Bolton NHS Foundation Trust

Bolton One

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Bolton One is a multi-purpose health and leisure centre located in the town centre of Bolton, which is part of Bolton NHS Foundation Trust.

A range of outpatient and diagnostic imaging services are provided from Bolton One including general outpatients, children's outpatients, rheumatology, biomechanics, physiotherapy, occupational therapy, podiatry, pre-operative assessment, breast screening, plain film x-ray and obstetric ultrasound. There is also a hydrotherapy pool.

We visited Bolton One on Wednesday 23rd March 2016 as part of the comprehensive inspection of Bolton NHS Foundation Trust.

Overall we rated Bolton One as 'Good' across the areas of safe, caring, responsive and well-led. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging and as a result, we haven't rated the effective domain for this location.

There were areas at Bolton One where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that paper records are stored securely.
- Ensure that appropriately skilled staff are in place to provide a biological therapy treatment service.

In addition the trust should:

- The trust should ensure that letters are provided to GPs in a timely way.
- The trust should ensure that patients are kept informed about any delays in outpatient and diagnostic imaging services and should monitor how long patients wait to be seen.
- The trust should ensure that the recovery plan for breast screening is completed within agreed timeframes.
- The trust should consider participating in the Imaging Services Accreditation Scheme (ISAS) and the Improving Quality in Physiological Services (IQIPS) accreditation scheme.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Outpatients and diagnostic imaging	Good 	• Outpatients and diagnostic imaging services were rated as good overall. Staff were encouraged to report incidents and lessons were learnt and shared. Infection control practices were good and audits were completed. Nursing, medical and allied health professional staffing was good with few vacancies. Procedures in relation to safeguarding adults and children were in place and understood and training rates were high. Improvements were needed in the way records were stored securely and records were not always available at the time of the patient appointment. • Services followed national and local guidelines based on evidence based practice. Local audits were completed to monitor performance against local guidelines and patient outcomes. Appraisal rates were high and staff were supported to develop extended knowledge and skills. • Care was good delivered to patients by caring, kind and compassionate staff. Patients were treated with dignity and respect. High numbers of patients would recommend outpatient and diagnostic imaging services to their friends and family. • The service was responsive to people's needs. Services had been planned to meet the needs of local people. Patients were given a choice about where they went for their appointment in some specialities and services had been developed to allow direct referral from GPs. Diagnostic waiting times had been consistently better than the England average between January 2014 and November 2015. Overall, the 95% 18-week target for non-admitted patients was met each month between April 2015 and December 2015. However the breast screening service was not meeting targets in relation to the recall of women for mammography. National targets had been extended locally to allow a recovery plan. Patients individual needs were understood and considered when delivering care and treatment. Adjustments were made to remove barriers to people accessing services.

Summary of findings

- Outpatients and diagnostic imaging services were well-led locally because governance systems were in place to support the delivery of high quality care. Risks were understood and managed to reduce any impact upon the quality of service deliver. Risk registers were reviewed and updated regularly although we saw there were not adequate plans in place to ensure that the rheumatology team had appropriately trained permanent members of staff to deliver the biologic therapy service.

Bolton One

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Detailed findings

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Background to Bolton One

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A range of outpatient and diagnostic imaging services are provided from Bolton One including general outpatients, children's outpatients, rheumatology, biomechanics, physiotherapy, occupational therapy, podiatry, pre-operative assessment, breast screening, plain film x-ray and obstetric ultrasound. There is also a hydrotherapy pool.

Our inspection team

Our inspection team was led by:

Chair: Paula Head

Head of Hospital Inspections : Ann Ford, Care Quality Commission

The team included two inspection managers, a CQC inspector, an outpatients nurse and a medical doctor.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We visited Bolton One on Wednesday 23rd March 2016 as part of the comprehensive inspection of Bolton NHS Foundation Trust.

Before visiting Bolton One, we reviewed a range of information we held about Bolton NHS Foundation Trust and asked other organisations to share what they knew. These included, Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held a listening event for people who had experienced care at Bolton NHS Foundation Trust on the

Detailed findings

15 and 17 March 2016 in The Royal Bolton Hospital and Bolton One. The event was designed to take into account people's views about care and treatment received at the hospital and community services. Some people also shared their experiences by email and telephone.

The inspection team inspected the following core services at Bolton One

- Outpatients and Diagnostic Imaging

As part of the inspection, we spoke with staff individually as requested. We talked with patients and staff from all outpatients areas. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment the trust.

