Foundation doctors training programme
- Acute Illness Management (AIM) training programme
- Sepsis Study Days
- Sepsis E-learning Sepsis Link Nurses

Technology and policy

- Redevelopment of EPR (Electronic Patient Record) - to ensure easier workflows and visual triggers for responding to deterioration
- Data dashboard – knowing our performance at a glance
- Revision of trust policy in line with new NICE Sepsis guidelines

Next Steps:

Recognition and response to patient deterioration remains a patient safety priority for the organisation and work with continue for many years. Below is a summary of work planned in 2025/26.

Deteriorating Patient Quality Improvement (QI) Collaborative
Collaborative teams are working on the below changes to their areas linked to the primary drivers:

- Improving Sepsis 6 compliance.
- Improving accuracy and timely completing of fluid balance.
- Testing Worry and Concern matrix as part of Martha's Rule roll-out.
- Introduction of Maternity Early Warning Score (MEWS) and Paediatric Early Warning Score (PEWS)
- Timely identification of patients with a learning disability at risk of respiratory deterioration

Teams will present updates and further develop their improvement ideas as learning sessions planned for June and October, before incorporated successful change ideas into a phase one change package.

Martha's Rule
This next phase will involve scaling Martha's Rule to all inpatient areas across the Trust and will include:

- Embedding Martha's Rule as business as usual
- Continuing to collect and analyse data to drive improvement
- Enhancing visibility and accessibility of escalation routes for patients and families
- Strengthening our feedback loops between staff, patients, and the improvement team

Reporting our progress:
All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress
The forums and governance committees which will provide progress, oversight and accountability for recognising and response to the deteriorating patient are summarised below:

- Deteriorating Patient Group
- Mortality Reduction Group
- Clinical Governance and Quality Committee
- Quality Assurance Committee
- Greater Manchester (GM) region Martha's Rule Collaborative

Quality Account Improvement Priorities 2025/26

Alongside **Priority 1 - Recognition and response to the deteriorating patient,** the new Quality Account improvement priorities for 2025/26 will be:

- **Priority 2 -** Releasing time to care – phase one – a focus on documentation
- **Priority 3 –** Communication – Involving our patient in their care and decision making

Priority 2 - Releasing time to care – phase one – a focus on documentation

Processes within healthcare evolve over time and in some cases changes and development have been grafted onto established working practices. There can be many different layers in addition to the patient process or journey. These include communication processes and administration or paperwork processes, and often involve a number of organisations or departments and sometimes do not always work as effectively as they could or intended to be.

Healthcare staff are spending more time away from patients due to a combination of factors, including increasing administrative burdens. These pressures lead to reduced time for patient care, which could impact on patient outcomes and staff well-being.

This Quality Account priority will employ the use of Lean methodology to initially focus on improving work processes around clinical documentation with the aim of releasing time to directly spend with our patients and other service users to ultimately improve patient care and staff morale.

Any learning gained from this first phase will be applied to other ward/departmental processes and environmental design, thus increasing time for face-to-face patient contact.

AIM:
Reduce staff time spent on documentation by 20% by 31/05/26 – phase one areas

Drivers for change:
Lean methodology will be the quality improvement framework used on this quality account and will be deployed through a Rapid Improvement Event model, to make timely and sustainment improvements. The key stages will be:

- Problem definition – including data to understand what the issues are
- Current state mapping and waste identification – to understand how processes currently run and identify opportunities for improvement
- Understanding value – clarifying the tasks/documentation that support clinical care
- Creation of ideal state – designing how the process should work
- Testing, implementing, monitoring and sustaining the new process
- Share and celebrate the outcomes
- Apply learning to other areas

A number of key stakeholders will be involved in this improvement work, including:

- Clinical staff who represent the MDT
- EPR and digital design teams
- Business Intelligence
- Governance team/s
- Quality Improvement

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

The forums and governance committees which will provide progress, oversight and accountability for Releasing Time to Care are summarised below:

- Divisional Governance
- Clinical Governance and Quality Committee
- Quality Assurance Committee

Priority 3 – Communication – 'involvement in decision making' as rated by our patients / service users

Communication is not just a matter of conveying information; it's a fundamental aspect of patient care and a key factor in building trust, promoting safety, and ensuring a positive patient experience. However, communication failures are a prominent reason for NHS complaints and this theme is replicated at Bolton. Not only can poor communication create a negative

overall experience for patients and their families, it can also make it difficult for patients to fully participate in their care and recovery.

Moreover, certain groups of patients, such as those with language barriers, limited literacy, or cognitive impairments, may be particularly vulnerable to the effects of poor communication. This can further exacerbate existing inequalities in healthcare access and outcomes.

Involving patients is vital to ensure equal access, experience and health outcomes and the first step to doing this is to be as inclusive as possible and listen to many voices when gathering and using feedback to improve how we communicate with our patients and service users and how we work with our patients in their care, treatment and decision making.

AIM:

- Minimum of 30 responses per month per team / department / ward by 31/03/26 – source FFT
- Evidence inclusivity in feedback from service users that reflect the local Bolton population such as patients who are/have; non-English as first language, no/reduced capacity, learning disability etc.

Drivers for change:
The key drivers and interventions for 2025/26 are summarised below:

Monitoring and methods of feedback and increase in response rate
- Baseline data collection of FFT response rate and inclusivity data
- Highlight teams/departments below 30 responses per month and set trajectory for improvement
- Highlight teams/departments above 30 responses per month and share approach for best practice learning and adoption
- Monthly tracking of response rates against minimum target per area
- Test alternative methods of feedback – e.g. qualitative face to face patient and carer discussions

Thematic analysis – what are our patients telling us
- Thematic review of response data to focus on areas for improved response
- Thematic review of FFT questions, split by department, demographic to understand any differences in our patient's outcome and experience
- Thematic review of qualitative data from alternative feedback source to understand if they differ from FFT data

QI methodology to plan and test ideas for improvement
- Based on the thematic reviews above – generate ideas for improvement
- Use Plan, Do, Study, Act (PDSA) methodology to test and refine these change ideas
- Monitor impact of change ideas, share and celebrate positive outcomes

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 Communication – 'involvement in decision making' as rated by our patients /

service users are summarised below:

- Clinical Governance and Quality Committee
- Quality Assurance Committee
- Quality and Patient Experience Forum
- Divisional Governance

Statement of assurance from the board

Review of services

During 2024/25 Bolton NHS Foundation Trust provided and/or sub-contracted 10 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 2024/25 represents 100% of the total income generated from the provision of relevant health services by the Bolton NHS Foundation Trust 2024/25

Participation in Clinical Audits and Research Activity

The NHS published a list of 91 Quality Accounts (*of which several fall under the same programme of work) in 2024/25.

During that period Bolton NHS Foundation Trust participated in 61 out of 91 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 30 audits:

Not Applicable

1. BAUS Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard Care Practices (I-DUNC)
2. British Hernia Society Registry
3. Cleft Registry and Audit NEtwork (CRANE) Database
4. Fracture Liaison Service Database (FLS-DB)
5. Mental Health Clinical Outcome Review Programme
6. Diabetes Prevention Programme (DPP) Audit
7. National Pulmonary Hypertension Audit
8. National Audit of Cardiovascular Disease Prevention in Primary Care (CVD Prevent)
9. National Bariatric Surgery Registry
10. National Adult Cardiac Surgery Audit (NACSA)
11. National Congenital Heart Disease Audit (NCHDA)
12. National Audit of Percutaneous Coronary Intervention (NAPCI)
13. National Audit of Mitral Valve Leaflet Repairs (MVLR)
14. UK Transcatheter Aortic Valve Implantation (TAVI)Registry
15. Left Atrial Appendage Occlusion (LAAO) Registry
16. Patent Foramen Ovale Closure (PFOC)Registry
17. Transcatheter Mitral and Tricuspid Valve (TMTV)Registry
18. National Clinical Audit of Psychosis (NCAP)
19. National Obesity Audit (NOA)
20. Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)
21. Prescribing Observatory for Mental Health (POMH): Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behavior

22. Prescribing Observatory for Mental Health (POMH): The use of melatonin
23. Prescribing Observatory for Mental Health (POMH): The use of opioids in mental health services
24. Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology and Reconstruction
25. Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma
26. Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery
27. Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers
28. UK Cystic Fibrosis Registry
29. UK Renal Registry Chronic Kidney Disease Audit
30. Paediatric Intensive Care Audit Network (PICANet)

