Bolton NHS
NHS Foundation Trust

BOLTON NHS FOUNDATION TRUST
QUALITY REPORT

Quality Report

Contents

Quality Report

Introduction

This Quality Report includes a review of the quality of healthcare provided by Bolton NHS Foundation Trust in 2014 – 15 and a forward look to our key priorities for 2015 – 16.

In line with the guidance provided by our regulator Monitor, the report is broken down into the following sections:

Part one statement on quality from our chief executive Dr Jackie Bene

Part two priorities for 2015/16

Part four statements of assurance from the board

Part five performance in 2014/15.

We have interspersed the sections and information that we are required to provide with additional information and case studies which we hope will be of interest to readers of the report.

We have been working closely with our commissioners – Bolton CCG to develop the services we deliver to the people of Bolton. An early draft of this report was shared with the CCG. They provided some useful feedback on the issues which matter to them and this has been incorporated into this final report. Our commissioners have been very supportive and we will continue working closely with them to ensure we provide the best possible care to the population we serve.

We have worked with our stakeholders to develop this Quality Account – statements from Bolton CCG, Bolton HealthWatch, our Council of Governors and the Overview and Scrutiny Committee are included at appendix one.

We aim to be open and transparent with the public we serve and will also provide updates on our progress in our Board meetings and at our Governor meetings. We welcome feedback from our patients and public and will use this to make improvements to the care we provide.

We have tried to use clear and understandable language wherever possible in this report, however the inclusion of some medical and healthcare terms is unavoidable. Further information about health conditions and treatments is available on the NHS Choices website

Quality Report

Statement of the Quality of Services from the Chief Executive

Delivering consistently high quality care is at the heart of our Trust's ambition and in 2014/15 we launched our Quality Strategy which aimed to support the delivery of this. Above all else, our commitment to the people of Bolton is that our services are **safe**, delivered with a **caring** attitude and provide an **effective** and **efficient** use of the resources bestowed unto us.

Already in the first year we have seen significant improvements in all work streams; we have reduced the number of pressure ulcers by 46% and almost halved the number of cases of C. difficile from 38 to 20. We have also started to make real progress within our intermediate services; our home based pathway performed above target with a peak of 351 referrals in January. These community services are one of the key factors in our work with the CCG to avoid hospital admissions and to ensure where possible patients are treated in their own homes.

So as we look to 2015/16 our emphasis will remain on delivering consistently high quality care for all our patients and their families. We have worked with our staff, our Foundation Trust members and our Council of Governors to select priorities which these key stakeholders feel will have the greatest impact on improving the quality of care for our patients.

These are:

- reducing mortality
- preventing harm from falls that occur within our care
- reducing healthcare acquired infections
- reducing medication incidents and
- reducing staff sickness levels

In addition to these areas of focus, this is a significant year for our community services. As the Better Care Fund has enabled the development of new and existing community services in Bolton we will have a major part to play in the integration of health, social and primary care services. We will do this by working closely and collaboratively with our GPs and colleagues in social services.

Where and when appropriate we will support more people to stay at home and be cared for thus avoiding needless hospital attendances and admissions.

We will support more people who have been in hospital to recover at home sooner than previously and we will support more people to care for themselves and prevent a deterioration in their health.

I hope you will find our Quality Report interesting and informative.

To the best of my knowledge, the information we have provided within this report is accurate.

Dr Jackie Bene

Chief Executive

28th May 2015

Priorities for improvement

In our Quality Report last year we launched our Quality Strategy and set ourselves an ambitious set of priorities for improvement with our main priority being to reduce harm to patients.

Priorities for improvement in 2014/15

Quality and Safety	
Indicator	**Measure**
Mortality	• **Standardised Hospital Mortality Index (SHMI) –** Preventing People from dying prematurely. ○ Reduce SHIMI to less than 1.0 ○ Reduce crude mortality by 10%
Infection Control	• 50% reduction in avoidable cases of C.Diff.
Harm Free Care	• Zero Tolerance of category 3 and 4 pressure Ulcers • 5% reduction in pressure ulcers categorised as avoidable • 10% reduction in hospital acquired VTE episodes • 5% reduction in falls with severe harm.
Medicines Management	• 95% harm free reported through the medicines safety thermometer
Patient Experience	
Friends and Family Test	• Expansion of the areas utilising the FFT questions • 5% increase in response rates
Real Time Patient Experience	• Implementation of 'real time;' data collection processes. • Development of 10 patient experience questionnaire processes across hospital and community
Lessons Learnt	• Development of "you said we did" processes for Friends and Family Test comments. • Evidence of lessons learnt being reported throughout the divisions and corporate structures.
Dementia	• 95% compliance with the Dementia Care bundle
	• 10% improvement of the experience of patients with dementia
Workforce	
Friends and Family Test	• Development of process to measure staff experience • 5% decrease in negative comments
Sickness Management	• reduction in overall sickness rates to 3.75%
Appraisal	• 80% completion of appraisal information
Mandatory Training	• 100% of available staff to have completed

Although all these priorities remain important to us we decided to consult with our staff, our members and our governors through an on line vote on last year's priorities to identify five key priorities for inclusion in this year's report.

We know that for our commissioners a key priority is the development of services to keep people out of hospital; the priorities selected are all vital in helping to reduce admissions and to reduce readmissions. Providing harm-free care will help to reduce the amount of time patients spend as inpatients.

Reducing our staff sickness rates is important to ensure we provide adequate staffing levels without relying on bank and agency staff. This is particularly important in the community where patients often rely on regular contact from a district nurse who is known to them.

Priorities for improvement

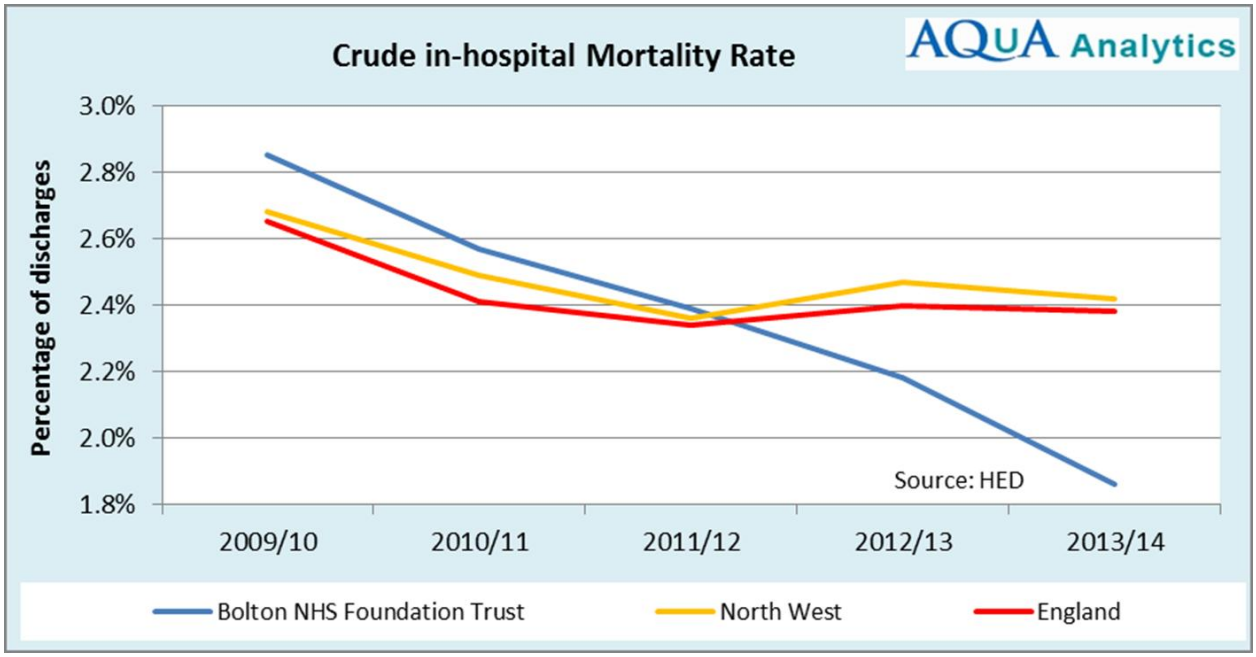
Reducing Mortality

Aim

Our objective is to continue our reduction in crude mortality and to be in the top 10% for risk adjusted mortality across the NHS.

Performance

The graph below shows our performance since 2009/10 in reducing our crude in-hospital mortality rate.



What we will do

Mortality rates will continue to be tracked at the monthly Mortality Reduction Group chaired by the Medical Director. The importance of early recognition and response to patients whose condition is deteriorating is recognised as being a key factor in saving lives.

We use the National Early Warning Scores (NEWS) which is a simple scoring system based on six measures - respiratory rate, oxygen levels, temperature, blood pressure, pulse rate and level of consciousness to determine if a patient needs further assessment and potentially admitting to critical care. In 2015/16, we aim to **increase our recording of accurate national early warning scores from 84% to 90%** and to improve our compliance with the response algorithm from 59% to 70%.

Priorities for improvement

Infection Control

Aim

Our overall aim is to prevent infection and harm to our patients.

We feel that a key step in achieving this is to achieve a 10% decrease in antibiotic prescribing through improved antibiotic stewardship.

Progress made since 2013/14

Although we made great progress in reducing the number of cases of Clostridium Difficile, an audit of antibiotic prescribing showed that 44% of patients were receiving at least one antibiotic. This is 10% above the national average at 33%.

What we will do

- The aim of the quarterly antibiotic audits is to demonstrate compliance with the antibiotic prescribing standards outlined in the Department of Health's Best Practice Guidance on Antimicrobial Stewardship in Hospitals.
- Approximately **44%** of patients included in the audit were on at least 1 antibiotic. This is an increase from Quarter 2 of 10% and above the national average of 33%.
- The audits demonstrate poor compliance with national prescribing standards.
- Recently updated antibiotic section of the in-patient prescription chart (daily signature section for review of IV antibiotics) to improve compliance with DH standards (3&4) has failed to demonstrate an improvement.

How progress to achieve these priorities will be monitored and measured

- Monthly Audits of practice are in place measured against the 5 national standards for antibiotic prescribing
- How progress to achieve these priorities will be reported
- Progress will be monitored through the Infection Control Committee and reported through to the Clinical Governance and Quality Committee for assurance on progress.

Priorities for improvement

Reduction in falls with harm

Aim

To achieve a 5% reduction in falls that are deemed preventable

To achieve a 10% reduction in falls where patients experience severe harm.

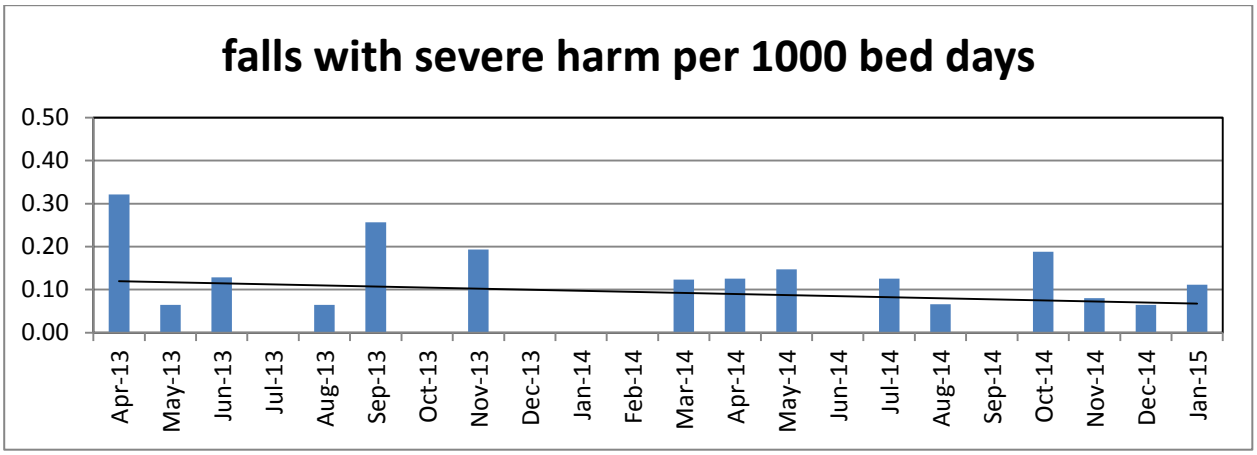
Why is a reduction in falls important?

Preventing patients from falling is a particular challenge because patients' safety has to be balanced against their right to make their own decisions about the risks they are prepared to take, and their dignity and privacy.

Although the majority of falls reported result in no harm, even falls without injury can be upsetting and lead to loss of confidence, increased length of stay and increased likelihood of discharge to residential or nursing home care, rather than to a patient's own home.

Evidence from research suggests patients in hospital are at greater risk from falls for a variety of reasons such as having had surgery affecting mobility or memory, sedation, pain relief, anaesthetic or other medication. Patients with dementia and delirium are at least twice as vulnerable to falls.

Progress made since 2013/14



What we will do

These aims will be achieved by continued implementation of the Falls Prevention and Management Strategy.

Key areas of development will be:

- Implementation of arms reach commode tagging.
- Full implementation of the Falls Management Plan documentation
- Continued evaluation of monthly data
- Continued implementation of the falls training
- The falls steering group will monitor progress against the aims.

Priorities for improvement

- The Falls Harm Free Care Panel will continue to report the outcome of all falls RCA's completed.
- Progress will be monitored by the Clinical Governance and Quality Committee and the Quality Assurance Committee.

Success for Home from Hospital scheme

Four months after its launch a scheme to provide support for elderly people following discharge from hospital has already helped almost 100 older people.

With more elderly people now living on their own the Home from Hospital scheme set up by Age UK aims to provide low level practical and emotional support as well as reduce the number of re-admissions to hospital in over 65s.

Volunteers help elderly people in the Bolton area settle in at home after a stay in the Royal Bolton Hospital by assisting them with day-to-day tasks such as shopping, collecting prescriptions or housework.

As well as providing six weeks of support the scheme also encourages older people to join lunch clubs or go along to other community activities that will help them adjust to being back home.

John Inman, Age UK Bolton's project officer for the scheme, said: "It's about getting older people back into the social swing and helping those that may not have the support they need at home.

"It's like a good neighbour service; sometimes our volunteers will just go round for a chat and provide emotional support for an elderly person."

Mr Inman spoke of one man who returned home from the hospital but his family weren't able to help with his recovery so the volunteers for the scheme were there to help him instead.

So far the scheme has been a success with positive feedback from clients and their families. Although progress started off slowly there are now more and more referrals from the hospital and more people volunteering for the scheme.

Bev Tabernacle, Acting Director of Nursing at Bolton NHS Foundation Trust, said: "Since its introduction the Home from Hospital scheme has provided some much needed extra support and care on discharge to elderly people of Bolton. The scheme has helped the hospital to optimise the range of services we can offer to elderly people being discharged, helping them to regain confidence and independence at home. We are very grateful to Age UK in supporting Bolton Foundation Trust with the introduction of this scheme and no doubt our patients who receive Age UK support are too."