Facts and data about Bolton One

Bolton One is a multi-purpose health and leisure centre located in the town centre of Bolton. A range of outpatient and diagnostic imaging services are provided from Bolton One including general outpatients, children's outpatients, rheumatology, biomechanics, physiotherapy, occupational therapy, podiatry, pre-operative assessment, breast screening, plain film x-ray and obstetric ultrasound. There is also a hydrotherapy pool. There were a total of 68,171 attendances at Bolton One between September 2014 and August 2015.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Bolton One is a multi-purpose health and leisure centre located in the town centre of Bolton. A range of outpatient and diagnostic imaging services are provided from Bolton One including general outpatients, children's outpatients, rheumatology, biomechanics, physiotherapy, occupational therapy, podiatry, pre-operative assessment, breast screening, ante-natal clinic, plain film x-ray and obstetric ultrasound. There is also a hydrotherapy pool. There were a total of 68,171 attendances at Bolton One between September 2014 and August 2015.

We visited Bolton One on Wednesday 23rd March 2016 as part of the comprehensive inspection of Bolton NHS Foundation Trust. During our announced inspection we visited the following areas: x-ray, general outpatients, physiotherapy, children's outpatients and pre-operative assessment.

We also carried out an unannounced inspection on 6th April when we visited the rheumatology and orthopaedic departments. We spoke with 25 staff, including nursing staff, doctors, support and administrative staff and allied health professionals. We also spoke with nine patients or their relatives using the services at the time of our inspection and reviewed twelve sets of patient records. We observed care and treatment and looked at information provided by the trust and other information we requested.

Summary of findings

Outpatients and diagnostic imaging services were rated as good overall because;

- Staff were encouraged to report incidents and lessons were learnt and shared. Infection control practices were good and audits were completed.
- Nursing, medical and allied health professional staffing was good with few vacancies. Procedures in relation to safeguarding adults and children were in place and understood and training rates were high.
- Services followed national and local guidelines based on evidence based practice. Local audits were completed to monitor performance against local guidelines and patient outcomes.
- Appraisal rates were high and staff were supported to develop extended knowledge and skills
- Care was good delivered to patients by caring, kind and compassionate staff. Patients were treated with dignity and respect. High numbers of patients would recommend outpatient and diagnostic imaging services to their friends and family
- The service was responsive to people's needs. Services had been planned to meet the needs of local people. Patients were given a choice about where they went for their appointment in some specialities and services had been developed to allow direct referral from GPs.

Outpatients and diagnostic imaging

- Diagnostic waiting times had been consistently better than the England average between January 2014 and November 2015. Overall, the 95% 18-week target for non-admitted patients was met each month between April 2015 and December 2015.
- Patients individual needs were understood and considered when delivering care and treatment. Adjustments were made to remove barriers to people accessing services.
- Outpatients and diagnostic imaging services were well-led locally because governance systems were in place to support the delivery of high quality care.
- Risks were understood and managed to reduce any impact upon the quality of service deliver. Risk registers were reviewed and updated regularly.

However,

- Improvements were needed in the way records were stored securely and records were not always available at the time of the patient appointment.
- The breast screening service was not meeting targets in relation to the recall of women for mammography. National targets had been extended locally to allow a recovery plan.
- There were not adequate plans in place to ensure that the rheumatology team had appropriately trained permanent members of staff to deliver the biologic therapy service.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because,

- Staff were encouraged to report incidents and lessons were learnt and shared.
- Diagnostic imagining services had established systems and practices in place to protect patients and staff from radiation.
- Infection control practices were good and audits were completed.
- Nursing, medical and allied health professional staffing was good with few vacancies. Bank or locum staff received appropriate inductions to departments.
- Procedures in relation to safeguarding adults and children were in place and understood and training rates were high.

However,

- Records were not always stored securely.
- Clinic notes were not always available at the time of the appointment.

Incidents

- There had been no never events reported for this service between March 2015 and March 2016. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never Event.
- Staff were encouraged to report incidents via an electronic reporting system. They told us that feedback about the outcome of incidents was given and learning was shared.
- Between February 2015 and January 2016, 262 incidents were reported via the National Reporting and Learning System (NRLS). The majority of these incidents were graded as no or low harm indicating there was a good reporting culture within outpatients and diagnostic imaging.