The national clinical audits and national confidential enquiries that Bolton NHS Foundation Trust did participate in during 2024/25 are as follows:

	Project Name /Work	Additional Information/ Individual Studies/Data Range	No. of cases submitted
1	British Association of Urological Society (BAUS) Data and Audit Programme	BAUS Penile Fracture Audit	2
2		Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	23
3	Breast and Cosmetic Implant Registry		12
4	Case Mix Programme (CMP) - Critical Care		564
5	Child Health Clinical Outcome Review Programme		7
6	Emergency Medicine Quality Improvement Projects:	a) Mental Health (Self-Harm)	405
7		b) Care of Older People	303
8		c) Time Critical Medications	182
9	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People1		19
10	Falls and Fragility Fracture Audit Programme (FFFAP):	National Audit of Inpatient Falls (NAIF)	3
11		National Hip Fracture Database (NHFD)	407
12	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)		Data yet to be published
13	Maternal, Newborn and Infant Clinical Outcome Review Programme		51
14	Medical and Surgical Clinical Outcome Review Programme		14
15	National Adult Diabetes Audit (NDA):	a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education -	Data yet to be published
16		c) National Diabetes Foot care Audit (NDFA)	
17		d) National Diabetes Inpatient Safety Audit (NDISA)	
18		e) National Pregnancy in Diabetes Audit (NPID)	53
19		f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	Data yet to be published
20		g) Gestational Diabetes Audit	
21	National Audit of Cardiac Rehabilitation		418

22	National Audit of Care at the End of Life (NACEL)		80
23	National Audit of Dementia(NAD)		52
24	National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Metastatic Breast Cancer (NAoMe)	25
25		National Audit of Primary Breast Cancer (NAoPri)	259
26		National Bowel Cancer Audit(NBOCA)	121
27		National Kidney Cancer Audit(NKCA)	15
28		National Lung Cancer Audit(NLCA)	69
29		National Non-Hodgkin Lymphoma Audit (NNHLA)	31
30		National Oesophago-Gastric Cancer Audit (NOGCA)	24
31		National Ovarian Cancer Audit(NOCA)	13
32		National Pancreatic Cancer Audit (NPaCA)	28
33		National Prostate Cancer Audit (NPCA)	155
34	National Cardiac Arrest Audit (NCAA)		48
35		National Heart Failure Audit(NHFA)	272
36		National Audit of Cardiac Rhythm Management (CRM)	218
37		Myocardial Ischaemia National Audit Project(MINAP)	412
38	National Child Mortality Database (NCMD) **not a National Audit, therefore no submission total*		N/A
39	National Comparative Audit of Blood Transfusion:	National Comparative Audit of NICE Quality Standard QS138	48
40		National Comparative Audit of Bedside Transfusion Practice	10
41	National Early Inflammatory Arthritis Audit (NEIAA)		92
42	National Emergency Laparotomy Audit (NELA)		146
43	National Joint Registry		691
44	National Major Trauma Registry		178
45	National Maternity and Perinatal Audit (NMPA)		4170
46	National Neonatal Audit Programme (NNAP)		74
47	National Ophthalmology Database (NOD):	Age-related Macular Degeneration Audit	386
48		Cataract Audit	1534
49	National Paediatric Diabetes Audit (NPDA)		154
50	National Perinatal Mortality Review Tool		39
51	National Respiratory Audit Programme (NRAP):	COPD Secondary Care	560
52		Pulmonary Rehabilitation	87
53		Adult Asthma Secondary Care	168
54		Children and Young People's Asthma Secondary Care	266
55	National Vascular Registry (NVR)		7
56	Perioperative Quality Improvement Programme (PQIP)		3
57	Sentinel Stroke National Audit Programme (SSNAP)		141
58	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		8
59	Society for Acute Medicine Benchmarking Audit (SAMBA)		148
60	UK Renal Registry National Acute Kidney Injury Audit		4304
61	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery		Data yet to be published

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
List applicable NCEPOD Studies and status which were participated in between 2024/2025

Rehabilitation following critical illness
Publication date: Spring 2025

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

Blood sodium
Publication date: Winter 2025

	Requested	Submitted
Case notes	6	6
Organisation Proforma	1	1
Clinical Questionnaire	6	3

Emergency Paediatric Surgery
Publication date: Late 2025

	Requested	Submitted
Case notes	7	7
Organisation Proforma	1	1
Clinical Questionnaire	7	3

Acute Limb Ischemia
Publication date: November 2025

	Requested	Submitted
Case notes	2	2
Organisation Proforma	1	1
Clinical Questionnaire	2	0

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

The Perinatal Mortality rates by trust/health board are taken from the perinatal mortality data viewer, which includes data up to 2023. It is a supplementary tool to the Perinatal mortality surveillance State of the Nation report (UK perinatal deaths of babies born in 2022) published by MBRRACE on 14/07/2024.

The results concern stillbirths and neonatal deaths among the 5,136 babies born within Bolton Hospital NHS Foundation Trust in 2023, 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 and Health Boards
Stillbirth	23	4.48	3.66	3.60
Neonatal death	14	0.59	1.39	1.84
Extended perinatal	37	5.06	5.03	5.44

For the purposes of the MBRRACE-UK section, extended perinatal death refers to all stillbirths and neonatal deaths. Of the 14 neonatal deaths, 13 were early neonatal deaths and one was a late neonatal death. There were zero postnatal deaths reported. There were also two late fetal losses, bringing the total number of deaths in 2023 to 39.

During the 2024-25 Quality Accounts, MBRRACE-UK published 2 national reports:

- **Perinatal mortality surveillance report (MBRRACE-UK) State of the Nation:** UK perinatal deaths of babies born in 2022
- **Maternity care-Saving Lives, Improving Mothers' Care (MBRRACE-UK) - State of the Nation October 2024:** Maternal Deaths from thrombosis and thromboembolism, malignancy and ectopic pregnancy 2020-2022, and morbidity findings for recent migrants with language difficulties.

The reports and the recommendations contained within, were directed with a gap analysis to the relevant members of staff for completion, to identify the Trust's current compliance with MBRRACE-UK's national recommendations.

The recommendations are recorded on the Trust Safeguard audit system as actions, and these are monitored through the Family Care Divisional Governance Board Committee. A summary of the recent recommendations and actions from the maternal death and perinatal documents has been received.

In addition to the above, the MBRRACE-UK perinatal mortality report of perinatal deaths of babies born in 2023 was published in February 2025. This is a supplementary report exclusively about stillbirths and neonatal deaths of babies born in the Trust in 2023 and contains information in addition to that which will appear in the published data, specific to our Trust and is only available to our Trust. The next national report is due to be published on 12 June 2025.

MBRRACE-UK made the following recommendation: *"The stabilised & adjusted mortality rates for your Trust were similar to, or lower than, those seen across similar Trusts and Health Boards. However, if the aspiration of your Trust is to seek rates comparable with the best performing countries, for example those in Scandinavia, ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths."*

There is currently an open action from an existing recommendation for 'Messages for the care of women with general medical and surgical conditions'

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

Current status: Funding required to support this and discussion with the Family Care Divisional Senior Leadership Team.

- We currently offer women "Mirena Coils" and "Depo-Provera" injection
- We discuss all forms of contraception and signpost women to the appropriate family planning service.
- We currently do not offer "Implanon" due to a lack of staff training.
- Business case required to take this action forward.
- Target date for review June 2025

There were **51** deaths of babies born within our organisation between 01 Apr 2024 and 25 Mar 2025. A breakdown of the details of these deaths is below:

- Late fetal loss: 4 (2024): 0 (2025)
- Stillbirths: 20 (2024): 7 (2025)
- Early neonatal deaths: 14 (2024), 4 (2025)
- Late neonatal death: 2 (2024), 0 (2025)
- Postnatal deaths: 0 (2024), 0 (2025)
- 2024 total: 40
- 2025 current total: 1

Type of death:

- Late fetal loss: 4
- Stillbirth: 23
- Neonatal death: 15

Timing of death:

- Antepartum stillbirth: 25
- Intrapartum stillbirth: 1
- Stillbirth of unknown timing: 1
- Early neonatal death: 14
- Late neonatal death: 1

Gestational age

- <24 weeks: 13
- 24-27 weeks: 13
- 28-31 weeks: 5
- 32-36 weeks: 4
- 37-41 weeks: 7
- >=42 weeks: 0

Mother’s age at delivery

- <20 years: 2
- 20-24 years: 5
- 25-29 years: 10
- 30-34 years: 12
- 35-39 years: 10
- >=40 years: 3

Mother’s ethnicity:

- White: 18
- Mixed: 1
- Asian or Asian British: 11
- Black or Black British: 8
- Other: 1
- Missing or declined: 3

Were the babies admitted to neonatal unit?