Priorities for improvement

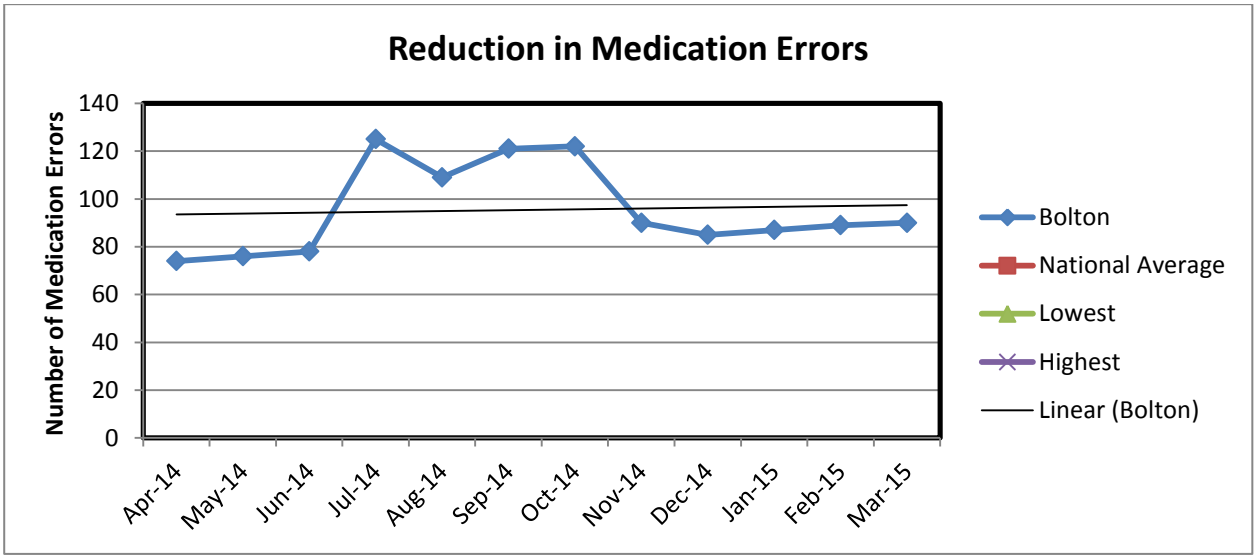
Reduction in medication errors

Aim

10% reduction in medication incidents related to the omission of a medication

Progress made since 2013/14

Some progress has been made in 2013/14, however we continue to encourage the reporting of medication incidents and have seen an upward trend in reporting.



For 2015/16 a focus will be on the reduction of medication incidents related to the omission of medication.

What we will do

- Audit processes for measuring the reduction for this group of incidents will be developed in Quarter 1 to establish the baseline on which to measure the 10% improvement.
- How progress to achieve these priorities will be monitored and measured
- Progress against the 10% reduction will be monitored through the Medications Management Committee.
- How progress to achieve these priorities will be reported
- Monthly data regarding incidents will be monitored and reported to the Medicines Management Committee.

Priorities for improvement

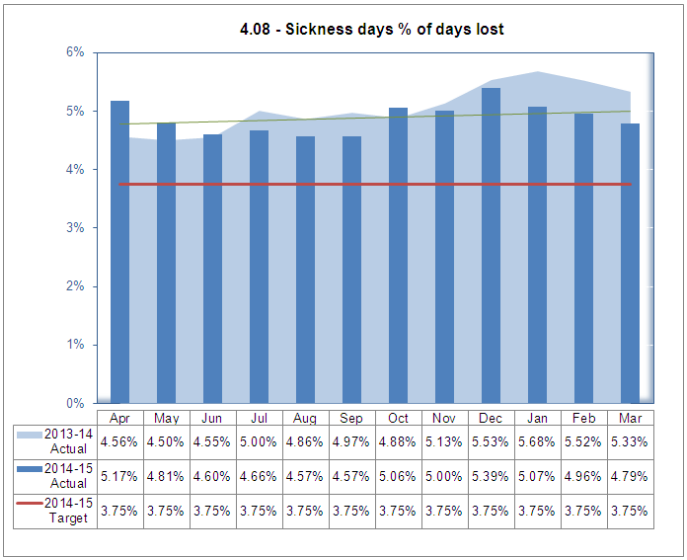
Reduction in staff sickness

Aim

We are aiming to reduce our staff sickness rate to 4.2%

Progress made since 2013/14

There has been a reduction in the percentage of sickness days to 4.9% compared to 5.04% in 13/14.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013-14 Actual	4.56%	4.50%	4.55%	5.00%	4.86%	4.97%	4.88%	5.13%	5.53%	5.68%	5.52%	5.33%
2014-15 Actual	5.17%	4.81%	4.60%	4.66%	4.57%	4.57%	5.06%	5.00%	5.39%	5.07%	4.96%	4.79%
2014-15 Target	3.75%	3.75%	3.75%	3.75%	3.75%	3.75%	3.75%	3.75%	3.75%	3.75%	3.75%	3.75%

What we will do

- Introduction of new attendance management policy, harmonising several different variants that were in operation across the organisation. This has helped make attendance management more straightforward and consistent.
- 200+ managers trained through either centrally organisation sessions or local divisional training
- Monthly audits carried out to ensure consistent application amongst managers. Overall trend shows an increase in return to work interview compliance. Focussed feedback and coaching provided to each manager.
- Mental wellbeing drop in sessions arranged locally within teams
- Referrals to staff physiotherapist for fast track treatment for MSK conditions
- As part of our People Strategy implementation, we have wider work planned on staff engagement and leadership. Evidence supports that effective practices in these fields can improve attendance management.

Respiratory Success Stories

CQUINN & Virtual Respiratory Clinic

The virtual respiratory clinic was established to provide GP colleagues with access to respiratory physicians to discuss respiratory cases and collaboratively plan to support care of patients in the community.

Between 17th October 2014 and 31st March 2015 the service received 106 calls with an average call time of 10.31 minutes

Feedback from GPs

- 'Very useful to be able to speak to respiratory consultant and discuss patients'
- 'Very impressed that consultant could see CXRs and blood results and we could reach a management plan immediately'
- 'Ability to discuss management option with patient at the same time as discussing with respiratory consultant!'
- 'Excellent service, it can only help GPs and patients with their care'
- 'Great service, avoided unnecessary admission to hospital'

Respiratory Rapid Access Clinic

The Respiratory Rapid Access Clinic was a natural progression of the Virtual Respiratory Clinic.

The goal was to offer a clinic appointment to respiratory patients within 24hours for rapid assessment. The clinic operated from 1st December to 31st March and saw 61 patients with 46 discharged from clinic

Feedback:

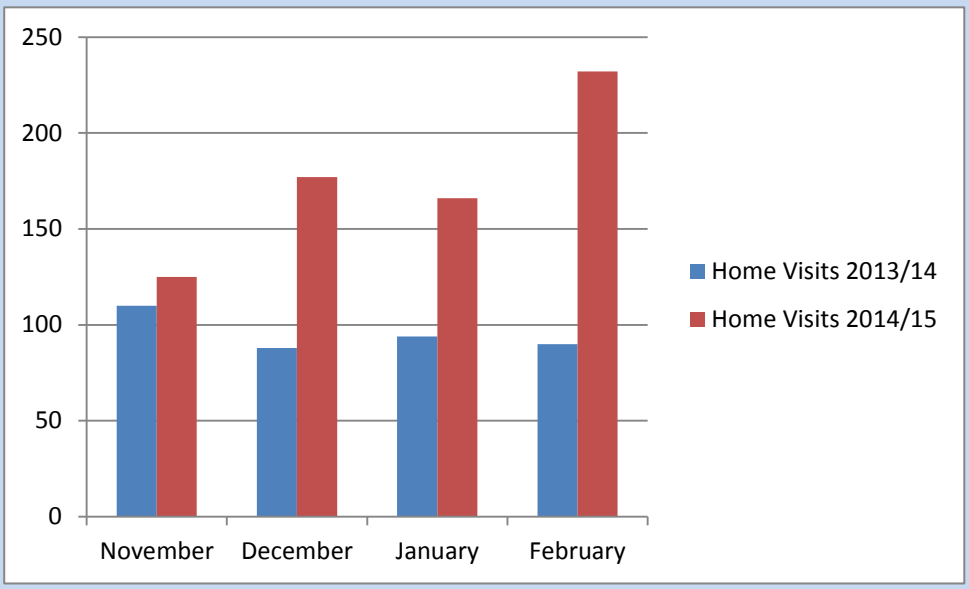
21 of 45 patients contacted for feedback

- Overall score - 9.42 out of 10
- 100% of patients who responded said staff were courteous and polite
- 86%% of patients who responded said there were clear follow up plans
- 100% of patients who responded said they would recommend the service
- One patient said he would give 15 out of 10!!
- One patient was so poorly, she doesn't remember anything! Patient's daughter-in-law said she felt 'comforted with a sense of relief that she was never left alone'. Within two hours of arrival, the patient was set up on NIV on a respiratory ward, with ceiling of treatment discussed with family. Patient recovered and is now at home.
- Patients often commented on a sense of feeling 'safe'

Support at home

As part of the winter pressure work, additional resources were allocated to support patients with respiratory conditions at home. Where possible, patients who were identified as 'high risk', or referred by the Rapid Access Clinic or RBH assessment areas were managed at home with a significant increase in the number of home visits compared to 2013/14

	November	December	January	February
Home Visits 2013/14	110	88	94	90
Home Visits 2014/15	125	177	166	232



Domiciliary IV Antibiotic Service for patients with Bronchiectasis

Patients with Bronchiectasis requiring IV antibiotics have traditionally needed to be admitted to hospital for a period of around 2 weeks to receive treatment. Patients often reported feeling disappointed at the need to come in and although they were not dissatisfied with their care would prefer to be at home. A patient survey undertaken by ourselves supported this when 85% of those surveyed said when asked they would prefer treatment at home. In October 2013 a Bronchiectasis patient Focus Group was held to ascertain what patients would like their service to look like. Many issues were discussed, one of which was feelings of being disempowered when they came into hospital. A long process ensued, mainly due to the fact that the treatment regime for this group of patients requires 3 doses of antibiotics, the last one being around 10pm, the current IV therapy team were set up to provide twice daily administrations finishing around 8pm.

In November 2014 the IV Bronchiectasis service started where the IV therapy team and the respiratory team work collaboratively to support this group of patients at home. Since November 5 patients with Bronchiectasis have been managed at home on IV antibiotics. This has saved the organization around 70 bed days but more importantly patients have received safe, effective and personalised care at home by a combined specialist team - collaborative working at its best.

Review of services

During 2014/15 Bolton NHS Foundation Trust provided and/or sub-contracted seven regulated activities (as defined by the CQC) across 38 specialities.

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

The income generated by the relevant services reviewed in 2014/15 represents 100% of the total income generated from the provision of NHS services by Bolton NHS Foundation Trust in 2014/15

Participation in Clinical Audits and Research Activity

National clinical audits and national confidential enquiries are tools that NHS organisations use to assess the quality of services provided, against the best available evidence-based guidance and standards**.**

At Bolton NHS Foundation Trust we undertake many clinical audits. We participate in all the national audits which are applicable to the organisation. This allows us to benchmark against other hospitals in England.

We also have a comprehensive programme of local clinical audits which clinical staff including consultants, junior doctors, nurses and allied health professionals conduct regularly to improve local areas of care.

National Clinical Audits and National Confidential Enquiries 2014/2015

These are "inspections" that are carried out nationally to investigate areas of care where there may have been problems nationally or where the patients may be particularly vulnerable. All hospitals are asked to take part in them so that all care across England can be monitored.

During 2014/15 **33** national clinical audits covered relevant health services that the Trust provides.

During 2014/15 the Trust participated in **100%** national clinical audits which it was eligible to participate in.

The national clinical audits the Trust was eligible to participate in during 2014/15 are tabled below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Participation	*Cases submitted*	%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	318	100
Adult Community Acquired Pneumonia	Yes	Collecting data up until May 15	NA
Bowel cancer (NBOCAP)	Yes	126	99%
Cardiac Rhythm Management (CRM)	Yes	253	100
ICNARC Case mix Programme	Yes	182 (April – September)	100
Diabetes (Adult) includes National Diabetes Inpatient Audit (NADIA)	Yes	80	-
Diabetes (Paediatric) (NPDA)	Yes	112	100

PROMs Elective surgery Groin Hernia Hip Replacement Knee Replacement Varicose Vein	Yes	568 182 176 181 29	56.3 58.7 73.3 71.3 14.1
Epilepsy 12 audit (Childhood Epilepsy)	Yes	**22**	96
Falls and Fragility Fractures Audit Programme The national audit of inpatient falls National hip fracture data base Fracture liaison	Yes	Delayed Data collection May-15 **tbc** No	
Fitting child (care in AE)	Yes	50	100
Head and neck oncology (DAHNO) **East Lancashire** **Christie** **Central Manchester**	Yes	318 116 42 160	100
Inflammatory bowel disease (IBD)*	Yes	162	100
Lung cancer (NLCA)	Yes	213	96.8
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	1 maternal 46 babies	100
NCEPOD	Yes	34 individuals	85
Mental health (care in AE)	Yes	50	100
National Audit of Intermediate Care	Yes	-	100
National Cardiac Arrest Audit (NCAA)	Yes	90	100
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme*	Yes	26	100
National Heart Failure Audit	Yes	173	100
National Comparative Audit of Blood Transfusion programme -National Comparative audit of information and consent for blood transfusion (2014) -NHSBT National Red Cell Cycle Survey 2014 (Cycle 1 and Cycle 2) -National Comparative Audit of Transfusion in Sickle Cell Disease,	Yes	250 16 cases 233 cases 1 case	100
National Emergency Laparotomy Audit	Yes	62	-
National Vascular Registry*	Yes	Unknown	-
National Joint Registry	Yes	448	99%
Neonatal intensive and special care (NNAP)	Yes	593	100
Oesophago-gastric cancer (NAOGC) **(2012-2014 Data inclusive)**	Yes	129	102
Older people (care in AE)	Yes	50	100
Prostate Cancer	Yes	170	100
Pleural Procedure	Yes	5	100
Rheumatoid and early inflammatory arthritis*	Yes	82	100
Sentinel Stroke National Audit Programme (SSNAP)	Yes	153	100
TARN ***2014 Inclusive***	Yes	137	42.9

Statements of assurance from the board

The reports of 16 national clinical audits were reviewed by the provider in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided

Audit Title	Report Published	Actions to improve the quality of healthcare provided
Myocardial Ischaemia National Audit Programme (MINAP)	Yes	Results discussed via cardiology governance meeting
ICNARC Case mix Programme	Yes	Production of an 'assurance' report that looks at any outlying issues such as In-hospital CPR an outlier, deaths of patients with low predicted mortality with themes as coding being highlighted.
Diabetes (Paediatric) (NPDA)	Yes	**Service improvement & development:** Enhance insulin pump expertise – 'Pump school', improve availability/ choice of insulin pumps **Team development:** Junior doctor education time & updates for consultant colleagues **Patient & carer feedback & involvement:** Patient information leaflets Seek service-user feedback for young persons' clinics **Audit / Diabetes Register / Research:** Continue NPDA & PREM audits. Work on diabetes national register. Continue MCRN project.
Inflammatory bowel disease (IBD)*	Yes	Continuous review via 6 weekly IBD service meetings- currently written, Ophthalmology and Pregnancy pathways
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Use of customised growth charts in all antenatal patients IT support for perinatal mortality database
NCEPOD	Yes	Please see below Gap Analysis and Action Plans
National Audit of Intermediate Care	Yes	The results were used to inform the redesign and rebalance of Intermediate Care and the proposals put forward in the September 2014 Better Care Fund submission
National Cardiac Arrest Audit (NCAA)	Yes	Local RCA have been completed by parent teams, with noticeable improvement in completion of DNAR. To facilitate further improvement the process of evaluation has changed by implementation of a review panel, meeting monthly combining mandate reviews and potential Critical incident for those applicable.
National Comparative Audit of Blood Transfusion programme	Yes	**Transfusion sample labelling** Continue transfusion sample zero tolerance i.e. all incorrect samples are discarded (a minority of qualifying samples may be tested under concession, as per transfusion policy) Evaluate implementation of positive ID system for blood samples using barcode technology (to be managed via HTC action plan) **Comparative Audit of patient information and consent** Continue to promote at clinical induction and face-to-face training (already recently incorporated into BT e-learning), - Evaluate possibility of including 'risks, benefits, alternatives' on consent section of transfusion form which would be an 'aide memoir' for staff taking consent and would positively record these aspects being addressed.
National Emergency Laparotomy Audit	No	Awaiting Report

National Vascular Registry	No	Awaiting Report
Neonatal intensive and special care (NNAP)	Yes	Reducing infections Improving temperatures on admission (trialling the use of trans-warmers) Supporting breast milk usage on the neonatal unit
Prostate Cancer	Yes	Presented November 2014
Rheumatoid and early inflammatory arthritis	No	Awaiting Report
TARN	Yes	**No**
Epilepsy 12 audit (Childhood Epilepsy)	Yes	**Initial clinical assessment** Improve percentage of children receiving appropriate first paediatric clinical assessment

During 2014/2015 **4** national confidential enquiries covered relevant health services that the Trust provides.