- Yes: 8
- No: 34

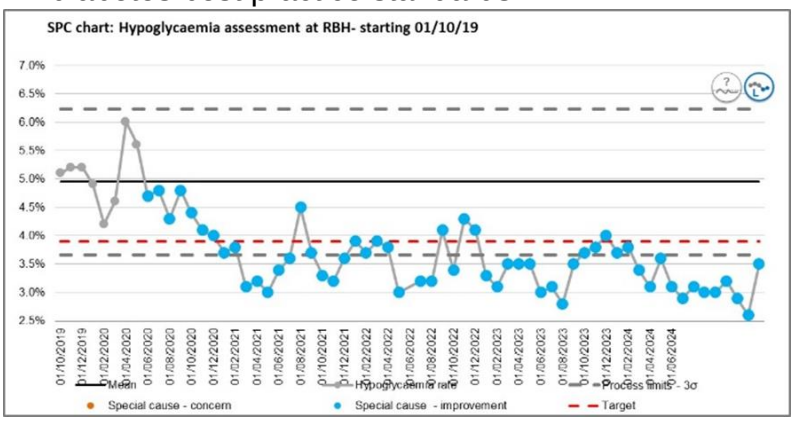
National Clinical Audits: Actions to Improve

The reports of 45 national clinical audits were reviewed by the provider in 2024/25 and Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

<table>
<tr><th></th><th>Audit Title</th><th>Status/Learning/Actions</th></tr>
<tr><td>1</td><td>Royal College of Emergency Medicine RCEM QIP Mental Health (Self-Harm)</td><td>• If patient left before ED clinician review was this acted upon? National results: Yes 46.04% Bolton - Yes 73%
• If patient left before Psych Liaison review was this acted upon? National results: Yes 33.22% Bolton Yes 57%
• If patient left before Psych Liaison review was a capacity assessment documented? National results: Yes 41.98% Bolton Yes 33%</td></tr>
<tr><td>2</td><td>Royal College of Emergency Medicine RCEM QIP Care of Older People</td><td>The department has performed above national average in the majority of this audits standards, demonstrating good care for older people in our emergency department with ongoing QI work to improve this:
• Postural blood pressure assessment after a fall and nursing staff to request medics
• Offering slipper socks as part of falls mitigation
• Bladder scans and medication review for delirium
• Increase awareness for Comprehensive Geriatric Assessment amongst Emergency Medicine clinicians</td></tr>
<tr><td>3</td><td>Royal College of Emergency Medicine (RCEM)

Time Critical Medications</td><td>Specific Year reporting period
• Year 1 Interim report period: 03 Oct 2023 - 03 Oct 2024
• Year 2 Interim report period: 03 Oct 2024 - 03 Oct 2025
• Year 3 Final report period: 03 Oct 2025 - 03 Oct 2026
Of the 182 records submitted, 175 are eligible for analysis.</td></tr>
<tr><td>4</td><td>Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People1</td><td>The Trust is fully compliant with all recommendations from the latest national Epilepsy 12 report.
Data collection for Cohort 6 is complete, publication of new report for data analysis and recommendations yet to be received</td></tr>
<tr><td>5</td><td>National Audit of Inpatient Falls (NAIF)</td><td>"The 2024 National Audit of Inpatient Falls (NAIF) Report on 2023 Clinical Data." – published in October 2024
This report made five recommendations, the trust is compliant with all of the four applicable recommendations. The remaining recommendation was designated for action by NHS England.</td></tr>
<tr><td>6</td><td>National Hip Fracture Database (NHFD)</td><td>“A broken hip – three steps to recovery.” was published in September 2024. This report made five recommendations for NHS England to implement and has been shared by the specialty for learning.</td></tr>
<tr><td>7</td><td>National Diabetes Foot care Audit (NDFA)</td><td>The NDFA is an ongoing data collection audit regularly inputted into the online collection tool.
Current available figures shown below:
<table>
<tr><th rowspan="2">Provider / Foot Care Service</th><th rowspan="2">Patients without episodes (n)</th><th colspan="2">2023-24</th></tr>
<tr><th>Episodes (n)</th><th>Outcome missing (n)
12 weeks</th></tr>
<tr><td>Bolton NHS Foundation Trust</td><td>-</td><td>224</td><td>0</td></tr>
</table>
</td></tr>
</table>

		Diabetes Centre, Bolton NHS Foundation Trust	-	224	0
		England and Wales Total	883	25,347	2,284
		2024/2025 data is expected July 2025.			
8	National Diabetes Inpatient Safety Audit (NDISA)	Several KPIs have been developed, following participation in the Quality Accounts, these include: 1. **Episodes of hypoglycaemia by month**. The target being 3.9% or below for each individual ward or department to maintain a 30% reduction. A dashboard has been developed which is circulated to each ward on a monthly basis so they can track their progress. BoSCA assessment includes diabetes best practice standards.			

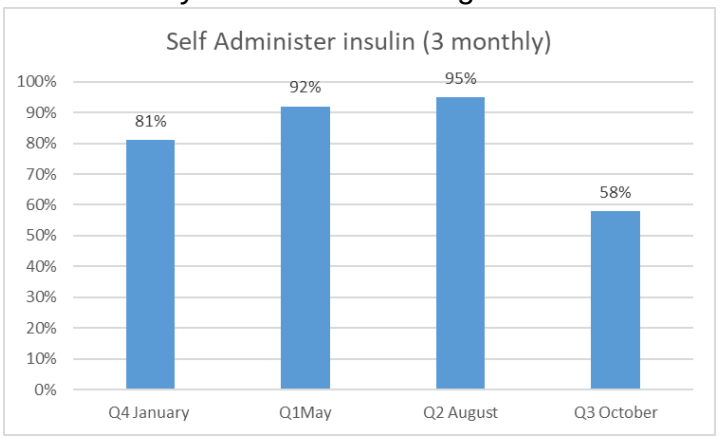


2. **Foot checks on admission** – the "Purpose T" risk-assessment has been adopted as the process to complete a foot check within 24 hours of admission, aligning to standard practice. The trust is 100% compliant (audit number 4365).

3. **Compliance and monitoring of mandatory diabetes training** in hypoglycaemia, insulin safety and foot assessment. Target 85 %

	J	F	M	A	M	J	J	A	S	O	N	D
AASD	81 %	72.8%	73.4%	71.6 %	73.6%	81.3%	86.4%	90.2%	91.2%	90.4%	91.2%	90 %
FCD	83.9%	83.5%	81.9%	83%	82.5%	73.77%	82%	85.7%	84.3%	86.3%	91.7%	92.5%
AAD	79%	73.3%	66.5%	66%	69.2 %	77.5 %	83.2%	89.1%	90.9%	91.4%	91.5%	91.7%
ICSD	90.8%	87.3%	90.3%	91.2%	92.7%	92.22%	94.2%	96.5%	97.1%	97.6%	97.2%	96.9%

4. Those eligible to **self-administer insulin** whilst in hospital – audited every three months. Target 80%



<table>
<tr>
<td></td>
<td></td>
<td>5. Monitoring of Getting it Right First Time (GIRFT) standards
 