During 2014/15 the Trust participated in **100%** national confidential enquiries which it was eligible to participate in.

The national confidential enquiries that the Trust was eligible to participate in during 2014/15 are listed below alongside the number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry.

The reports of the national confidential enquiries that were reviewed by the provider in 2014/15 intends to take the following actions to improve the quality of healthcare provided and is documented below via a heat map and a Gap Analysis

<table>
<tr><th></th><th></th><th>Number cases Included</th><th>Local Gap Analysis Completed
Outcomes of published Report</th></tr>
<tr><td>1</td><td>Tracheostomy Care
May 2014</td><td>N=19/21 Cases
90%</td><td>25 recommendations – Are we compliant?
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20
21 22 23 24 25</td></tr>
<tr><td></td><td colspan="3">Action Plan:
Recommendation 13: Trusts should have a protocol and mandatory training for trache care including guidance on humidification, cuff pressure, monitoring and clean of the inner cannula and resuscitation. Clinical practice re trache care should be the subject of local quality improvement initiatives. Tube data should be clearly recorded and available for review at the bedside and thereafter facilitated by a ‘passport’ for each patient.</td></tr>
<tr><td>2</td><td>Lower Limb Amputation
Nov 2014</td><td>N=4/6 Cases
67%</td><td>20 recommendations – Are we compliant?
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20</td></tr>
<tr><td></td><td colspan="3">Action Plan:
Recommendation 6: When patients are admitted to hospital as an emergency with limb-threatening ischaemia, including acute diabetic foot problems, they should be assessed by a relevant consultant within 12 hours of the decision to admit or a maximum of 14 hours from the time of arrival at the hospital

During working hours this is achieved. There have been some recognised teething problems since the commencement of the out of hours service with Manchester. Meetings are ongoing to iron out these problems

Recommendation 7: A model for the medical care of amputees should be introduced (which includes regular review by a physician and a surgeon throughout the in-patient stay).</td></tr>
</table>

Statements of assurance from the board

Local Audits:

The main purpose of clinical audit is to deliver improvements in clinical practice. A systematic approach to the implementation of clinical audit action plans is therefore strongly advised. Such an approach may include the identification of local barriers to change, and organisational or resource constraints which preclude implementing change.

211 Local Audits were registered between April 2014 and March 2015.

The reports of **49** local clinical audits were reviewed by the provider in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	*Snap shot Actions*	Themes of Change in Practice
Audit of the reasons for WLE inpatient stay at Bolton	8 areas showed improvements where needed eg. pain and nausea and vomiting - *Using interpectoral block to reduce morphine*. Drowsiness – *Day Case Bay is being piloted M1*	Introduction new clinic process
Re-Audit: minimum endoscopic data set required when reporting the findings of Barrett's Oesophagus	Since 2013 Increased awareness of the guidelines , Allocate 2 points for Barrett's surveillance on endoscopy lists Barrett's surveillance on special lists/ certain endoscopists re-audit for newly diagnosed Barrett`s. If not enough time for quadrantic biopsies, re-book gastroscopy with more points( BSG guidelines) Endobase Barrett`s oesophagus format: optional to mandatory	Introduction new clinic Process
Re-Audit: Use of capnography in ICU	Provision for recording whether capnography monitoring was used should be part of the post-tracheostomy paperwork, and this should be easily auditable	Training Issues Documentation
Re-Audit: Endoscopy Patient Satisfaction Survey	Leaflets/contact number and reduce the number of appointments being made by telephone.	Leaflets
Placement of central venous catheters	Introduction of checklist to be used for CVC insertions in emergency theatres	Introduction of local guidance
Appropriate administration of medication via enteral tubes or to patients with swallowing difficulties	Development of guidance, re- distribute questionnaire, publish results for rapid improvement	
Audit of new optometric referrals to a hospital glaucoma clinic	Increase availability referral forms in community with future Introduction electronic recording systems	Documentation
Re-Audit: Death Certificate Audit	Crib sheet designed to assist junior doctors	Documentation
Re-Audit: Audit of effectiveness of the Hydrotherapy Service	New awareness to increase follow-up exercise Continue to run the Tues and Fri Hydrotherapy group sessions to capacity to ensure cost effectiveness.	Training Issues Documentation
Re-Audit: Transfusion sample labelling	Change in procedure of immediate effect	Procedure
Re-Audit: Local Audit of Transfusion Special requirements	Implement new system (barcoding)	Training Issues

Statements of assurance from the board

Re-Audit: Local of Bedside Practice	Raise awareness staff at Transfusion Mandatory Training ID bands issues on SCBU/NNU raise within areas for further action	Training
Acute NIV	Introduce new working	Standard Working
Liver Biopsy- safety and compliance	Change in procedure with immediate effect	Change in procedure
DNAR/Escalation on AMU	Development of escalation document to complement the new national DNACPR document	Documentation
Inadvertent hypothermia in ICU	Introduction of fluid warming devices	change in procedure
Re-Audit: Emergency Surgery - Timescales for surgical Intervention (Abscesses revisited)	Change in working practice by introducing golden patient Combined with introducing severity and LRINEC scores	Standard Working
Re-Audit: NICE 50 CG – compliance of admissions to Critical Care	Process all cc admissions which are perceived to have failed the escalation process completed in real time on admission with results could be fed back to the MRG +/- the clinical team involved	Process Root Cause Analysis
National Comparative Audit of patient information and consent 2014	1. Continue to promote at clinical induction and face-to-face training *(already recently incorporated into BT e-learning),* 2. Evaluate possibility of including 'risks, benefits, alternatives' on consent section of transfusion form which would be an 'aide memoire' for staff taking consent and would positively record these aspects being addressed. 3. Is it possible to include on discharge summary	Standard Working Training Documentation
Vision care pathway in hearing impaired children	Survey of current practice in the NW Paediatric Audiology group regarding adherence to guidelines including local protocols re timing of Ophthalmology referrals and methods of adherence to the protocols	Documentation Training
Point of Care Pregnancy Testing Audit	Move to a single urine pregnancy kit in the Trust to prevent variance and formalise training procedures for pregnancy testing	Change in Procedure Training
Transfusion User Survey: General Survey Department	Communication when blood is ready for collection to cascade trainers to take back to work areas	Further Training
Audit of usefulness of ventilating agent in VQ lung scans	Try alternative and cheaper ventilation agent than Krypton	Change Product
Predictors of Atrial fibrillation/recurrence post cardioversion	New AF clinic to be introduced	New clinic
Plantar Fasciopathy Audit	-Regular documentation at the time of assessment of height and weight. -Access and dialogue between clinician and patient with regards weight management when deemed a contributing factor.	Process Documentation (inc leaflets)
Review of flow rate services in Urology	Bladder Scanner O/Ps Reduction in number of flow rate clinics All patients fill in IPSS form at flow rate apt	Change in Process and procedures

A telephone patient satisfaction survey regarding switching from IV Pamidronate or Ibandronate to IV Zoledronate	It is recommended that in treatment switching QI scenarios a structured framework is used where verbal information is supplemented with printed information with a contact number for any subsequent queries. To be presented BSR Rheumatology April 2015, Manchester	Change in process
C-Section Anaesthesia - Technique and Failure Rates	Re-design of the anaesthetic chart	Documentation
An Audit of the number of self-referrals of women for a mammogram for the period of 03/02/2014 to 16/03/2014 and its impact on the Breast Unit.	Increase staffing levels to accommodate the increase in screening numbers. Provide screening secretaries with relevant information to give to patients over the age of 70 (telephone enquiries). Information leaflets for the over 70s to be generated DoH to contact Breast units and inform them of breast awareness campaigns before they commence.	Documentation Process
The Future Standards	Raise awareness with all staff (including nursing staff) the time window of 4 hour review by middle grade or consultant Written notice in A&O Discussion with A&O staff	Training
Wound Infection in high risk Caesarean section – PICO dressing	Ensure correction of anaemia in postnatal period Interrupted sutures /clips to all eligible women Disseminate information (as recommended by RCOG in obesity CMACE guideline) in lessons of the week Include 'PICO' on CS proforma - K2 Recruit all eligible women Increase community involvement in following post-op women with PICO	Process Training Documentation
Perineal & wound care clinic	Cascade findings of audit to staff Suturing training for staff Literature review of perineal suturing techniques and suture material Observational audit re asepsis during perineal repair	Training
Re-audit Severe Sepsis in Obstetrics	<u>Educate multidisciplinary team :</u> Appropriate documentation of 'SIRS/SEPSIS/SEVERE SEPSIS/SEPTIC SHOCK' Completion of Sepsis 6 in the 'Golden Hour' Improve Sepsis 6 Implementation (Oxygen & Urine Output) Improve Severe Sepsis Screening <u>Prelabour rupture of membranes</u> Reintroduce prophylactic intrapartum antibiotics for all women with SROM > 18 hours Ensure induction of all women with SROM by 24	Training Process Documentation

	hours Staff education regarding asepsis during catheterisation - Include in list of mandatory training items	
Paediatric Wardex Prescription Chart completion	Improve practice of all paediatric prescribers. Disseminate information: Present to new junior doctors at induction Only administer drugs if Wardex patient identifiers, allergy box and weight are properly completed Increase nursing staff awareness	Training Process Documentation
Record Keeping 2014 - Community Paediatrics	Ensure allergy status recorded in all notes All entries in notes to have time of entry and author's name and designation clearly recorded Letters to be usually max 2 sides in length (unless exceptional circumstances) and to list medication	Documentation
62 day Cancer Pathway in Gynaecology	Improve awareness of the 62 day pathway Promote a proactive approach to organising further investigations for patients on the 62 day pathway Promote earliest possible follow up in clinic following completion of investigations	Training
Re-audit Safe Swab Practice in Central Delivery Suite –May 14	Audit results to be shared Spot check use of white boards and documentation Share results with Elective Division in order that they can re-audit WHO checklist compliance	Training Process
Prelabour rupture of membranes (PROM)	Re-audit prospectively with larger numbers to provide more outcome data	Re-audit
Preterm Prelabour rupture of membranes (PPROM)	Update trust guideline to include addition of MgSO4 and flow charts for management <34/40 and >34/40. Highlight importance of intrapartum IV antibiotics for ALL	Documentation Training
Atypical endometrial hyperplasia	Continue to manage all cases of atypical endometrial hyperplasia as likely co-existent cancer Create awareness of all staff of patients on the 62 day pathway to expedite investigations Work with radiologists to ensure timely MRI scans	Process Training
Record Keeping 2014 – Acute Paediatrics	Review and redesign of A&O proforma to address patient identification on every page Disseminate findings of this audit and points for improvement (daily entries for all patients, all entries to be dated and timed) Consider introduction of discharge checklist for medical and nursing staff – possibly on the back of the coding form	Training Process Documentation
CQC Puerperal Sepsis	Ratify and disseminate 'Guideline for the prevention and management of sepsis in	Training Process

	pregnancy and the puerperium' Ensure learning across the Maternity Unit in relation to: - clinical suspicion of sepsis, in the presence of two or more SIRS criteria, - consider alternative explanations for SIRS - consider alternative to treating as sepsis. Hourly monitoring for the next two to four hours. - initiating the sepsis pathway, document suspected source of infection and ensuring all elements are implemented. Review mechanisms for ensuring that when any investigation is performed results are reviewed and acted on in a timely manner Review and improve compliance with hand hygiene and dress code policy Review theatre practices Improve patient education regarding hand and wound hygiene (Leaflet in development) Review indications for Emergency Caesarean Sections – when procedures are performed out of hours Complete detailed audit of diagnosis and management of sepsis and present at Audit Review setting for patients with non-emergency problems/ complications following delivery Update Maternity Unit teaching on antibiotics and breastfeeding	Documentation
CQC outliers audit 2014 – fetal distress	Dissemination of coding issues Review trends regularly - Look at fetal distress trends on CHKS Live in 6 months Disseminate audit outcome to division	Training Process
Gynaecology note keeping audit 2014	Improve documentation amongst medical staff Disseminate information at induction and reminder at every opportunity Undertake antibiotic prescribing audit	Documentation Training
Caesarean section surgical site infection	Interrupted skin sutures in all previous CS PICO dressing in all eligible women (BMI>35, Diabetes, Previous SSI) PICO proformas to be filled including indication Iron infusion in anaemic patients (postnatal) Disseminate audit results Hand hygiene education Educate staff on correct wound swab technique	Training Process Documentation

	Discuss pre-op hygiene with women	
Women's experience of feeding & caring for their baby: support received during maternity, health visiting & neonatal care.	Develop a curriculum/a that cover all the standards including the International Code, using our guidance Implement a breastfeeding assessment tool and written information for mothers Ensure for all mothers: Skin-to-skin contact Effective breastfeeding according to their individual needs Staff ensure that mothers formula feeding are supported Parents are supported to develop a close and loving relationship with their baby Mothers of babies in the Neonatal or Special Care Baby Unit encouraged to express their breast milk for their baby.	Training Process Documentation
Pregnancy in diabetes NPID	Provide preconception counselling service	Change in process
Down's Syndrome Screening 2014	Optimise number of women receiving 1st trimester screening Give high risk result within 3 working days Quality indicators for diagnostic procedure Increase number of diagnostic procedures performed to ensure all operators have >30 procedures per year Improve completion of request forms for screening Improve number of women completing anomaly scan in timeframe 18-20+6	Change in process
Heavy Menstrual Bleeding (HMB)	No actions required	
Record Keeping and Consent Audits 2014/15 Elective Care Acute Adult Family Care	A robust selection of Record Keeping & Consent Audits have been successfully completed in 2014/15. A new data collection proforma was launched in January 2015 encompassing GMC Record Keeping and NHSLA Consent guidelines including auditing capacity assessments and cause for concern patients.	

The number of patients receiving relevant health services provided by the Trust that were recruited during the period to participate in research approved by a research ethics committee was 827

Community Research Award

The Research Department had four separate nominations shortlisted at this year's Greater Manchester Clinical Research Awards, where clinical research staff from Greater Manchester Hospital Trusts and GPs' surgeries celebrated excellence in health care.

Congratulations to our Core Research Team who won the Best Contribution to Community Research Award. The team were rewarded for all their hard work in creating opportunities for increased numbers of patients, from all populations, to get involved in research across a variety of settings, including taking research out of the hospital to share the benefits across the extended community trust.

The team also picked up three runners up awards. The VTE Research Team for Best Research Debut, and Alison Loftus, R&D Manager and Emma McKenna, Research Nurse in the Outstanding Contribution to Research Category.

Chief Operating Officer of the Clinical Research Network: Greater Manchester, Debbie Vinsun, said: "Clinical research provides the evidence we need to improve treatments for patients, and having a strong research culture helps to create a strong health service. By providing more opportunities for patients to consider research alongside their other treatment options, we can contribute towards a healthier Greater Manchester. The research awards provide a great way to recognise and reward some of the people and teams who make health care research in our region so successful and dynamic."

Goals agreed with Commissioners

A proportion of Bolton NHS Foundation Trust income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between the Trust and Bolton Clinical Commissioning Group, through the Commissioning for Quality and Innovation payment framework.

In 2013/14 Bolton NHS Foundation Trust achieved 88.6% of its CQUIN target, and received £3.9m of its £4.4m target

In 2014/15 Bolton NHS Foundation Trust achieved almost 100% of the £4.4m CQUIN target agreed with commissioners.

For 2015/16, we have agreed National CQUINS covering areas such as Acute Kidney Injury, sepsis, dementia and reducing avoidable admissions and local CQUYINS on the theme of unscheduled care – ambulatory care, improved timeliness and quality of clinical correspondence, reduced admissions for long-term conditions, improved internal processes and increased admission straight to assessment areas.

Statements of assurance from the board

Care Quality Commission Registration

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. This means that as well as checking individual services, they look at how well the two sectors work together. There are many people who need to use both health and social care services and it is important that their care is as 'joined up' as possible.

The CQC do this by:

Driving improvement across health and social care.

Putting people first and championing their rights.

Acting swiftly to remedy bad practice.

Gathering and using knowledge and expertise, and working.

The CQC registration system for health and adult social care aims to ensure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights.

If the CQC has concerns that a provider is not meeting essential standards of quality and safety, they aim to act quickly, working closely with commissioners and others, and using their enforcement powers.

The 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 Trust during 2014/15.

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

Data Quality

The Trust submitted records during 2014/15 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records relating to admitted patient care which include the patient's valid NHS number

	Admitted Patient Care		Outpatient Care		Accident and Emergency Care	
	Apr 13 - Jan 14	**Apr 14 - Jan 15**	**Apr 13 - Jan 14**	**Apr 14 - Jan 15**	**Apr 13 - Jan 14**	**Apr 14 - Jan 15**
Bolton	99.80%	99.80%	99.90%	99.90%	99.10%	99.20%
National	99.10%	99.20%	99.30%	99.30%	95.70%	95.20%

The percentage of records relating to admitted patient care which include the patient's General Medical Practice Code

	Admitted Patient Care		Outpatient Care		Accident and Emergency Care	
	Apr 13 - Jan 14	**Apr 14 - Jan 15**	**Apr 13 - Jan 14**	**Apr 14 - Jan 15**	**Apr 13 - Jan 14**	**Apr 14 - Jan 15**
Bolton	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
National	99.90%	99.90%	99.90%	99.90%	99.10%	99.20%

Apr 14 - Jan 15 data is taken from the SUS data quality dashboard based on the provisional April 2014 to January 2015 SUS data at month 10 inclusion date

Information Governance

The Trust Information Governance Assessment Report overall score for 2014/15 was 25% and was graded green

Clinical Coding Audit

The Trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

An Internal Audit review of clinical coding gave assurance that "overall the Trust has effective processes and procedures for Clinical Coding of clinical activity…random sampling within the Clinical Coding team suggests that the clinical coding process is well established and operates in a consistent manner." (PwC April 2015)

The Trust will be taking the following actions to improve data quality

When errors are identified in data, they are highlighted and investigated further to determine the reasons for the error and where appropriate further training is provided for staff.

Much of our data is benchmarked nationally using CHKS Methodology. In addition to this we receive assurance on the accuracy of our data quality through an annual report on non-financial data from our internal auditors, a review of metrics included in this report performed as part of the audit conducted by our external auditors and other external audit reports as appropriate.

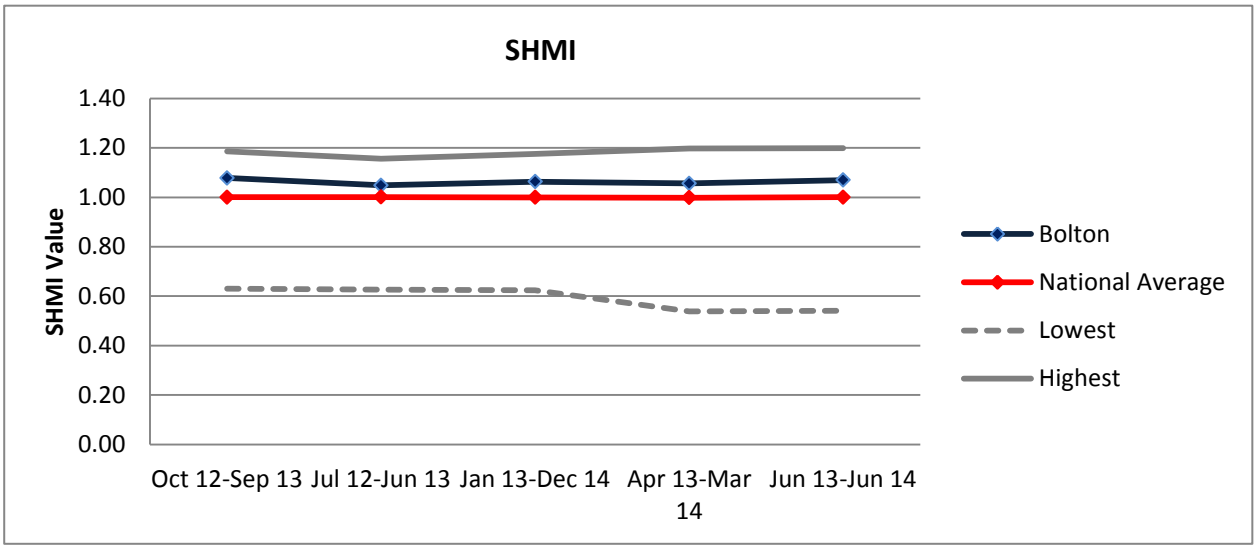
Reporting against core indicators

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 the Health and Social Care Information Centre (HSCIC).

Mortality

The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period

Value	Oct 12-Sep 13	Jul 12-Jun 13	Jan 13-Dec 14	Apr 13-Mar 14	Jun 13-Jun 14
Bolton	1.08	1.05	1.06	1.06	1.07
National Average	1.00	1.00	1.00	1.00	1.00
Lowest	0.63	0.63	0.62	0.54	0.54
Highest	1.19	1.16	1.18	1.20	1.20
Bolton Banding	2	2	2	2	2



We consider that this data is as described for the following reasons:

The data has been obtained from the Health & Social Care Information Centre (HSCIC)

The Trust has planned the following actions to improve this indicator and so the quality of its services, by:

Monthly mortality meeting chaired by the Medical Director

Implementation of level one facilities for monitoring patients within ward areas

Increase intensive care consultants within critical care

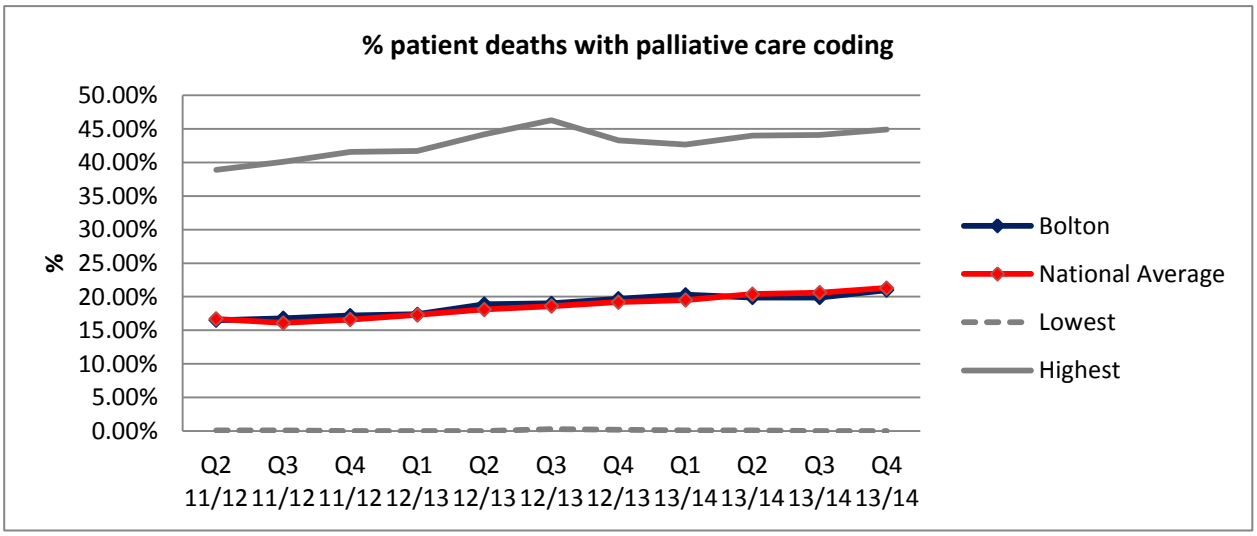
External critical care outreach.

Reporting against core indicators

Palliative care coding

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.

Overall Score	Oct 12-Sep 13	Jan 13-Dec 13	Apr 13-Mar 14	Jul 13-Jun 14
Bolton	20.96%	21.74%	23.94%	24.16%
National Average	21.30%	22.30%	23.90%	24.80%
Lowest	2.70%	1.30%	6.40%	7.40%
Highest	44.90%	46.90%	48.50%	49%



We consider that this data is as described for the following reasons:

The data has been obtained from the Health & Social Care Information Centre (HSCIC)

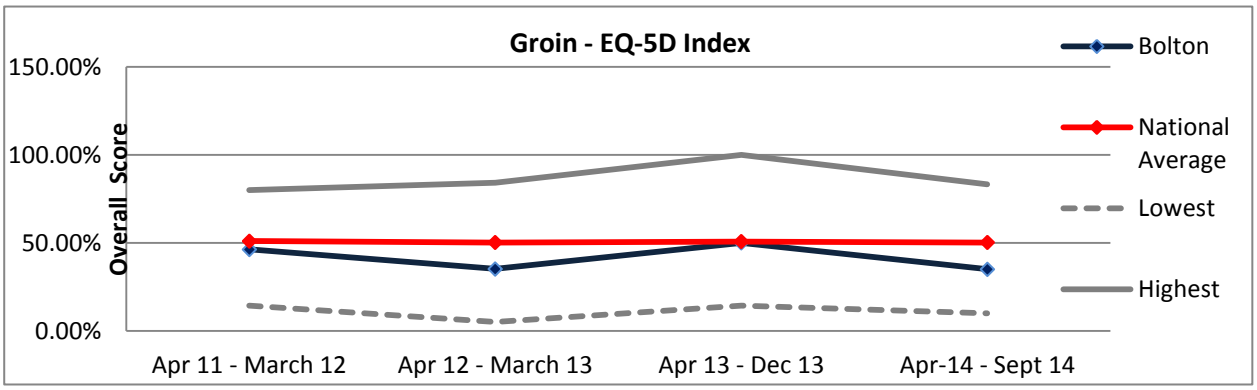
The Trust has taken the following actions to improve this indicator and so the quality of its services, by:

- We continue to audit the quality of our clinically coded data for deceased patients as part of our mortality reviews to ensure it is an accurate reflection of the patient's diagnoses and procedures
- 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
- Quality of clinical coding in relation to deceased patients is discussed, with action being taken to address any queries
- Our mortality review programme, which includes validation of the clinical coding for the patient's spell of care

Patient reported outcome measures

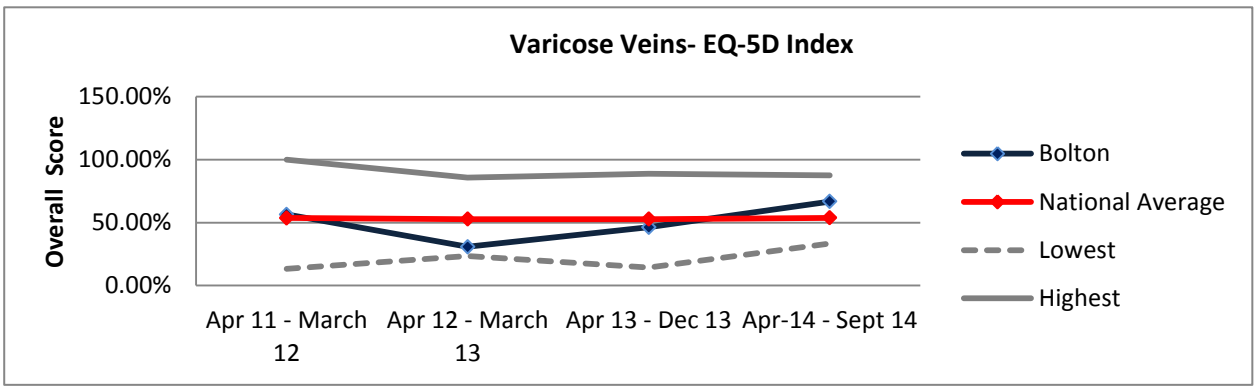
Groin hernia surgery

Overall Score	Apr 11 - March 12	Apr 12 - March 13	Apr 13 - Dec 13	Apr-14 - Sept 14
Bolton	46.30%	35.20%	50.00%	35.00%
National Average	51.00%	50.20%	50.70%	50.20%
Lowest	14.30%	5.00%	14.30%	10.00%
Highest	80.00%	84.20%	100.00%	83.30%



Varicose vein surgery

Overall Score	Apr 11 - March 12	Apr 12 - March 13	Apr 13 - Dec 13	Apr-14 - Sept 14
Bolton	56.40%	30.80%	46.20%	66.70%
National Average	53.60%	52.80%	52.80%	53.80%
Lowest	13.30%	23.50%	14.30%	33.30%
Highest	100.00%	85.70%	88.90%	87.50%



We consider that this data is as described for the following reasons:

The data has been obtained from the Health & Social Care Information Centre (HSCIC)

The Trust has taken the following actions to improve this indicator and so the quality of its services, by:

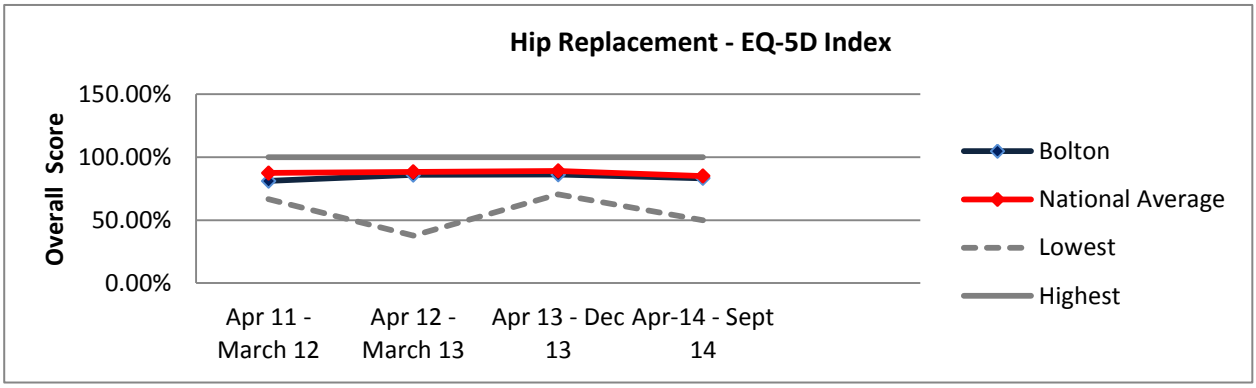
Centralisation of pre-operative services to standardise information received,