6. NDHARMS
<table>
<tr><th>Year</th><th>Hypo <2.2</th><th>DKA</th><th>HHS</th><th>Foot</th><th>Total numbers occurring in ED</th><th>Total harms</th></tr>
<tr><td>2021</td><td>13</td><td>9</td><td>0</td><td>0</td><td>1</td><td>22</td></tr>
<tr><td>2022</td><td>19</td><td>2</td><td>2</td><td>0</td><td>1</td><td>23</td></tr>
<tr><td>2023</td><td>16</td><td>7</td><td>0</td><td>0</td><td>3</td><td>23</td></tr>
<tr><td>2024</td><td>30</td><td>11</td><td>2</td><td>1</td><td>6</td><td>44</td></tr>
<tr><td>2025</td><td>13</td><td>1</td><td>0</td><td>0</td><td>0</td><td>14</td></tr>
</table>
</td>
</tr>
<tr>
<td>9</td>
<td>National Pregnancy in Diabetes Audit (NPID)</td>
<td>National Pregnancy in Diabetes Audit 2021 and 2022, England and Wales State of the Nation (2021-22 data) published in 2023. Gap analysis completed confirming the Trust is compliant all applicable recommendations
Data entry for 2024-25 is ongoing, current data below:
Patient demographics:
• Type 1: 10
• Type 2: 43
• MODY: 0
• Other: 0
• Not Specified: 0
• Total pregnancies: 53
Diabetes Type 1 Summary:
• BMI-Mean Average: 25.45
• Age-Mean Average: 30
Diabetes Type 2 Summary:
• BMI-Mean Average: 32.74
• Age-Mean Average: 33
Pregnancy Outcomes by Diabetes Types;
• Type 1: 10 Live births, 0 Stillbirths, 0 Terminations and 0 Miscarriages
• Type 2: 39 Live births, 3 Stillbirth, 1 Terminations and 1 Miscarriage
• Total Pregnancy Outcomes: 49 Live births, 3 Stillbirths, 1 Termination and 1 Miscarriage.</td>
</tr>
<tr>
<td>10</td>
<td>Gestational Diabetes (GD) Audit</td>
<td>Data is collected nationally via the Maternity Services Data Set (MSDS). 2024/2025 national reporting is not yet available, a Dashboard will be available for services to see their performance in the key metrics relating to GD.</td>
</tr>
</table>

		. **Please note that this is separate from the National Pregnancy in Diabetes Audit*
11	National Audit of Cardiac Rehabilitation (NACR)	NACR Quality and Outcomes Report (Jan-Dec 2023) published and sent with recommendations for gap analysis. The recommendation below is partially compliant with the following caveat: *To have all patient data submitted in a timely period - Delay to inputting due to reduced staffing* Currently - temp staff supporting input.
12	National Audit of Care at the End of Life (NACEL)	January 2024- December 2024 was NACEL 2024 Bolton submitted 80 cases and 14 staff surveys Report to be published August 2025
13	National Audit of Dementia (NAD)	A section of the dementia audit looked at Delirium Screening in the first 24 hours and Bolton figures are excellent compared to national results and previous submissions. • 100% of the audit population (52 patients) had a delirium screen completed (National average 91.5%) • 96% of the patients had delirium screen completed within the first 24 hours (National average 86%) • Use of "4AT" delirium assessment tool has improved up to 54% (National average 44 %) • Of the 52 patients 10 patients had proven delirium and all of them had a clear delirium management and delirium care plan (100%). This is above the national average of 57%
14	National Audit of Metastatic Breast Cancer (NAoMe)	"National Audit of Metastatic Breast Cancer State of the Nation Report 2024." The trust is compliant with all four of the recommendations.
15	National Audit of Primary Breast Cancer (NAoPri)	"National Audit of Primary Breast Cancer State of the Nation Report 2024." The trust is compliant with all four of the recommendations.
16	National Bowel Cancer Audit (NBOCA)	"National Bowel Cancer Audit State of the Nation Report." This report made five recommendations, of which the trust is compliant with four. The fifth recommendation is part of an ongoing discussion at the Greater Manchester Cancer board, though the Trust has a process in place to make sure the care offered to patients is the best it can be.
17	National Kidney Cancer Audit(NKCA)	"National Kidney Cancer Audit State of the Nation Report 2024". This report has made five recommendations for information only.
18	National Lung Cancer Audit(NLCA)	"National Lung Cancer Audit State of the Nation Report 2024." This report made five recommendations, of which the trust is compliant with four. The fifth recommendation is partially compliant due to unavailability of figures from the NLCA. However, the Trust has undertaken a CQUIN for stage I and II patients for over four quarters, and are assured that we meet this recommendation.
19	Non-Hodgkin Lymphoma Audit (NNHLA)	"National Non-Hodgkin Lymphoma Audit State of the Nation Report 2024." This report has made five recommendations of which the trust is 100% compliant
20	National Oesophago-Gastric Cancer Audit (NOGCA)	"National Oesophago-Gastric Cancer Audit State of the Nation Report." This report has made four recommendations for information

		only.
21	National Ovarian Cancer Audit (NOCA)	“National Ovarian Cancer Audit State of the Nation Report 2024.” This report has made five recommendations for information only.
22	National Pancreatic Cancer Audit (NPaCA)	“National Pancreatic Cancer Audit State of the Nation Report 2024.” This report has made five recommendations for information only.
23	National Prostate Cancer Audit (NPCA)	“National Prostate Cancer Audit State of the Nation Report 2024.” The trust is compliant with all four applicable recommendations
24	National Cardiac Arrest Audit (NCAA)	Data completeness is 100% for all metrics except Patient's Ethnicity, which is 83%.
25	National Heart Failure Audit (NHFA)	The Trust is compliant with eight of the nine national recommendations from the NHFA 2024 Report. Recommendation: *All patients should be referred for Cardiology and Specialist Heart Failure Nurse follow-up, ideally leaving hospital with their first appointment.* Non-compliance: Nurses led 2-week post discharge clinic set up for Heart failure with reduced ejection fraction but not commissioned. Current bid to use Virtual ward to expand this. Total number of submissions for QA 2024-2025: n272 Deadline for all data submissions for the period of 1st April 2024 to 31st March 2025 data is the 31st May 2025.
26	National Audit of Cardiac Rhythm Management (CRM)	The Trust is compliant with all the latest Cardiac Rhythm Management 2024 summary report.
27	Myocardial Ischaemia National Audit Project (MINAP)	Support for data collection remains on the Risk Register (5477), Total submissions since April 2024: n412
28	National Child Mortality Database (NCMD)	The National Child Mortality Database (NCMD) published a thematic report on the deaths of children with a learning disability and autistic children aged 4-17 years, based on data from April 2019 to March 2022. Gap analysis complete with two applicable recommendations • Recommendation 5 is compliant. • Recommendation 1 is not compliant *Ensure reasonable adjustments are discussed with and provided for all children with a learning disability, autistic children, and where necessary their families and carers, and that the details of these needs are appropriately captured in the "reasonable adjustments digital flag" in their clinical record.* Digital flag to be added following diagnosis and introduction off a hospital passport for some children which details reasonable adjustments

<table>
<tr><td>29</td><td>National Early Inflammatory Arthritis Audit (NEIAA)</td><td>The trust is an outlier for the National Inflammatory Arthritis Audit for NICE Quality Standard 2, ‘the patients with suspected inflammatory arthritis need to be seen within three weeks of referral via the GP’.
Actions to address this include improve patients' recruitment and the recruitment of clinicians to support national audit. Data collection is underway – awaiting national report publication.</td></tr>
<tr><td>30</td><td>National Emergency Laparotomy Audit (NELA)</td><td>“Ninth Patient Report of the National Emergency Laparotomy Audit.”
This report makes three recommendations, not applicable to the trust</td></tr>
<tr><td>31</td><td>National Joint Registry</td><td>“National Joint Registry 21st Annual Report 2024.”
The report is for information only.</td></tr>
<tr><td>32</td><td>National Major Trauma Registry</td><td>From April 2025 all hospitals are required to submit data within 30-days of patient discharge or death. The Learning from Deaths committee will use the GM preform to guide this process and to give feedback on the outcomes to the network.</td></tr>
<tr><td>33</td><td>National Maternity and Perinatal Audit (NMPA)</td><td>The NMPA does not currently display any previews of clinical audit results and they are yet to receive 2023/2024 data. The next State of the Nation report is due to be published in June 2025 and will cover births over 2023.
NMPA uses three measures as indicators which are subject to outlier reporting. These indicators have been case-mix adjusted to consider the different maternal demographic and clinical characteristics at each trust/board, as far as is currently possible.
The three indicators are:
1. Proportion of women and birthing people giving birth vaginally to a singleton baby between 37+0 and 42+6 weeks of gestation, who experience a third or fourth degree tear.
2. Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more.
3. Proportion of live born, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7.
NMPA have advised that the Trust is a potential alarm-level outlier for the first indicator (3rd/4th degree tears). This means that the indicator lies outside the expected range of values for a trust/board of this size, with a result that is higher than the upper 99.8% control limit (greater than 3 standard deviations (SD) above the mean). This is not necessarily an indication of poor performance, but it does require investigation.
Potential Outlier: Third- or fourth-degree tear
Indicator National Mean (%): 3.40
Trust/Board Adjusted Result (%): 4.77
Key facts for Quality Account period 2024-25:
<table>
<tr><th></th><th>Babies born</th><th>Bookings</th><th>Spontaneous Deliveries</th></tr>
<tr><td>April 2024</td><td>425</td><td>495</td><td>45%</td></tr>
<tr><td>May 2024</td><td>425</td><td>495</td><td>40%</td></tr>
</table>
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<tr><td></td><td></td><td>
<table>
<tr><td>June 2024</td><td>405</td><td>450</td><td>45%</td></tr>
<tr><td>July 2024</td><td>415</td><td>525</td><td>43%</td></tr>
<tr><td>August 2024</td><td>415</td><td>435</td><td>44%</td></tr>
<tr><td>September 2024</td><td>440</td><td>475</td><td>44%</td></tr>
<tr><td>October 2024</td><td>435</td><td>520</td><td>42%</td></tr>
<tr><td>November 2024</td><td>370</td><td>445</td><td>41%</td></tr>
<tr><td>December 2024</td><td>430</td><td>445</td><td>44%</td></tr>
<tr><td>January 2025</td><td>410</td><td>495</td><td>41%</td></tr>
<tr><td>February 2025</td><td colspan="3">Not yet available from the MSDS Dashboard.</td></tr>
<tr><td>TOTAL</td><td>4170</td><td>4780</td><td></td></tr>
</table>
Current total of babies born since April 2024: 4170. This number will be used for the total NMPA submissions for the annual Quality Report.
</td></tr>
<tr><td>34</td><td>National Neonatal Audit Programmed (NNAP)</td><td>Neonatal audit–Summary report on 2023 data (NNAP) published October 2024, the trust is fully compliant with all recommendations</td></tr>
<tr><td>35</td><td>Cataract Audit</td><td>“Seventh Annual Report of the National Cataract Audit.”
This report made seven applicable recommendations, of which six were compliant. The remaining recommendation was to consider partaking in Patient Reported Outcome Measures (PROMs) before and after surgery, this was considered.</td></tr>
<tr><td>36</td><td>National Paediatric Diabetes Audit (NPDA)</td><td>First Year of Care Parent and Patient Reported Experience Measures (PREMs) 2024 – Six recommendations with two not fully compliant
Current gap within the Paediatric Diabetes service for a psychologist to consider.
Data entry for the QA 2024-25, please see below the patient characteristics for Royal Bolton Hospital:
Total number of eligible patients submitted: 154
Total number of eligible patients with Type 1 diabetes: 146
Number of patients aged 12 and above on day 1 of audit with Type 1 diabetes: 84
Number of patients with Type 1 diabetes with a complete year of care in audit period: 116
Number of patients with Type 1 diabetes aged 12+ with a complete year of care in audit period: 60
Number of patients who died within audit period: 0
Number of patients who transitioned/ left service within audit period: 22
Number of patients with coeliac disease: 11
Number of patients with thyroid disease: 6
Number of patients using (or trained to use) blood ketone testing equipment: 121
Number of patients with Type 1 diabetes using a real time continuous glucose monitor: 140
Data submission to continue until end of submission deadline.</td></tr>
<tr><td>37</td><td>National Perinatal Mortality Review Tool (PMRT)</td><td>One open action regarding the provision of adequate resourcing of PMRT review teams, including administrative support.
The following mortality reviews which were carried out using the national Perinatal Mortality Review Tool are a summary of perinatal mortality reviews completed for deaths which occurred since April 2024:</td></tr>
</table>

		• Number of stillbirths and late fetal losses reported: 29 • Number of neonatal and post-neonatal deaths reported: 20 • Total perinatal deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period since April 2024: 39
38	COPD Secondary Care	Dashboards are completed regularly for the monthly Respiratory Governance meetings, with total patients and the number of discharge bundles completed. For QA 2024-25, 560 patients entered for this national audit NRAP Breathing Well gap analysis completed and the Trust is not fully compliant with recommendations three and four. Target review date for these two recommendations is May 2025 • R3: All people with asthma and COPD discharged from hospital after an acute event should have a current self-management plan. Where this is not achieved, services should work towards a target of 75% by May 2026. Services should prioritise patient-centred approaches and explore the role of clinically approved digitally supported self-management. In England, integrated care boards should work with providers to ensure that there is adequate resource to support frontline clinicians in the delivery of patient's discharge bundles. Current practice: Education and training on-going with respiratory staff regarding safe management of patients admitted with AE asthma/COPD and promote the use of discharge care bundles • R4: All patients requiring pulmonary rehabilitation should have timely access to the intervention, in line with recommendations from NICE and the British Thoracic Society's clinical statement on pulmonary rehabilitation. Where that's not achieved, services should work towards a target of 70% of patients starting a PR programme within 90 days of referral, and 70% of patients with acute exacerbation of COPD starting within 30 days of referral, by May 2026. Current practice: • Assessment process in review with aim of assessing more patients as well as implementing additional walk test. • Introduction of an opt-in letter to be sent to all referred patients prior to placing them on a waiting list with a view to reducing DNA's and waiting list. • Current demand outstrips level of staffing and this is on the agenda for the monthly PR meeting.
39	Pulmonary Rehabilitation	Dashboards are completed regularly for the monthly Respiratory Governance meetings. There are no outstanding actions for Pulmonary Rehab. 87 patients have been entered for the 2024/25 Quality Account.
40	Adult Asthma Secondary Care	Dashboards are completed regularly for the monthly Respiratory Governance meetings, with total patients and the number of discharge bundles completed. For QA 2024-25, 168 patients have been entered for this national audit.

		Respiratory care – Organisational audit 2024 report published and sent with gap analysis review date
41	Children and Young People's Asthma Secondary Care	Two recommendations open from the latest NRAP the Breathing Well national audit report: Recommendation 1: All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency. In England, the Department of Health and Social Care, NHS England and integrated care boards should work together to provide increased resource to all acute, mental health and maternity services in England, so that every provider develops and implements a comprehensive inpatient tobacco dependency service. Current practice: Not yet achieving national average regarding smoking cessation advice in parents who smoke and children who smoke (documented). There is ongoing work on the ward to raise the profile of identifying smoking parents and signposting them to help with smoking cessation (for all not just asthma). There is also a specified QI project for this issue. The smoking cessation team are coming to the ward this month to share information, and the ward teams have started to use some up-to-date local resources. Recommendation 2: All people with asthma and COPD discharged from hospital after an acute event should have a current self-management plan. Where this is not achieved, services should work towards a target of 75% by May 2026. Services should prioritise patient-centred approaches and explore the role of clinically approved digitally supported self-management. In England, integrated care boards should work with providers to ensure that there is adequate resource to support frontline clinicians in the delivery of patient's discharge bundles. Current practice: Most recent data shows PAAP given (documented) in 60% patients (national average 46.4%). Ongoing work within the working group for specialised asthma documentation which should prompt documentation and preparation of individual personalised Asthma Action plans (PAAP). Progress to be reviewed from April 2025
42	National Vascular Registry (NVR)	"National Vascular Registry, State of the Nation Report 2024." This report made five recommendations all of which were not applicable to the Trust.
43	Perioperative Quality Improvement Programme (PQIP)	The report based on data March 2023 to March 2024, titled "Report 5." report is for information only.
44	Sentinel Stroke National Audit Programme (SSNAP)	SSNAP plan to run an organisational audit of acute and post-acute services in May 2025. Awaiting further information. Please see current scoring and submissions • SSNAP level: C • SSNAP score: 69.4 • Case ascertainment band: A • Audit compliance band: D • Combined Total Key Indicator level: A

		• Combined Total Key Indicator score: 81.7 • Team-centred post-72h all teams' cohort: 70 Number of patients admitted/discharged for each quarter published by SSNAP: • April-June: 69 admitted, 71 discharged • July-September: 72 admitted, 69 discharged • Current totals: 141 admitted, 140 discharged
45	Society for Acute Medicine Benchmarking Audit (SAMBA)	Findings of SAMBA Local Report (June 24 data): Bolton submitted 73 patient-level records to SAMBA24. The report focuses on 58 emergency medical admissions that were presented for initial assessment on SAMBA Day. 15 submissions were recorded as planned re-attendances to Same Day Emergency Care (SDEC) and excluded from the primary analysis. A total of 43 admissions (74.1%) arrived during the daytime (08:00 - 19:59) and 15 admissions (25.9%) arrived overnight. Submissions for Quality Account report: • 75 (Winter SAMBA24) • 73 (Main SAMBA24) • 148 (Total across QA 2024-25)