Reporting against core indicators

Patient reported outcome measures

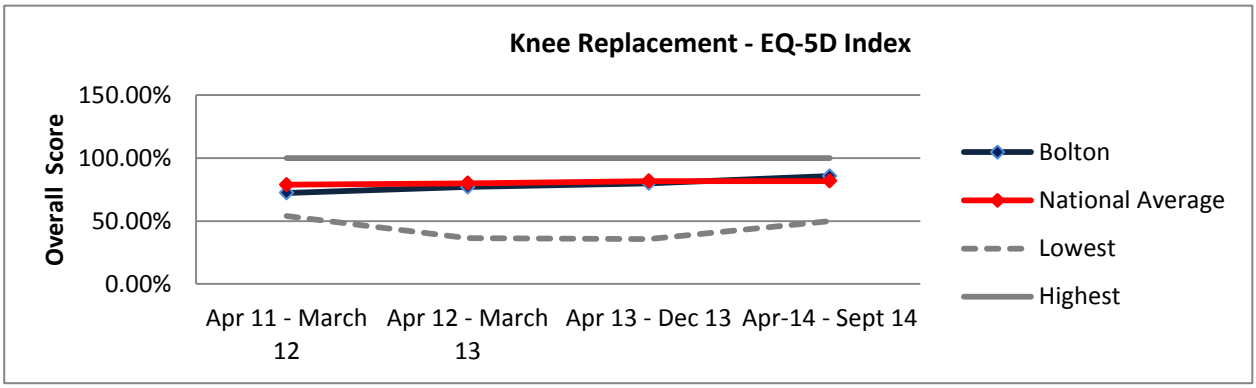
Hip replacement surgery

Overall Score	Apr 11 - March 12	Apr 12 - March 13	Apr 13 - Dec 13	Apr-14 - Sept 14
Bolton	81.10%	85.90%	86.20%	83.30%
National Average	87.50%	88.30%	89.10%	85.00%
Lowest	66.70%	37.60%	70.60%	50.00%
Highest	100.00%	100.00%	100.00%	100.00%



Knee replacement surgery

Overall Score	Apr 11 - March 12	Apr 12 - March 13	Apr 13 - Dec 13	Apr-14 - Sept 14
Bolton	72.30%	77.10%	80.00%	85.70%
National Average	78.80%	80.00%	81.80%	81.80%
Lowest	53.90%	36.40%	35.70%	50.00%
Highest	100.00%	100.00%	100.00%	100.00%



We consider that this data is as described for the following reasons:

The data has been obtained from the Health & Social Care Information Centre (HSCIC)

The Trust has taken the following actions to improve this indicator and so the quality of its services, by:

Work has commenced with the CCG in relation to thresholds for surgery

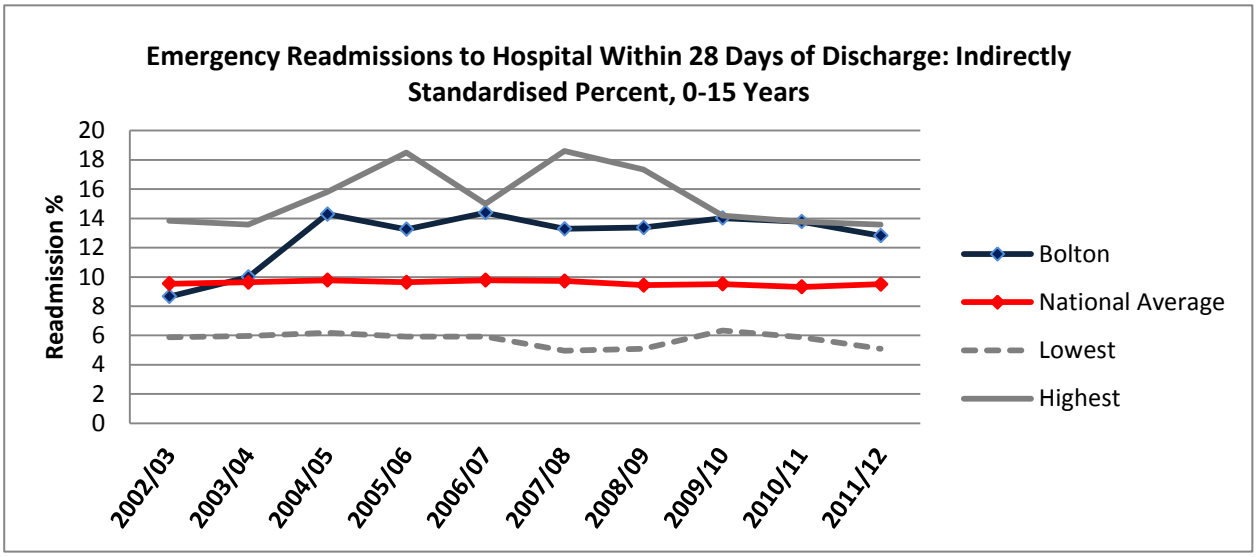
Continue to adhere to implant best practice

Readmissions within 28 days

The percentage of patients readmitted to hospital within 28 days of being discharged during the reporting period.

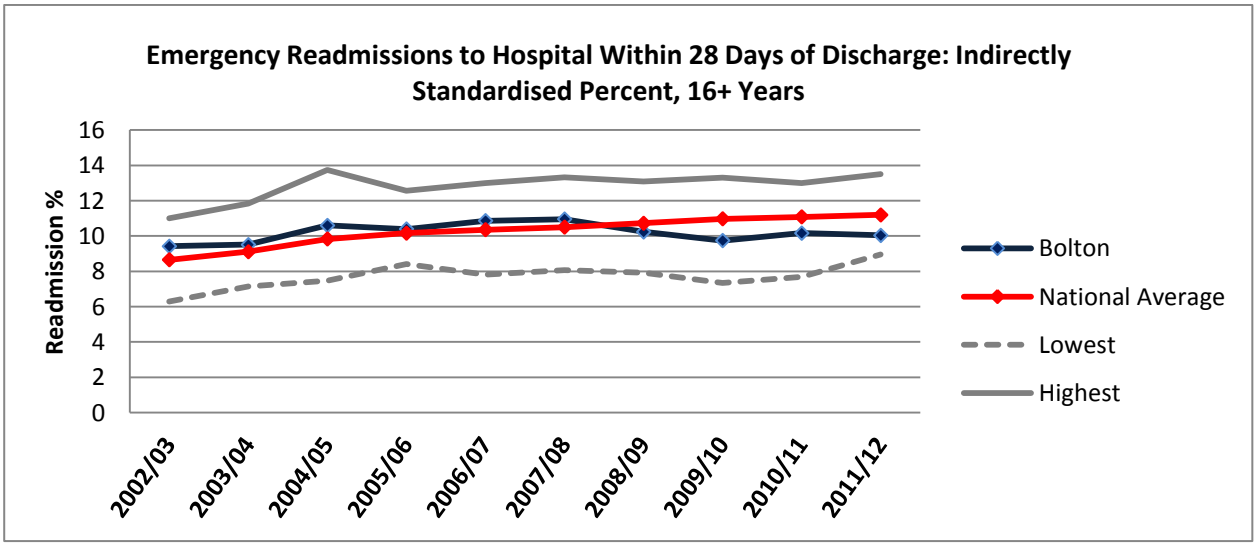
Aged 0 to 15

Readmission	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Bolton	14.29	13.25	14.39	13.29	13.37	14.02	13.78	12.82
National Average	9.78	9.64	9.78	9.72	9.44	9.52	9.32	9.5
Lowest	6.18	5.92	5.93	4.95	5.1	6.33	5.87	5.1
Highest	15.8	18.49	14.99	18.61	17.34	14.2	13.78	13.58



Aged 16 or over

Readmission %	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Bolton	10.6	10.39	10.86	10.95	10.24	9.74	10.17	10.04
National Average	9.83	10.17	10.36	10.5	10.73	10.97	11.08	11.2
Lowest	7.47	8.42	7.82	8.07	7.92	7.34	7.68	8.96
Highest	13.74	12.56	12.99	13.32	13.08	13.3	13	13.5



Reporting against core indicators

We consider that this data is as described for the following reasons:

The data has been obtained from the Health & Social Care Information Centre (HSCIC)

The Trust has taken the following actions to improve this indicator and so the quality of its services, by:

- Established a clinically led readmission group
- Working collaboratively with the CCG to carry out a follow up audit to determine causes
- Further work is on-going around risk stratification of high risk patients with long term conditions.

Readmissions

We recognise that reducing unnecessary readmissions to hospital is better for patients and better for the NHS and that this is a high priority for our commissioners.

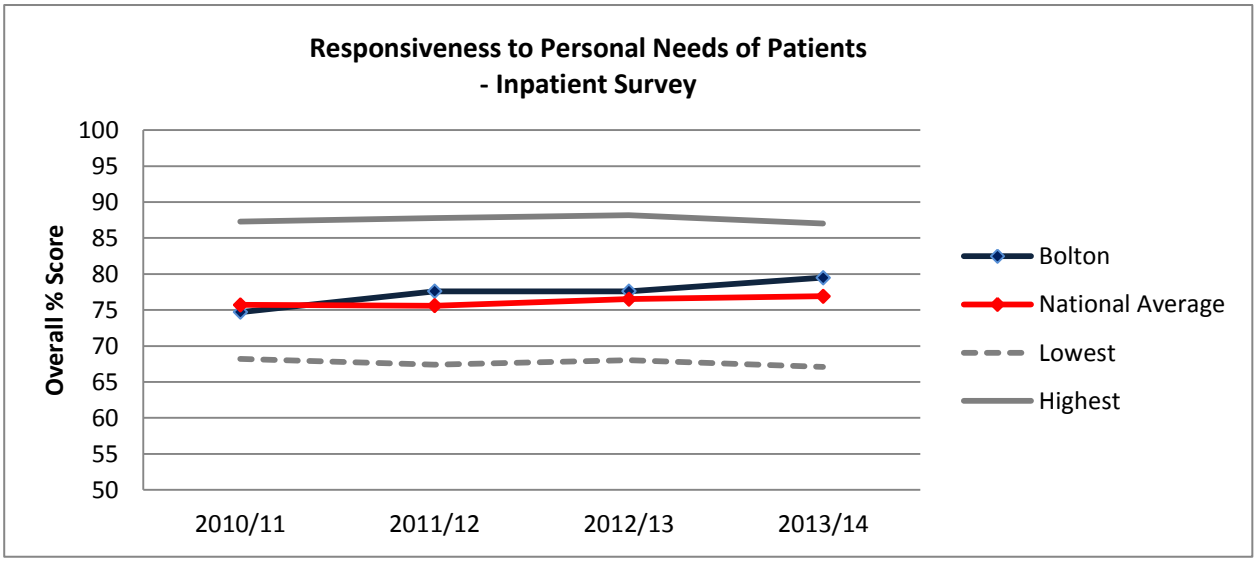
Readmissions occur for a variety of reasons, many have clinical needs which can only be addressed in Hospital or are readmitted within 30 days to a different specialty for an unrelated condition. However some readmissions can be due to poorly planned discharge, lack of awareness of support in primary care or support services in the community or poorly managed patient anxiety, these can be classified as avoidable readmissions.

We will work closely with our commissioners to understand the reasons for these avoidable readmissions and to implement the actions to reduce them.

Responsiveness to patients' personal needs

The Trust's responsiveness to the personal needs of its patients during the reporting period, as reported in the annual inpatient survey

Overall Score	2010/11	2011/12	2012/13	2013/14
Bolton	74.7	77.6	77.6	79.5
National Average	75.7	75.6	76.5	76.9
Lowest	68.2	67.4	68	67.1
Highest	87.3	87.8	88.2	87.0



We consider that this data is as described for the following reasons:

The methodology follows exactly the detailed guidelines determined by the Survey Co-ordination Centre for the overall National Inpatient Survey programme.

We triangulate our staff and patient survey data with that from the CQC in-patient survey, which gives a more accurate method of identifying patient concerns. Data from other surveys including the Friends and Family test can also be used to give a clearer picture of patients' concerns.

The Trust has taken the following actions to improve this indicator and so the quality of its services, by:

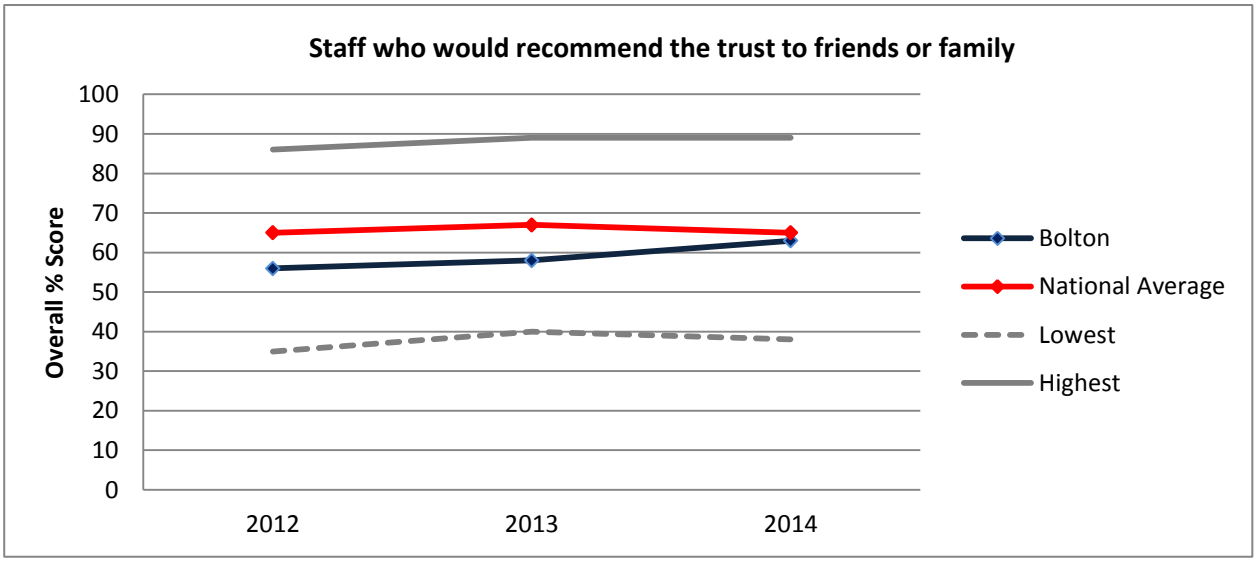
- The development and implementation of the PATIENT, Family and Carer integrated experience strategy.
- Review and refining of the complaints process
- Focus on development of learning logs
- Implementation of the Bedside Booklet
- Analysis of patient stories

Family and friends

Staff

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

Overall Score	2012	2013	2014
Bolton	56	58	63
National Average	65	67	65
Lowest	35	40	38
Highest	86	89	89



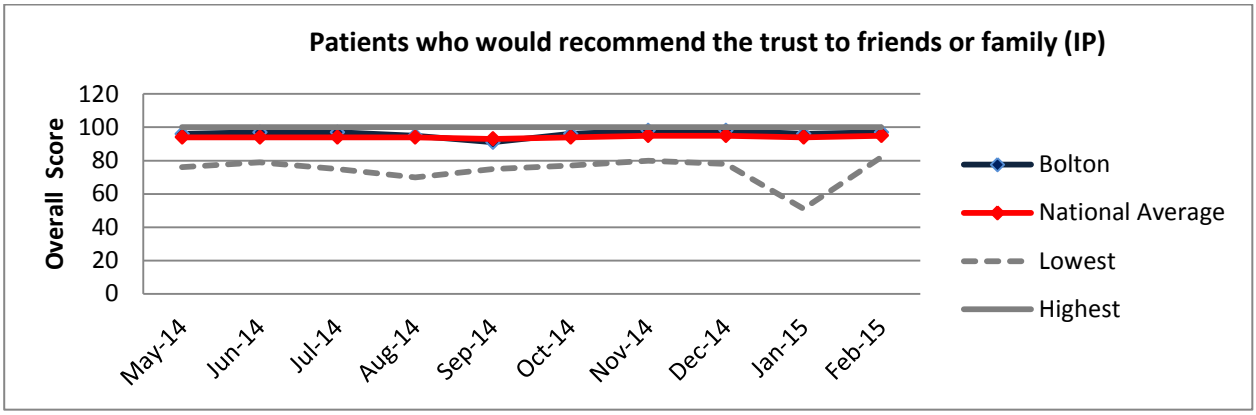
Inpatients

The number of patients who having been inpatients would recommend the Trust to their family and friends. The Friends and Family test was changed to per cent who would recommend in May 2014, therefore prior year comparator figures are not available.

The organisation has continued to improve response rates for FFT and has maintained scores above the national average across the reporting year.

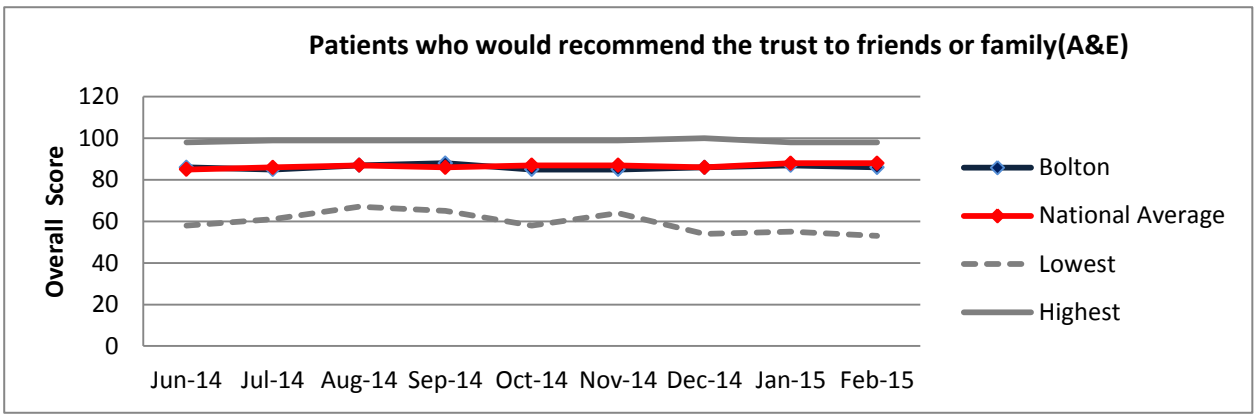
Percentage recommended

Overall Score	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Bolton	96	97	97	95	91	96	98	98	96	97
National Average	94	94	94	94	93	94	95	95	94	95
Lowest	76	79	75	70	75	77	80	78	51	82
Highest	100	100	100	100	100	100	100	100	100	100



Accident and Emergency Friends and Family Test

Overall Score	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Bolton	86	85	87	88	85	85	86	87	86
National Average	85	86	87	86	87	87	86	88	88
Lowest	58	61	67	65	58	64	54	55	53
Highest	98	99	99	99	99	99	100	98	98



We consider that the friends and family data is as described for the following reasons:

The data has been obtained from the Health & Social Care Information Centre (HSCIC)

The Trust has taken the following actions to improve this indicator and so the quality of its services, by:

- Focusing A/E on the data collection process and asking patients the question in a variety of formats including text messaging.
- Communication the process to the public.
- Implementation of the 'you said' 'we did' process for feedback.

Bolton NHS Foundation Trust has adopted a campaign which encourages all staff to build good communications with patients by introducing themselves at the outset. The #hellomynameis national campaign was started by Leeds doctor Kate Granger when, as a terminally ill cancer patient herself, she found that some health staff didn't even say who they were before carrying out checks or procedures on her.

Kate was invited to explain the campaign and officially launch it in Bolton by junior doctors, supported by Trust Chief Executive Jackie Bene. Kate did this at the induction day for new junior doctors at the Royal Bolton Hospital this week.

"It's more than just common courtesy," said Kate. "It's about building connections and the start of a relationship. We introduce ourselves in real life, why not in hospital?"

Bolton junior doctors Rita Prajapati, Caroline Bailey and Megan Steward are particularly keen to improve patient experience.

Rita heard Kate speak at a leadership school. She said: "We were inspired by what Kate had done and wanted her to share her experience with other trainees in the North West."

Dr Bene said health staff were trained in communication, but didn't always remember to use that training.

"It is so important," she said. "All staff need to think about what it's like for the patient."

The Trust will be displaying and using the #hellomynameis logo on every ward and will be explaining it at induction days for all staff.

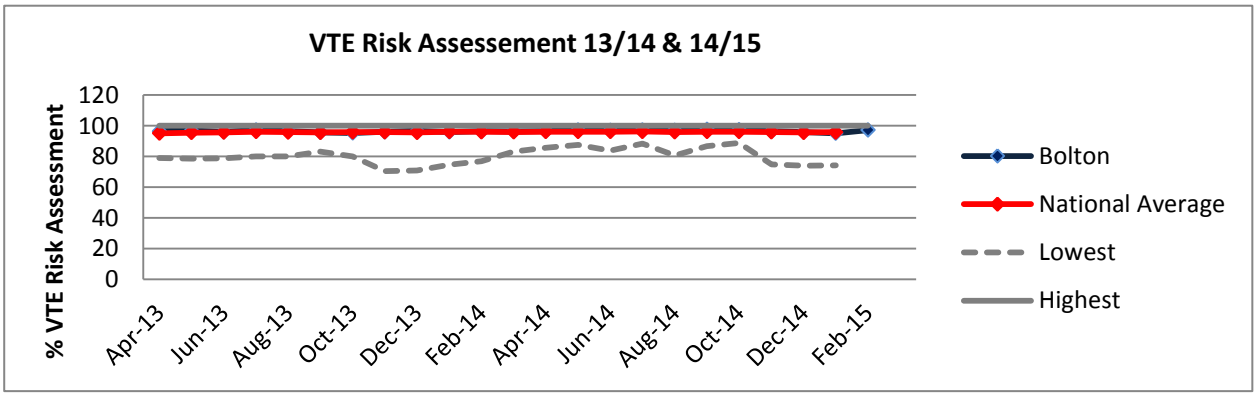
More information about the campaign can be found at www.hellomynameis.org.uk Kate has also built up a following of over 26,000 on Twitter @GrangerKate.

Risk assessment for VTE

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Overall %	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Bolton	96.5	96.9	96	97.2	96.6	95.7	95.3	96	96.7	95.9	96.5	96.4
National Average	95.1	95.5	95.7	96.1	95.8	95.6	95.9	95.9	95.6	96.1	96	95.9
Lowest	79	78.6	78.8	80.1	80.1	83.1	80.1	70.5	70.8	74.6	77	83.2
Highest	100	100	100	100	100	100	100	100	100	100	100	100

Overall %	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Bolton	96.54	97.19	96.97	97.16	97.06	97.67	97.54	96.44	95.9	95.1	97.2	
National Average	96.1	96.1	96.1	96.3	95.9	96.1	96.1	95.9	95.6	95.8		
Lowest	85.7	87.6	83.7	88.4	80.6	86.7	88.9	74.9	74	74.1		
Highest	100	100	100	100	100	100	100	100	100	100	100	



We consider that this data is as described for the following reasons:

The data has been obtained from the Health & Social Care Information Centre (HSCIC)

In 2013/14 we set ourselves the priority of reducing hospital acquired VTE episodes by 10%

	2013 - 2014	2014 - 2015	reduction
Total number of hospital acquired Thrombosis (HAT)	76	70	8%
Number of HAT deemed avoidable	8	4	50%
Percentage of avoidable HAT in relation to total HAT	10.5%	5.7%	45.7%

VTE Exemplar Site

The Royal Bolton Hospital has been named as the first national exemplar site in Greater Manchester for its work in identifying patients at risk of developing potentially deadly blood clots and preventing them from occurring.

Since the hospital's focus on venous thromboembolism (VTE) started in 2010, staff have worked tirelessly so that now 96% of patients have a risk assessment on admission meeting NICE recommendations of 95% or above. In 2010 it was only 24.38%. Those patients who are at high risk of developing a clot are given medication and/or compression stockings.

Consultant Dr Arun Kallat explains: "VTE can happen either in hospital or in the community if someone keeps still for a long period of time – for instance on a long haul plane journey, or lying in a hospital bed. In these circumstances they are more likely to develop a blood clot in their legs and this can travel to their lungs and potentially be fatal.

"We can never prevent all blood clots, but by doing a risk assessment for as many patients as possible and giving drugs or stockings when appropriate, we can reduce the likelihood of clots occurring by around 60%."

In order to tackle the problem Dr Kallat and his colleagues used a variety of methods including the appointment of a nurse champion, a nurse-led DVT (deep vein thrombosis) clinic, support for patients and families, development of a VTE / hospital associated clots database and a highly successful awareness raising campaign amongst staff.

Remarkably, for a non-teaching hospital yet to introduce electronic patient records, Dr Kallat, Beatrice Fox, Nurse Consultant, and Sister Wendy Morrison, DVT Champion Nurse, painstakingly reviewed the clinical records of over 6000 patients one at a time to make the hospital database as accurate as possible. Root cause analyses of patients developing clots in the legs and lungs during their hospital stay or following discharge up to three months are done looking for themes and then sharing the learning with staff.

"We've had our success by changing the culture," added Dr Kallatt. "Patient safety has to be at the top of everyone's priorities."

Bolton is one of 21 sites to be given National Exemplar Status in venous thrombo-embolism (VTE) following a site visit from the VTE Prevention Programme Team NHS England.

Clostridium difficile

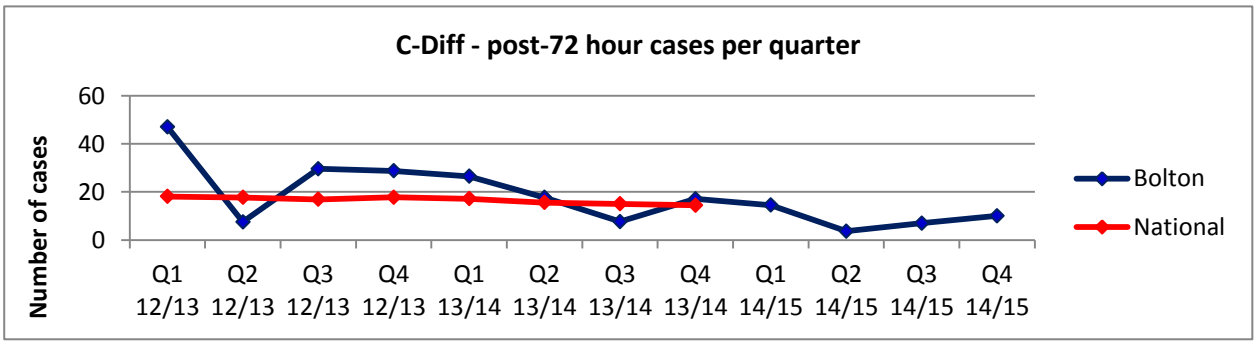
The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged two or over during the reporting period.

Note: Highest and Lowest rates are not available by quarter. National rates unavailable for 2014/15.

	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Bolton	47.04	7.47	29.62	28.79
National	18.07	17.68	16.91	17.76

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
Bolton	26.49	17.67	7.62	17.1
National	17.14	15.6	15.05	14.41

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Bolton	14.49	3.65	6.94	10.04
National				



We consider that this data is as described for the following reasons:

The data has been obtained from the Health Protection Agency (HPA)

The Trust has taken the following actions to improve this indicator and so the quality of its services, by:

Introduction of a deep cleaning programme

Handwashing basins and gel now outside all ward areas

Weekly strategic meetings to discuss all cases

Improved scrutiny of antibiotic management

Investment in estate

Collaborative working across the health economy

Investment in the infection control and prevention team

Clear guidance and policy

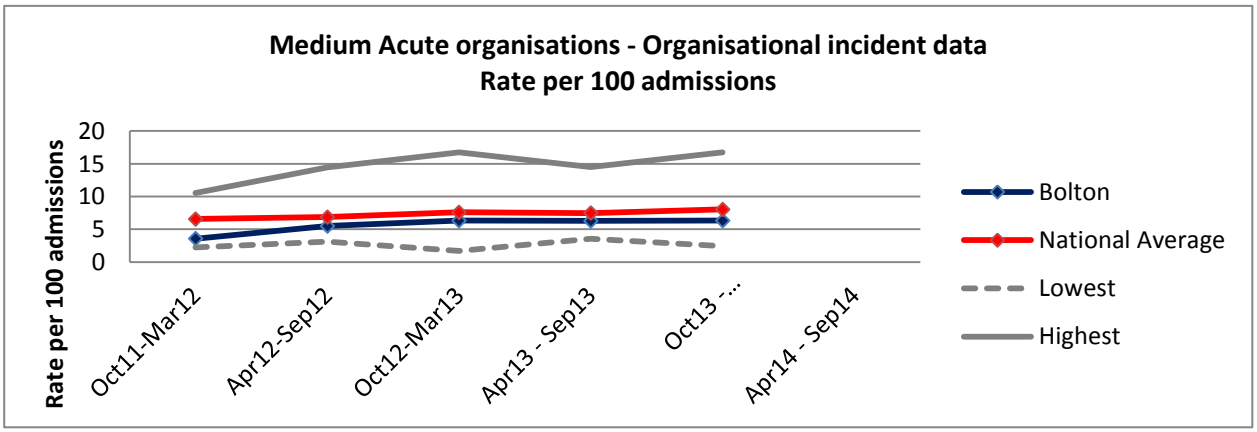
Patient safety incidents

The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Number and rate of Incidents

Number of incidents	Oct11-Mar12	Apr12-Sep12	Oct12-Mar13	Apr13 - Sep13	Oct13 - Mar14	Apr14 - Sep14	Oct14-Dec14
Bolton	1369	2260	2600	2793	4449	5017	5846
National Average	2454	2603	2871	2896	3083		
Lowest	745	843	631	1535	1048		
Highest	4459	4552	5272	4888	5495		

Rate per 100 admissions	Oct11-Mar12	Apr12-Sep12	Oct12-Mar13	Apr13 - Sep13	Oct13 - Mar14	Apr14 - Sep14	Oct14-Mar15
Bolton	4.99	6.63	7.36	8.84	8.85	9.83	10.81
National Average	6.56	6.87	7.59	7.47	8.03		
Lowest	2.21	3.11	1.68	3.54	2.41		
Highest	10.54	14.44	16.73	14.49	16.76		

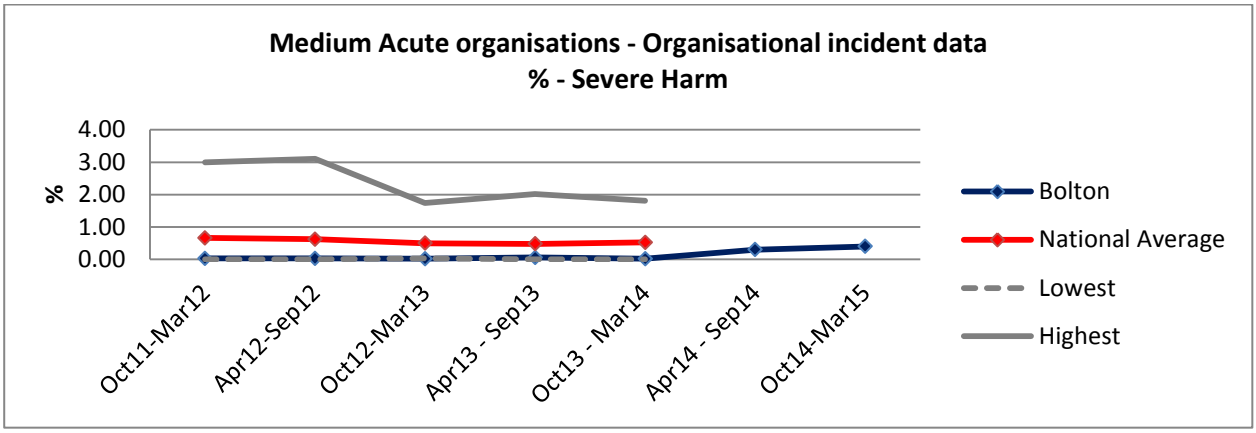


Number and rate of incidents resulting in severe harm

Number of severe harm	Oct11-Mar12	Apr12-Sep12	Oct12-Mar13	Apr13 - Sep13	Oct13 - Mar14	Apr14 - Sep14	Oct14-Mar15
Bolton	13	15	10	24	8	12	32
National Average	15	15	13	14	15		
Lowest	1	0	1	0	0		
Highest	80	61	50	69	50		