Local Clinical Audits

307 Local clinical audits were registered and reviewed by the provider in 2024/25 and Bolton NHS Foundation. The breakdown is as follows:

Driver	**N**
Clinical Interest	26
Clinical Outcome	1
CNST	34
Complaint	1
CQC	4
External Audit	8
Incident (Divisional Review)	3
Incident (SI Review)	15
Local Standard	26
Monitoring	17
National Regulations	55
NICE Clinical Guidelines (CG)	13
NICE Guidance (NG)	17
NICE Quality Standards (QS)	6
NICE Technical Appraisal (TA)	1
Patient Satisfaction	4
Quality Improvement	42
Record Keeping/Documentation/L	2
Royal College	17
Trust Policy	8
Trust SOP	7
Grand Total	**307**

Local Clinical Audits, examples of learning and actions to improve

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

Project Name	Actions
Acute Paediatrics (3-yearly audit) Management of Diarrohea and Vomiting in Children Under 5 (NICE CG84)	• To be addressed in induction of medical staff that occurs every 4-6 months • Poster highlighting the focus of improvement. • Re-audit of ten case notes in 12 months, full re-audit in 3 years • During next EPR document update request tick box to record if written patient information provided
Acute Paediatrics Paediatric Information Leaflets (includes both audit cycles)	• Consultants to model good practice regarding info leaflet use. • Ensure all the team is aware of digital posters in the waiting room and healthier website together to use if info leaflet not available in house. • Get people to document that they have given out info leaflet - .INFO (acronym expansion on EPR can obtain from me)
Anaesthetics Drug EPR Prescription Audit Re-Audit	• Discuss audit at anaesthetic departmental audit meeting highlighting medication errors experienced • repeat audit of drug prescribing in one year to check improvement in attainment of prescribing standards • Re-audit drug prescribing in theatres by anaesthetic department
Audiology Vertical Audit of pathway for children identified with permanent childhood hearing impairment.	• To develop a method of recording stage A's for ABR. • Record conversations and parents' wishes in patient's journal and develop an IMP to document regular reviews as the child's needs change. • Add tolerances to journal template and record SII in patient journal if appropriate outcome measures cannot be used. To document appropriate use of SII in SOP. • Document in patient's journal when a leaflet has been handed out and to update SOPs to ensure all staff know what leaflets should be provided at certain stages.
Audiology NICE Guidelines for Otitis Media with Effusion in Children Under 12	• Documentation Improvements: • Introduce standardized templates in the electronic records system to ensure all key areas are covered in consultations. • Provide educational materials (leaflets, web resources) that provide detailed OME information, including symptoms, management strategies, risks (e.g. smoking, water exposure post-surgery), and post-treatment care at every clinic visit. • Conduct clinician training sessions for staff to improve OME awareness and history-taking and ensure comprehensive assessments and consistency with information delivery.
Breast Surgery Assessment of the use of the Clinical Frailty Score within triple assessment clinics as per NABCOP guidance	• Essential that we continue to complete the Fitness Assessment Tool • Continue to collect the data to enable future review • Achieve 100% completion of all data required • Amplify this is important for decision making within the MDT
ENT Management and	• Implementation of guidance posters for on-call doctors covering ENT for common and serious conditions

referral of new ENT admissions out of hours.	
Gynaecology NCEPOD Endometriosis Study	• Audit of diagnosis, management and follow up of patients with endometriosis) to confirm compliance. • Review practice and develop endometriosis care pathway. • Review Trust compliance with NICE Guidance NG73
Maternity Services & Obstetric Obstetric Cholestasis	• Direct patients to patient information leaflet on intrahepatic cholestasis in pregnancy and this to be documented in notes. • Patient information leaflet to be approved through governance process. • Letter to be given to patient on postnatal ward and encouraged to arrange blood tests and review within 6 weeks
Maternity Services & Obstetric Re-Audit: Risk assessment each AN contact including place of birth and personalised care plan	• Audit findings to be shared with the Antenatal matron/community matron/ANC manager. • ANC manager/team leaders to discuss staff huddles.
Maternity Services & Obstetric OASI (Quarterly Audit)	• Staff training for Midwives and Doctors all deliveries - including with episiotomy and instrumental • Update staff and reinforce importance of incident reporting all incidences of 3rd and 4th degree tears
Maternity Services & Obstetric Re-Audit: Induction of Labour - LGA risks and benefits discussion	• Use of induction of labour proforma and management of large gestational age proforma to be standard in all antenatal areas
Neonatal Services Getting it right first time - Umbilical venous line	• Design an umbilical venous catheter (UVC) care bundle, including use of ultrasound guidance for line placement, guidance on securing of UVCs and guidance on monitoring and prevention of displacement.
Neonatal Services Audit of congenital CMV - are all babies with symptomatic congenital CMV being referred to audiology for assessment and follow up?	• Clarity of roles regarding use of “BadgerNet” system. • Will be measurable/achievable by production of guideline to be reviewed by department. • May be scope to gain input from Infectious disease and Audio-vestibular medicine for ratification
Ophthalmology Assessment of the initial management of the contact lens related corneal infections in the eye casualty clinic	• Recommended triaging the urgent referral aiming at seeing suspected keratitis cases on the same day of referral. • Recommendation to use the slides for quicker results • An educational session will be arranged
Oral Maxillo Facial Services	• Implement staff training and 'refresher' sessions to allow the team members to facilitate better information provision during

A review of the adult Intravenous Sedation service PREMs within Royal Bolton Hospital Oral Surgery Department	pre-sedation checks. • Provide patients with resources and techniques for relaxation and stress management prior to the sedation visit. • To develop patient information aids, utilising flow charts or videos to improve the general understanding of what happens during the sedation visits. • Develop comprehensive post-procedure care instructions. • Introduce a routine follow-up call a few days after the procedure to address any patient concerns. • To expand the IV sedation provision to a younger patient cohort (12- to 15-year-old) to reduce the GA waiting lists. • Introduction of an out-patient anaesthetic led sedation service for ASA III or ASA IV patients.
Radiology Protectional Referral Justification Information and Compliance	• Encourage Radiographers to utilise authorisation guidelines. • Encourage and educate more radiographers to take time in justifying requests and ensure all details are correctly filled out via CPD. • Have authorisation guidelines available in all X-ray rooms including orthopaedic rooms. • Encourage outpatient clinics to use EPR to simplify justification process for radiographers thus improving service.
Radiology - Breast Screening Client Satisfaction Survey 1: acceptability of the screening service. (Service specification no. 24 standard 12 Appendix 2) NHSBSP Continuous Audits	• Send the questionnaire digitally to allow people to complete via a QR code and no need to post. • Look at implementing an evening clinic monthly to enable people to attend in an evening- staff allowing • Sharing patient feedback regularly with the team helps the staff to see how patients feel- all feedback is anonymous but can be filtered by clinic and date of appointment if there were any recurring issues.
Respiratory Medicine NCEPOD - Community Acquired Pneumonia	• Undertake a chest X-ray in patients with suspected community-acquired pneumonia: • Within four-hours of arrival at hospital • Provide a formal report within 12 hours of the X-ray. Use clinical support tools such as CURB65* and NEWS2, in combination with clinical judgement to determine: • The most appropriate pathway of care for patients with community-acquired pneumonia - ambulatory or inpatient • Which investigations are needed • Antibiotics to use as initial treatment • Treatment escalation decisions This supports NICE QS 110 Quality Statement 4
Safeguarding RE-AUDIT Benchmark Audit: Deprivation of Liberty (DoLS) and Mental Capacity Act Staff Understanding	• Provide further training to address the gap of knowledge, bespoke to specialties within the trust, e.g. bite-size sessions that can be accessed via different digital platforms. • Seven-minute briefings regarding MCA and DoLs • The MCA and DoLs training to be updated • Audit for community teams to identify learning needs.

Urology To compare a single institute outcome of HOLEP(Holmium laser enucleation of the prostate) against the standards set out by BAUS	• Incorporate IPSS, SHIM and IIEF-5 scores on EPR • 3- and 6-months post op follow up (long term follow up to see if it is only a transient condition)

Participation in Clinical Research

57 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 2024/25. 6462 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 2024/25 was not conditional on achieving quality improvement and innovation goals agreed between Bolton NHS Foundation Trust and any person or body they entered a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The mandatory CQUIN scheme has been paused.