% Degree of harm - Severe	Oct11-Mar12	Apr12-Sep12	Oct12-Mar13	Apr13 - Sep13	Oct13 - Mar14	Apr14 - Sep14	Oct14-Mar15
Bolton	0.03	0.03	0.02	0.06	0.02	0.30	0.40
National Average	0.66	0.62	0.5	0.48	0.52		
Lowest	0.00	0.00	0.03	0.00	0.00		
Highest	3.00	3.10	1.74	2.02	1.81		

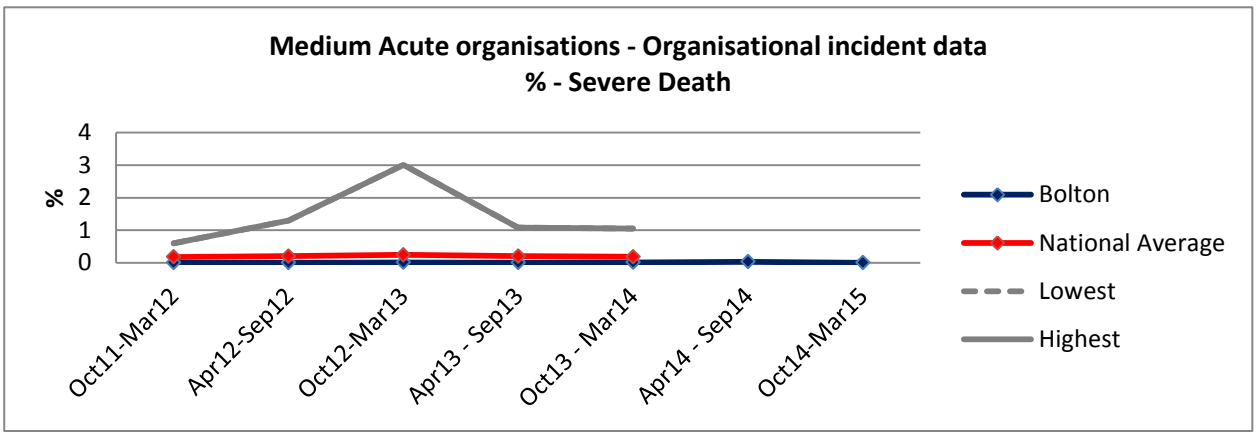
Reporting against core indicators



Number and rate of incidents resulting in death

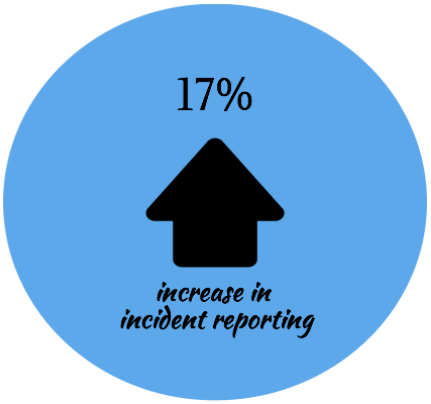
Degree of harm - Death	Oct11-Mar12	Apr12-Sep12	Oct12-Mar13	Apr13 - Sep13	Oct13 - Mar14	Apr14 - Sep14	Oct14-Mar15
Bolton	1	0	3	1	6	3	1
National Average	4	5	5	6	5		
Lowest	0	0	0	0	0		
Highest	14	34	32	37	25		

% Degree of harm - Death	Oct11-Mar12	Apr12-Sep12	Oct12-Mar13	Apr13 - Sep13	Oct13 - Mar14	Apr14 - Sep14	Oct14-Mar15
Bolton	0	0	0.01	0	0.01	0.03	0.00
National Average	0.18	0.2	0.24	0.2	0.18		
Lowest	0	0	0	0	0.00		
Highest	0.6	1.3	3.01	1.08	1.05		



We consider that this data is as described for the following reasons:

The data has been obtained from the National Patient Safety Agency (NPSA)



The Trust has taken the following actions to improve this indicator and so the quality of its services, by:

- Introduction of new risk management strategy
- Risk management training for clinical risk managers
- New risk management committee established
- Introduction of "harms" meeting to review incidents and ensure appropriate actions are taken
- External training programme for managers to undertake RCA training
- Review of the current electronic incident reporting system to ensure investigation conclusion can be logged

How we performed on Quality and performance in 2014/15

In our Quality Report for 2013/14 we set ourselves a series of key priorities for improvement.

Where these priorities are discussed elsewhere in the report we will refer to that data to avoid repetition.

Safety		
Indicator	**Measure**	**Page**
Mortality	• Preventing people from dying prematurely. ○ Reduce SHIMI to less than 1.0 ○ Reduce crude mortality by 10%	58, 79
Infection Control	• 50% reduction in avoidable cases of C.Diff.	59, 91
Harm Free Care	• Zero tolerance of category 3 and 4 pressure Ulcers	96
	• 5% reduction in pressure ulcers categorised as avoidable	96
	• 10% reduction in hospital acquired VTE episodes	89
	• 5% reduction in falls with severe harm	60
Medicines Management	• 95% harm free reported through the medicines safety thermometer	62
Patient Experience		
Friends and Family Test	• Expansion of the areas utilising the FFT questions • 5% increase in response rates	86
Real Time Patient Experience	• Implementation of 'real time;' data collection processes.	97
Lessons Learnt	• Evidence of lessons learnt being reported throughout the divisions and corporate structures.	99
Dementia	• 95% compliance with the Dementia Care bundle	100
Effectiveness		
Sickness Management	• reduction in overall sickness rates to 3.75%	63
Appraisal	• 80% completion of appraisal information	101
Mandatory Training	• 100% of available staff have completed MT	101

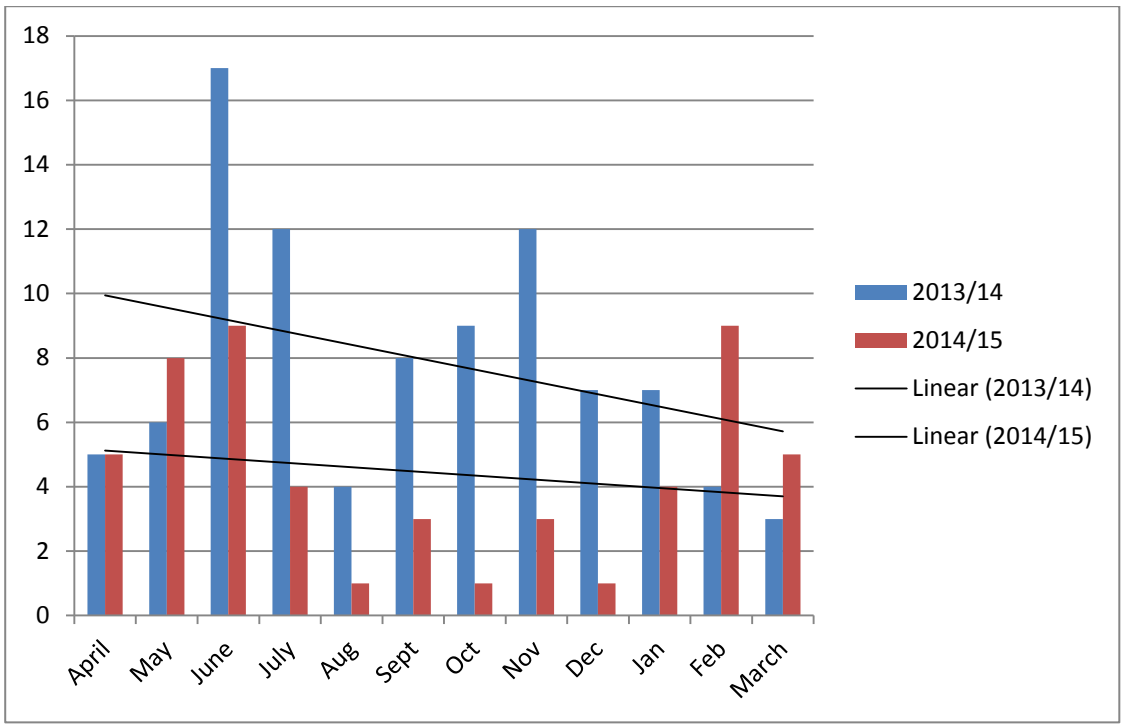
Performance in 2014/15

Reduction in Pressure Ulcers

Zero Tolerance of Category 3 and 4 pressure Ulcers

5% reduction in pressure ulcers categorised as avoidable.

Overall, there have been 123 pressure ulcers in 2014/15 compared to 228 in the previous year, a reduction of 46%.



Hospital Acquired

We have continued to see Category 3 and 4 pressure ulcers in 2014/15; however we have seen a considerable percentage reduction in these categories.

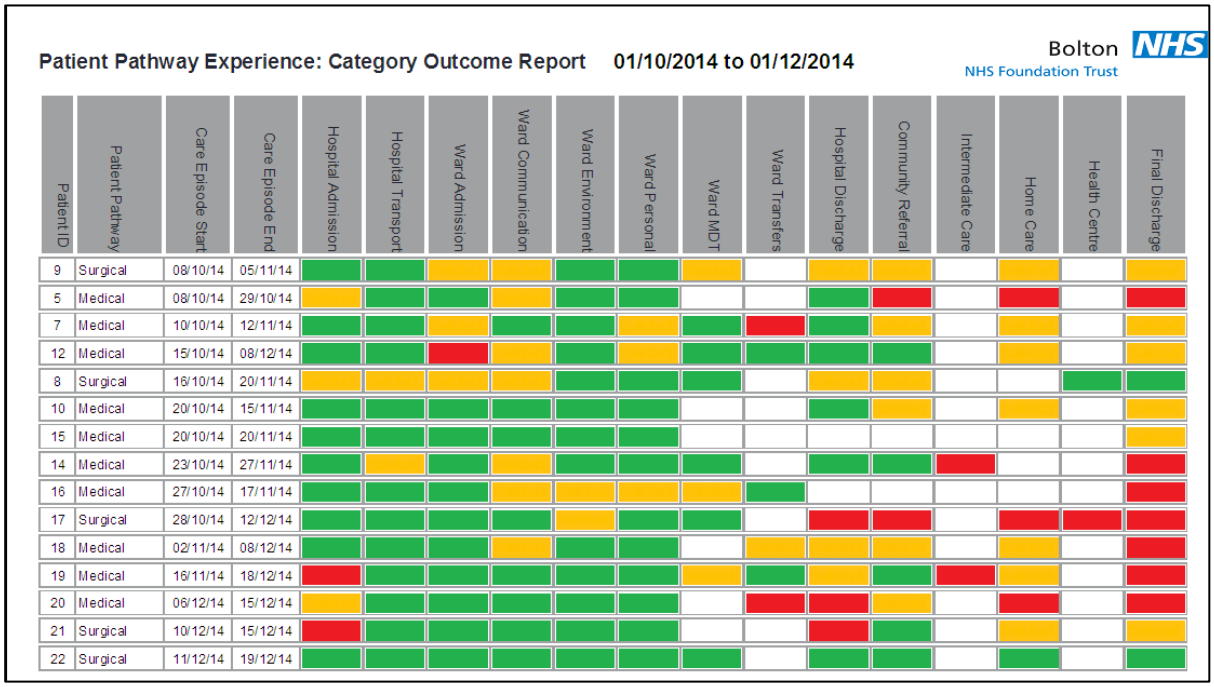
Grade	**2013/14**	**2014/15**	**Percentage Reduction**
Grade 2	60	33	45%
Grade 3	29	19	35%
Grade 4	5	1	80%

Community Acquired

Grade	**2013/14**	**2014/15**	**Percentage Reduction**
Grade 2	102	51	50%
Grade 3	20	15	25%
Grade 4	12	9	25%

Monitoring Real Time Patient Experience

The Meridian Real time patient experience module is currently being rolled out across the Hospital and Community. We have undertaken work this year to collate patients' stories to inform this work across the wards and departments. Themes form this work have fed into the patient experience strategy work plan.



Patient Pathway Experience: Category Outcome Report 01/10/2014 to 01/12/2014

Bolton NHS Foundation Trust

Patient ID	Patient Pathway	Care Episode Start	Care Episode End	Hospital Admission	Hospital Transport	Ward Admission	Ward Communication	Ward Environment	Ward Personal	Ward MDT	Ward Transfers	Hospital Discharge	Community Referral	Intermediate Care	Home Care	Health Centre	Final Discharge
9	Surgical	08/10/14	05/11/14														
5	Medical	08/10/14	29/10/14														
7	Medical	10/10/14	12/11/14														
12	Medical	15/10/14	08/12/14														
8	Surgical	16/10/14	20/11/14														
10	Medical	20/10/14	15/11/14														
15	Medical	20/10/14	20/11/14														
14	Medical	23/10/14	27/11/14														
16	Medical	27/10/14	17/11/14														
17	Surgical	28/10/14	12/12/14														
18	Medical	02/11/14	08/12/14														
19	Medical	16/11/14	18/12/14														
20	Medical	06/12/14	15/12/14														
21	Surgical	10/12/14	15/12/14														
22	Surgical	11/12/14	19/12/14														

These themes related to the pathway relating to discharge. The focus for meridian in 2015/16 will be to develop a suite of measures to generate further understanding of this process and what learning can be achieved.

Patient Stories summary

At the start of each Board meeting the Board hear first-hand from a patient or carer who has experienced care from the Trust either within the hospital or within their own home or community setting. The Board does not have prior knowledge of the story and every effort is made to ensure that over the course of the year a wide range of views are heard from a broad sample of the services we provide.

Where issues are identified in the experiences related by the patient an action plan is developed which is overseen by the Quality Assurance Committee.

Stories in 2014/15 have included some very positive experiences but have also raised some issues which the Board have taken extremely seriously and are addressing.

Excerpts from the minutes recording some of these stories are included on the following page:

Patient Stories

April 2014

R attended to provide her story of the support provided by the family nurse partnership who provided one to one support to help her through her pregnancy and in the first two years of her baby's life.

R had no negative feedback for any of the health services she had received although on reflection identified that additional support to explain scans and investigations could have helped.

The family nurse partnership team were also in attendance to provide an overview of the evidence based support provided for young mothers in Rachel's position to improve outcomes through observation and interaction with the mother and baby.

September 2014

D first became ill in 2013 and was admitted to hospital for investigations for gastrointestinal problems. The following points were made regarding D's experience and treatment:

D found that on the whole staff were supportive and calming however she did not always understand what the doctors and nurses were telling her - simpler instructions and explanations avoiding the use of jargon and medical terminology would have helped

Ward rounds when there were several members of a team around the bed made D feel uncomfortable - it would have helped if there had been fewer people on these rounds.

December 2014

Mr and Mrs A attended with their baby F to tell their story of F's premature birth and subsequent stay on the neonatal unit.

F was delivered at 23 weeks weighing 523g and after five months on the neonatal unit was discharged to home where he continues to make good progress.

Mr and Mrs A asked for their thanks to all staff involved in F's care to be recorded and passed to the unit. They felt that throughout F's treatment they had been kept well informed and had been well supported through a stressful period.

March 2015

AN attended the Board to relate his experiences of an episode of care which included a wait of over seven hours in the Accident and Emergency Department. AN presented at A&E in the early hours of a Sunday morning with severe abdominal pain and query appendicitis. A decision was made by the doctors in A&E to admit for surgery, he then had a wait of seven hours before being transferred to a ward where he waited for a further seven hours before surgery.

Surgery was successful and he was discharged home the following day.

AN advised that although he did not sleep well while waiting he felt well cared for with regular checks and offers of pain relief to ensure he was not in any discomfort during this time.

AN is now fully recovered and back at work following surgery.

Lessons Learnt

In our 2013/14 report we agreed that one of our key priorities would be to ensure we learn through listening to patient feedback and through our response to incidents.

We agreed to use every opportunity to learn from incidents, complaints and litigation by reflecting on our practice and where necessary changing systems of work to ensure that patients are safe in our care and that repetition of avoidable harm is prevented.

The Serious Incident procedures have continued to evolve to ensure appropriate dissemination of change and learning, and work is now focusing on learning from litigation and complaints.

In responding to these events we have recognised the implication and responsibilities inherent in our duty of candour.

We have also taken every opportunity to learn from national benchmarking including national audit publications such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

Patient Safety Walkrounds have provided valuable opportunities for senior leaders to discuss safety issues with frontline staff. The feedback from these walkrounds has been shared through the Assurance Committees.

Never Events

Unfortunately, in 2014/15 we were responsible for five patients in our care experiencing never events. These were all in relation to surgery although each involved a different theatre and different surgeon/team.

Our five Never Events for 2014/15 are as follows:

- One wrong size lens implanted – Ophthalmology
- One wrong facial skin lesion excised – Plastic Surgery
- One wrong hip replacement component implanted – Trauma & Orthopaedics
- One retained vaginal swab – Obstetrics
- One wrong tooth extracted – Dental Surgery.

We take these very seriously; investigations have been undertaken/initiated for each incident. The Royal College of Surgeons has been contacted with a view to commissioning a review of theatre services; this will be supported by additional internal audit resource from PwC.

We aim to further develop and share our learning from multiple sources, including, but not limited to, patient feedback, inspections and our response to incidents. Where appropriate we will request additional external advice to provide additional assurance.

Dementia 95% Compliance with Dementia care bundle (screening)

We reached our end of year target regarding the Dementia Screening process against the Find, Assess, Investigate and Refer (FAIR) access for dementia care bundle. The end of year percentage is 98.1%.

	Target	Apr	May	Jun	Jul	Aug	Se	Oct	Nov	Dec	Jan-	Feb	Mar	Year
Dementia screening	90%	98.5	91.0	94.3	98.6	94.1	100.0	96.9	92.7	99.7	94.4	93.0	95.3	96.4
Dementia risk assessment	90%	100	100	100	100	100	100	100	100	100	100	100	100	100
Dementia referral	90%	93.8	88.0	100.	100.	100.	100	100	100	100	100	100	100.	99.5
Dementia – FAIR	90%	97.4	93.0	98.1	99.5	98.0	100.0	99.0	97.6	99.9	98.1	97.7	98.4	98.1

The Dementia Steering group has been re-launched, and the action plan developed against the National Dementia Strategy has been revised. We have had some success with interventions to support Dementia patients on the ward areas:

- Working in partnership with Care UK to implement nutrition volunteers.
- Purchase of the 'My Life' dementia software for all complex care wards including community Intermediate Care services.
- Continued assessment of the experience of carers of people with dementia. However we have not achieved our target of 10% improvement in the carer experience – and this work remains a priority for the Steering group for 2015/16.

In 2015/16 a continued focus will be placed on Dementia with the appointment of a Dementia Nurse Specialist to work across the hospital and Community services to raise the profile of Dementia care.

In 2015/16, we are planning to focus our charitable fundraising on raising additional funds to provide further enhancements to the environment to support our patients with dementia.

Staff Appraisal and Mandatory Training

	13/14	14/15
Staff Appraisal	82.4%	79.1%
Mandatory Training	83.9%	89.8%

Mandatory Training

Throughout 2014/15 the Organisational Development Team have continued to refine and embed the e-learning training for staff which has significantly reduced the amount of time spent on classroom based attendance for annual mandatory training updates. This approach has enabled us to improve on previous performance and although we have not reached our ambitious target of 100% we have made significant improvements.

We continue to offer a blended approach to delivery (where appropriate), with additional classroom based sessions offered to support elements of the mandatory training programme where face-to-face delivery of peer group interaction or the demonstration of physical skills i.e. moving and handling techniques is essential to further embed learning and increase understanding.

This approach has also allowed us to further develop the training within our Education & Training prospectus so that we can pro-actively support service development priorities.

We continue to work closely with universities and higher education institutions to ensure that our staff have access to undergraduate and postgraduate programmes of study that enhance their skills, knowledge and competence whilst keeping them abreast of advances in patient care and as a result, improving the quality of their patients' experience.

Staff Appraisal

A growing body of evidence shows that, as one would expect, there is a direct link between a satisfied and engaged workforce and the quality of care patients receive.

An appraisal provides both an individual and his/her supervisor with the opportunity to reflect on how well the individual has met agreed targets and objectives over the past year, to identify any training needs and areas for personal development and to review any issues or concerns that the staff member or supervisor may have.

We set ourselves the target of ensuring that at least 80% of our staff receive an appraisal; unfortunately we have narrowly missed this target. We will continue to monitor the completion of appraisals and will take action to ensure we achieve this target in 2015/16.

Performance in 2014/15

Medical Education

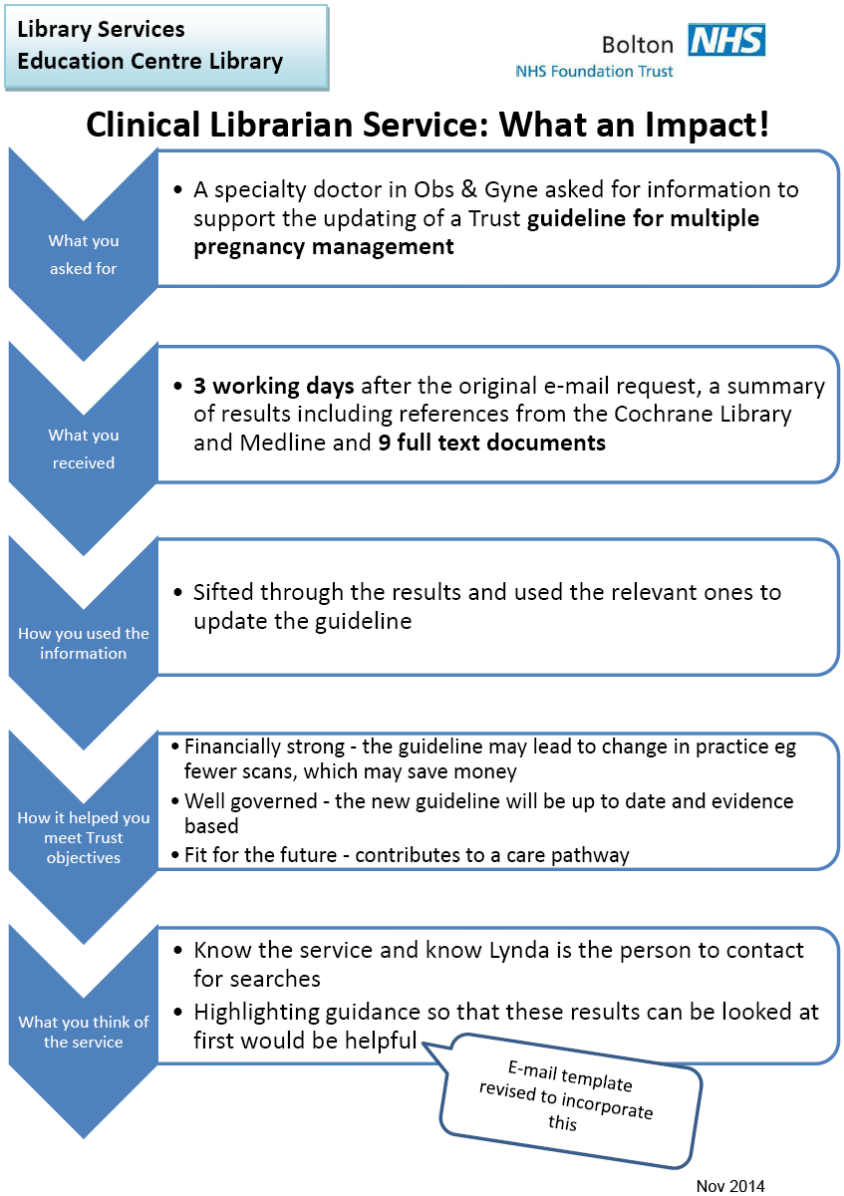
Royal Bolton Hospital has maintained the reputation as a centre for excellence in medical education.

During the last 12 months RBH has been Lead Education provider for 78 Foundation doctors in their first two years of training and 157 higher trainees across all specialties. Also we have been host to 166 Manchester medical students, receiving teaching and training in medicine, surgery, obstetrics, gynaecology, paediatrics, ophthalmology to name but a few.

For postgraduate education quality has been assured by a favourable Health Education visit report and GMC survey results. A recent Manchester Medical School quality assurance assessment has shown Bolton to be delivering a high quality of training and also to be very popular with medical students; it was commented that Bolton is well ahead when compared to other similar providers.

Something which the medical education team are particularly proud of is the investment by the Trust in refurbishment of the medical student accommodation, which is now of a high standard.

Looking to the future the medical education team have recently expanded by the appointment of a Simulation Lead.



Performance against the Monitor Risk Assessment Framework

Indicator	Apr 13 to Mar 14	Target		Apr 14 to Mar 15	Target	
Referral to Waiting Times - Admitted	94.80%	90%	✓	93.30%	90%	✓
Referral to Waiting Times - Non Admitted	96.60%	95%	✓	97.10%	95%	✓
Referral to Waiting Times - incomplete	96.30%	92%	✓	93.30%	92%	✓
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	96.50%	95%	✓	92.40%	95%	✗
Maximum waiting time of 62 days from urgent referral to treatment for all cancers - from urgent GP referral to treatment	86.70%	85%	✓	90.8%	85%	✓
Maximum waiting time of 62 days from urgent referral to treatment for all cancers - from consultant screening service referral	93.00%	90%	✓	96.8%	90%	✓
Maximum waiting time of 31 days from diagnosis to treatment of all cancers - surgery	99.30%	94%	✓	100.0%	94%	✓
Maximum waiting time of 31 days from diagnosis to treatment of all cancers – anti cancer drug treatments	100.00%	98%	✓	100.0%	98%	✓
All cancers 31-day wait from diagnosis to first treatment	99.00%	96%	✓	98.2%	96%	✓
Cancer: two week wait from referral to first seen, all cancers	94.90%	93%	✓	97.5%	93%	✓
Cancer: two week wait from referral to first seen, symptomatic breast patients (cancer not initially suspected)	96.20%	93%	✓	94.7%	93%	✓
Clostridium difficile - meeting the C. difficile objective	38	28	✗	20	48	✓
Certification against compliance with requirements regarding access to health care for people with a learning disability	100%	100%	✓	100%	100%	✓
Data completeness community service referral to treatment	99%	50%	✓	99.3%	50%	✓
Data completeness community services - referral information	100%	50%	✓	100%	50%	✓
Data completeness: community services - treatment activity information	100%	50%	✓	100%	50%	✓

Foundation Trust Governors

As Foundation Trust Governors we have worked closely with the Directors of the Trust and will continue to do so during 2015/16. We are hoping that in 2015/16 we will be able to further develop our working relationship. In particular are looking to increase the contact we have with the Non-Executives of the Trust to ensure we fulfil our statutory duty to hold them individually and collectively to account for the performance of the Trust.

We welcome the publication of the Quality Report and congratulate the Trust on the results achieved particularly with regard to the reduction in the number of cases of C difficile and the implementation of the policies to reduce harm from pressure ulcers and falls, which are starting to show results.

In the second half of the year we expressed our concern with regard to a deterioration in performance against the A&E target, we have been made aware of the challenges in achieving this target and the actions taken and are hopeful that the required improvements will be made.

We welcomed the proposal to invite votes from our Foundation Trust members in selecting the five priorities for focus in 2015/16 and we look forward to receiving regular updates on the steps taken to achieve these goals.

We are also keen to ensure that the Trust plays a full part with Bolton CCG and Bolton Council Health and Wellbeing Board to increase integrated care to the people of Bolton.

We have been assured that although savings have been made this has not been at the expense of quality.

We hope that the same effort and determination will continue in 2015/16 and look forward to continuing to support, in our role as critical friend, the Trust in the coming year.

Bolton NHS FT Council of Governors

May 2015

Feedback from NHS Bolton Clinical Commissioning Group (CCG)

NHS Bolton CCG welcomes the opportunity to comment on Bolton FT's 2014/15 Quality Account.

We have been working closely with the Trust to seek assurance on the delivery of safe, effective, and personalised services and we note that the content of the Quality Account is consistent with information provided throughout the year. However, performance of the services commissioned by NHS England, and not the CCG, are not referenced within the report e.g. screening services.

We are pleased to see the launch of their Quality Strategy and their commitment to the Sign up to Safety national campaign. We hope in 2015/16 the Trust's Quality Improvement Team become increasingly visible and there are opportunities to work together to improve the quality of care throughout the health economy.

Successful partnership working is key moving forwards and this is exemplified by the FT sharing our strategic aim of reducing hospital admissions and working towards home based care. We welcome the examples of this strategy in action throughout the report.

There has been a significant increase in the awareness of incident reporting within the Trust which in turn creates opportunities to learn in a supportive safety culture. It is hoped that this work results in a reduction in harm.

We do however note with concern the number of surgical Never Events that have occurred in the last year and we expect to see significant improvement in this area. We acknowledge the implementation of a number of initiatives resulting from investigations carried out already and await the review by the Royal College of Surgeons. We look forward to seeking further assurance when we visit the Theatres in the coming months.

In recognising the importance of supporting staff at work we hope to see a focus on improving staff well-being holistically and not solely on an aim to reduce staff sickness.

We note the positive impact harm free care has on patient outcomes and we are pleased to see the direction of travel in reducing the number of falls resulting in severe harm. We would however like to see greater ambition with regard to reducing harm from preventable falls.

We commend the on-going contribution to national audits and would like to see the learning that results from these in a similar way to which the local audits evidence changes in practice.

We have welcomed the opportunity presented by the FT to be members of their Quality Assurance Committee, Mortality Reduction Group, and Patient Inclusion and Experience Group. This level of transparency and collaboration has been productive for the health economy, as has the Trust's expert contribution to the health economy Infection Prevention and Control Committee hosted by the CCG.

The work on VTE is most commendable and the progress made towards National Exemplar status demonstrates the huge potential within the organisation. It is encouraging to see other examples within the Account and we hope to see further examples of innovation and achievement in the coming year.

The patient voice is vital for service development and we are pleased to see the implementation of the Meridian Real Time Patient Experience module within the Trust. We look forward in 15/16 to seeing a continued and sustained emphasis on co-production along with a greater emphasis on equality and diversity from the Trust, as both an employer and provider of care within our diverse community.

In summary the Account demonstrates the Trust's overall commitment towards providing Quality services and also acknowledges the need for continuous quality improvement, outlining these priority areas accordingly. We fully understand the challenges that lay ahead for the whole health economy but we firmly believe that in creating an open, transparent and collaborative partnership with the FT, and always focusing on what is best for the patient, we will overcome these challenges together.

Dr Colin Mercer

Clinical Director for Governance and Safety Bolton CCG

Michael Robinson

Associate Director for Integrated Governance and Policy Bolton CCG

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor 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 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 2014/15 and supporting guidance;

the content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2014 to April 2015
- papers relating to Quality reported to the Board over the period April 2014 to April 2015
- feedback from the commissioners dated
- feedback from governors
- feedback from local HealthWatch
- feedback from local Health Overview and Scrutiny Committee.
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, May 2015
- the 2014 national patient survey
- the 2014 national staff survey
- the Head of Internal Audit's annual opinion over the Trust's control environment
- Care Quality Commission intelligent monitoring report dated March 2015.

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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

David Wakefield

28th May 2015