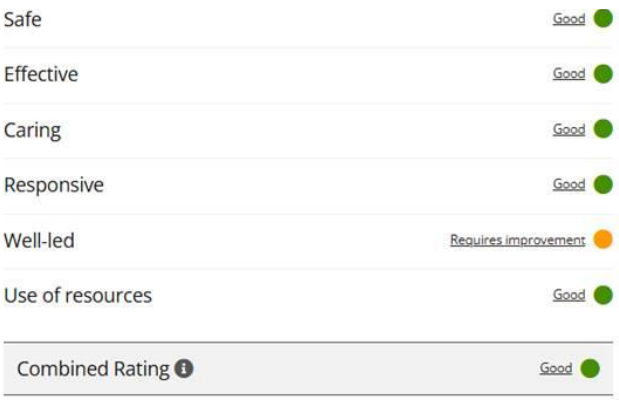
Care Quality Commission Registration

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 2024/25. Bolton NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Bolton NHS Foundation Trust was inspected by CQC on 24 May 2023 and 07, 08, 09 June 2023 and reported in October 2023 and achieved an overall rating of Good. The report included 28 recommendations to further improve the services provided by the Trust.

The Trust's Clinical Governance and Quality Committee monitors the progress of the actions related to the recommendations and in April 2025 was provided with assurance that 27 of these have been completed with evidence and that the remaining one recommendation is complete and in progress of awaiting validation of the evidence.

CQC ratings grid:



Data Quality
Bolton NHS Foundation Trust submitted records during 2024/25, to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- **which included the patient's valid NHS number was:**
  - 99.9% for admitted patient care;
  - 99.9% for outpatient care; and
  - 99.7% for accident and emergency care

- **which included the patient's valid General Medical Practice Code was:**
  - 94% for admitted patient care;
  - 99.6% for outpatient care; and
  - 99.1% for accident and emergency care.

Action to Improve Data Quality
Bolton NHS Foundation Trust will be taking the following actions to improve data quality:

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

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

Clinical Coding Audit
Bolton NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission.

Learning from Deaths
During 2024/25, 1224* of Bolton NHS Foundation Trust patients died in hospital.
**This figure aligns with the inclusion criteria of the Learning from Deaths process.*

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

- 330 in the first quarter;
- 286 in the second quarter;
- 310 in the third quarter;
- 298 in the fourth quarter.

In 2024/25 (between April 2024 and March 2025), 110 structured judgement case reviews and 49 cardiac arrest root cause analysis investigations (where the patient did not survive) have been carried out in relation to 1248 of the deaths included above.

Out of 110 structured judgement cases recorded, in 0 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:

- 21 Case record reviews in the first quarter; Investigations = 0
- 43 Case record reviews in the second quarter; Investigations = 0
- 44 Case record reviews in the third quarter; Investigations = 1
- 2 Case records reviews in the fourth quarter; Investigations = 0

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

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

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

Learning Disabilities Mortality Review (LeDeR)
The LeDeR mortality review process is firmly embedded within the Bolton locality, maintaining strong links with the Greater Manchester Local Area Contact to ensure learning from Bolton reviews is shared appropriately across organisations. We continue to have robust locality representation at the Greater Manchester panel meeting, helping to identify themes from completed reviews and ensuring locality involvement in agreeing any required actions to address ongoing health inequalities for people with learning disabilities and/or autism.

Since January 2022, the programme has received death notifications for those aged four and

above who have a learning disability and/or autism. As in recent years, reviews are completed by an external review team, hosted by NHS Cheshire and Merseyside under a memorandum of understanding agreement. Once learning is agreed from the completed reviews this is shared via appropriate locality forums, including the Learning Disability and Autism Strategic Improvement Group, the Learning Disability Partnership Board and the Learning from Deaths Committee. A Greater Manchester report is published annually, this the Bolton locality data.

From 1 April 2023 to 31 March 2024, there have been 11 completed LeDeR reviews for Bolton residents, all adults aged between 31 and 80. All individuals had a primary diagnosis of learning disability with no autism only reviews completed. The leading cause of death continues to be respiratory conditions, with over 63% of deaths attributed to pneumonia or other respiratory causes.

All completed reviews evidenced that individuals were diagnosed with at least one long term health condition with over 72% having numerous long term conditions (multimorbidity). Both the Greater Manchester and Bolton locality reviews continue to evidence that the average age of death is significantly lower for adults with learning disabilities, with this population dying, on average, over 20 years earlier than the non-learning disabled peers. Over 81% of completed reviews were hospital deaths, indicating that additional work is required around advanced care planning for the LD population.

There is a locality action plan aimed at addressing learning from deaths and a Greater Manchester work plan, outlining a number of workstreams aimed at addressing identified health inequalities. We also contribute to the Greater Manchester learning disability strategy which aims to share good practice across Greater Manchester to enable shared learning and improvement.

There is a need to continue to encourage mainstream services to report deaths of people with learning disabilities and/or autism to the LeDeR platform; the majority of current notifications are made by specialist learning disability services, therefore highlighting a missed opportunity to learn from the deaths of those who do not access specialist services or who have an autism only diagnosis.

Seven-day services

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes across all seven-days for patients admitted to hospital in an emergency. Providers have worked to achieve all the four priorities identified in 2015, developed with the support of the Academy of Medical Royal Colleges. The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

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

However, this remains a focus for Bolton NHS FT and throughout 23/24 we prioritised Standard 2 - Time to first Consultant review and Standard 8 - ongoing review by Consultant.

The audit was undertaken in November 2024 and demonstrated for standard 2 that two thirds of patients are now seen within 14 hours of admission, up from less than half in 2019. If reviews by consultants after 14 hours are included then this figure rises to 82%. The audit for

Standard 8 confirmed that for the 55% of patients who required either a once or twice daily review by a consultant or a delegate only were completed which informed the improvement priorities and is continuing.

The utilisation of the Board Assurance Framework to assess performance against these four priority 7DS continues to align the clinical standards on an annual basis. This audit and oversight of required improvement actions will continue throughout 2025.

Raising Concerns

Effective speaking up arrangements help our organisation to protect our patients and improve the experience of our workers. Making sure all our workers have a voice and feel safe and able to speak up about anything that gets in the way of providing safe, high-quality care or affects their workplace experience. This includes matters relating to patient safety, the quality of patient care and the culture within the working environment. To support this, managers need to feel comfortable having decisions and authority challenged. Speaking up and the matters that the issues highlighted, however difficult to hear, should be welcomed and looked at as opportunities for learning and development.

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

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

Guardian of Safeworking – NHS Doctors in Training

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

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

Reporting against core indicators – *latest published data to 12/05/25*

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

Indicator	2024/25	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2023/24	2022/23
Mortality: The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for (01/24 – 12/24) latest published data available	SHMI Value = 117.61 (01/24 – 12/24) Band 1 Higher than expected	SHMI value = 100	SHMI Value = 69.91 (01/24 – 12/24) Band 3 Lower than expected Chelsea and Westminster Hospital NHS Foundation Trust	SHMI Value = 133.23 (01/24 – 12/24) Band 1 Higher than expected Chesterfield Royal 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 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 = 107.64 (12/22-11/23) Band 2 (As expected)	SHMI Value = 108.17 (12/21 – 11/22 Band 2 (As expected) 1
The percentage patients' deaths with palliative care coded at either diagnosis or specialty level for the period (01/24 – 12/24) Latest published data	38%	44%	66% University College London Hospitals NHS Foundation Trust	17% 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	37% (12/22 – 11/23)	33% (12/21 – 11/22

Indicator	2024/25	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2023/24	2022/23
Patient reported outcome scores for hip replacement surgery (April 23 to March 24) latest data available	72.3% (2023/24)	77% (2023/24)	86.9% (2023/24) Imperial College Healthcare NHS Trust (RYJ) Based on adjusted health gain	74% (2023/24) Benenden Hospital	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: Although some PROMS data was submitted for hip replacement and knee replacement – there were insufficient records to deem statistically viable and calculate any adjusted health gains, therefore not published nationally. However, national clinical audit section outlines findings from the records submitted, with actions to address	67% April 22 to March 23 Measure EQ-5D Index	70% April 21 to March 22
Patient reported outcome scores for knee replacement surgery April 23 to March 24 latest data available	64.3% (2023/24)	73.4% (2023/24)	78% (2023/24) Imperial College Healthcare NHS Trust (RYJ) Based on adjusted health gain	61% (2023/24) Guy's and St Thomas' NHS Foundation Trust		76% April 22 to March 23 Measure EQ-5D Index	71% April 21 to March 22
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 10.9% for discharges in March 2025 *(based on Payment By Results national guidance, exclusions apply)*						
28-day readmission rate for patients aged 16 or over *							
The percentage of admitted patients' risk-assessed for Venous Thromboembolism	94.00 (04/24 to 03/25)	national submission paused since pandemic, therefore no comparative data available			Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by: • VTE Nurse Champion • Nurse-led DVT Clinic • VTE database • Staff Awareness • RCA of patients developing clots for continuous learning and improvement	98.22 04/23 to 03/24	96.94% (04/22 to 03/23)

Indicator	2024/25	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2023/24	2022/23
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	40.4 (23/24)	20.9 (23/24)	47.7 (23/24) Isle of Wight	5.0 (23/24) North Lincolnshire and Goole	Bolton NHS Foundation Trust considers that this data is as described for the following reasons: Rate as published on the Public Health Profiles. National data is published in September each year. There is no data published yet for 2024/25 Therefore, latest available published data is 2023/24 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.	43.0 (22/23)	32.7 (21/22)
Number/ Rate of patient safety incidents per 1000 bed days latest data available (NRLS)	The annual publishing of this data is paused while future publications are considered in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. Most up to date data is April 2021/Mar 22				Bolton NHS Foundation Trust considers that this data is as described for the following reasons: The data has been obtained from the National Reporting and Learning System (NRLS) There is no patient safety data for 22/23 as the publishing of the annual data has been paused while it is considered how future publications are brought in line with the introduction of the Learn	Most up to date data is April 2021/Mar 22	61.5 per 1,000 bed days N = 12,420 Apr/21 to Mar/22

Indicator	2024/25	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2023/24	2022/23
Number of above patient safety incidents that resulted in severe harm or death latest data available (NRLS)	The annual publishing of this data is paused while future publications are considered in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. Most up to date data is April 2021/Mar 22				from Patient Safety Events (LFPSE) service to replace the NRLS. Bolton NHS Foundation Trust Risk & Assurance team have undertaken: • Implementation of new national Learning from Patient Safety Events Service, replacing NRLS • Implementation of new national Patient Safety Incident Response Framework (PSIRF)	Most up to date data is April 2021/Mar 22	N = 33 10 deaths 23 Severe harms Apr/21 to Mar/22
Inpatient Friends and Family Test (Jan-25)	95% (Jan-25)	94% (Jan-25)	100% (Jan 25) The Royal Orthopaedic Hospital NHS Foundation Trust	72% (Jan 25) The Princess Alexandra Hospital NHS 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	97.08% (Feb-24)	96.4% (Feb-23)
Accident and Emergency Friends and Family Test (Jan-25)	86% (Jan-25)	80% (Jan-25)	56% George Eliot Hospital NHS Trust	97% County Durham and Darlington NHS Foundation Trust		78.29% (Feb-24)	87.1% (Feb-23)

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PART 3

Performance against Trust selected metrics

Improving care,
transforming lives...for a better Bolton

Performance against Trust selected metrics

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

	Indicator/Measure	**2024/25**		**2023/24**	**2022/23**
Patient Safety Outcomes	Mortality - SHMI	See page 41			
	C.*Diff* – number of cases	See page 43			
	Pressure ulcers by category: • Cat 2 • Cat 3 *plus unstageables from 24/25* • Cat 4 *Data source – Bolton NHS Foundation Trust's incident reporting system*	Hospital 186 35 0	Community (significant learning) 112 (0) 99 (0) 5 (1)	256 3 7	304 16 1
Patient Experience	Friends and Family Test inpatients • Response rates • Recommendation rates *Data source – captured locally, submitted nationally, and published by NHS England*	20% 97% (Mar 25)		28.2% 96.7% (Mar 24)	25.6% 96.2% (Mar 23)
	Lessons Learnt	See below			
Effectiveness	Sickness rates *Data source – captured via local attendance management system (E-roster and ESR), submitted nationally, and published by NHS Digital*	4.6% (Mar 2025)		5.2% (Mar 24)	4.6% (Mar-23)
	Appraisal rates *Data source – captured via local ESR and reported locally for Board report*	85.3% (Mar 2025)		83.6% (Mar 24)	84.1% (Mar-23)
	Mandatory Training compliance *Data source – captured via local training and development system (Moodle and ESR)*	91.4% (Mar 2025)		90.3% (Mar 24)	85.3% (Mar-23)

The above data is reflective of 2024/25 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 2024/25 used a variety of methods to ensure that learning is captured, shared, and embedded in a timely manner.

Capture: Incidents, complaints, claims, audits, and Inquests provide us with the opportunity

to reflect when our practice could have been better, the Governance Team are central to ensuring that the intelligence gleaned from such events is accurate and focused on learning.

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

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

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

Indicator for disclosure (limited to those that were included in both RAF and SOF for 2016/17)	**Apr 24-Mar 25**	**Target**	**Achieved**	**Apr 23-Mar 24**	**Apr 22-Mar 23**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway (as at 31/03/2025)	55.42%	92%	X	48.9%	60.29%
A&E: Maximum waiting time of four from arrival to admission, transfer, or discharge (average for the year)	64.5%	95%	X	61.24%	59.48%
All cancers: 62-day wait for first treatment from:					
• Urgent GP referral for suspected cancer (04/24 – 03/25)	82.66%	85%	X	80.23%	81.72%
• NHS Cancer Screening Service referral (04/24 – 03/25)	88.99%	90%	X	84.73%	82.91%
Clostridium difficile - meeting the C. difficile objective *National data is published in September each year. Therefore, latest available published data is 2023/24*	88 (2023/24)	N/A	N/A	93 (2022/23)	66 (2021/22)
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 31/03/2025)	95.05.%	99%	X	89.6%	86.1%
Venous thromboembolism (VTE) risk assessment included in "**Reporting against core indicators section"**					

Bolton NHS Foundation Trust Quality Account 2024/25 – Statement from Greater Manchester Integrated Care Board

NHS Greater Manchester (NHS GM) welcomes the opportunity to comment on the Quality Account for NHS Bolton Foundation Trust (FT) 2024/25. NHS GM is required to act with a view to securing continuous improvements in the quality of services for patients and their outcomes, with a regard to clinical effectiveness, safety, and patient experience.

We welcome the ongoing commitment to the values of the organisation and the locality which underpin the approach to high quality, safe and effective services for the people of Bolton.

Bolton FT place particular emphasis on engagement and communication to improve quality and have continued to be open and transparent in the way in which they engage with service users, carers and staff as well as the wider public.

NHS GM reviews and monitors the performance and quality of NHS services commissioned from Bolton FT through the regular Locality System Quality Groups and contract meetings. We have continued to work collaboratively with Bolton FT to adapt how we gain oversight and assurance of quality and performance. During 2024/25 we saw Bolton FT senior leadership team attend and contribute to the Bolton Locality System Quality Group. This increased collaborative working demonstrates Bolton FT's commitment to work with system partners on quality and safety.

Within the 23/24 Quality Account, Bolton FT set out three priority areas for delivery and improvement in 2024/ 25, these were:

- C.difficile infection reduction – Resulting in an 11% reduction in C.difficile Toxin (CDT) infections and launch of a C.difficile Change Package trust wide from June 2025.
- Enabling and empowering staff through the development of quality improvement skills – Resulting in a 68% increase of staff trained in the fundamentals of Quality Improvement and 78% increase in QI projects registered centrally.
- Recognising and response to the deteriorating patient – Commissioning a Quality Improvement Collaborative to test improvement ideas on the identification and escalation of deterioration across various specialties, acute and community settings, different identification pathways and patient groups and demographics. Learning session one commenced in February 2025.

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

Through this Quality Account, Bolton FT clearly demonstrate their commitment and ambition to improving the quality of care and services delivered. Priorities for 2025/ 26 have also been set as follows:

- Recognising and response to the deteriorating patient
- Releasing time to care – phase one – a focus on documentation
- Communication – involving our patient in their care and decision making

To the best of NHS GM's knowledge, the information contained in the Account is accurate

and reflects a true and balanced description of the quality of provision of services provided by Bolton FT. We will continue to work collaboratively with Bolton FT in 2025/26 to ensure ongoing high-quality services are provided in line with commissioning priorities.

Mark Fisher
Chief Executive
NHS Greater Manchester Integrated Care Board

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