Outpatients and diagnostic imaging

- Staff were able to explain how learning from incidents was shared and gave examples of how practice had been changed. For example there had been a trend of incidents relating to late ambulance transport and therefore an agreed set of actions ("standard work") were put into place to deal with this problem happening again in the future.
- One serious incident was reported for diagnostic imaging between January 2015 and January 2016. This related to an error in the recall process for a high risk patient requiring cancer screening. A patient was not recalled in August 2014 and was subsequently diagnosed with cancer in August 2015. The incident was investigated in a robust way using a root cause analysis model and identified staffing and system issues had led to this error. The investigation identified that 35 other patients may have been affected by this incident. Letters of apology had been sent and patients had been recalled for screening. Learning from this incident had been shared within the department, the wider trust and external partners. All identified action points had been completed at the time of our inspection.
- The diagnostic imaging service reported radiation incidents under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000. These regulations place a duty on services to protect patients from harm. Between January 2015 and March 2016, nine incidents were reported to the CQC. Three of these incidents were due to the image taken not being sent to the picture archiving and communication system (PACS) system and three were repeat mammography's being undertaken. New systems had been put in place to reduce the likelihood of these types of incidents happening in the future.
- Senior staff understood the duty of candour.The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We saw evidence that the duty of candour regulation had been applied correctly. This meant that the trust had been open, transparent and had apologised when things had gone wrong with a patient's care or treatment. Some more junior staff we spoke with were unaware of and did not understand the duty of candour regulation.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy. Patients told us areas were clean and that staff washed their hands which reflected what we saw.
- An "I am clean" labelling system was in use which supported staff in identifying equipment that had been cleaned.
- We saw staff using personal protective equipment such as gloves and aprons to prevent the spread of infection. There were sufficient handwashing facilities and hand sanitiser dispensers available in all areas we visited. Recent handwashing audits showed that compliance with trust policy was over 97% in general outpatients and radiology, 98% for rheumatology, 100% for acute paediatrics and physiotherapy.
- There were procedures in place in radiology to manage patients with known or suspected communicable diseases. Patients were scheduled at the end of the list and additional PPE was used, along with additional cleaning procedures.
- Departments had infection control link staff who provided staff with updates in infection control. Monthly environmental audits were completed which showed a good level of compliance with the trusts expected standards to prevent the spread of infection.

Environment and equipment

- Emergency grab bags were available for adult and paediatric patients. This equipment was tagged and checked weekly.
- All the equipment we checked including vital observations machines had been maintained correctly and was clearly labelled with the date that the next test or service was due.
- At the main reception desk, there was a barrier and signs to advise patients to wait away from the receptionist area to maintain patient confidentiality. The trust had been limited in the provision of signage and notice boards by the owner of the Bolton One facility

and there were temporary signs in use. We were told that permission had been gained to add permanent signs to ensure patients could more easily identify where they needed to go.

- Exposure to radiation was audited in radiology. Staff wore devices to monitor radiation levels and the results were received fortnightly via another provider. Sufficient numbers of lead jackets were available to protect staff from radiation. Access to non-ionising radiation areas was restricted via key code access and warning signs were displayed on doors. The radiation protection committee met regularly and staff were aware of radiation protection supervisors.

Medicines

- Medicines were stored appropriately in all areas we visited. Keys to medicines cupboards or fridges were stored in the clinic room in a locked 'key safe' and only designated staff knew the key code.
- Stock medicines and expiry dates were checked weekly and fridge and room temperatures were recorded to ensure medicines were stored within the correct temperature range.
- Medical gases were stored safely and securely.
- Hospital prescriptions were issued at outpatient appointments and patients were able to attend the onsite pharmacy to collect their medication.
- During times that the pharmacy was closed, FP10 prescription forms were issued for patients to use at their local pharmacy. The FP10 forms were stored securely in a locked drawer within a locked room.

Records

- Data provided by the trust showed that over 99% of all case notes requested throughout the trust were provided 2015. However, this figure did not reflect what nursing staff and doctors in outpatient clinics told us during our inspection. This figure related to the number of case notes provided but not necessarily at the time of the patient appointment. This meant that there was no log of how many patients were seen without the full record available.
- If notes were not available, medical records printed the last available clinic letter for the clinician to view.
- The trust told us that all possible actions were taken to locate patient notes. On average between July 2015 and December 2015, 151 sets of patient notes were not available each month at the time of the patient's appointment. In July this had risen to 201 sets of records. The target was that this would happen on less than 55 occasions per month.
- Staff in medical records told us that misfiling and poor case note tracking could lead to delays in the availability of clinic notes. The health records library was 'open' meaning that staff from any department could access the library to take or return notes. This had been identified as one of the issues in quickly locating notes. There were plans to introduce a closed library and a bar code tracking system.
- Medical records were supplied to Bolton One via an internal delivery system. Records were delivered two days in advance of the clinic but staff told us that there were times, particularly for early morning appointments, when records were not available if the appointment had been made at short notice. Children's outpatients told us this was on the risk register and that incidents were logged when notes were not available. However when we reviewed the risk register, this was not detailed as a risk and we did not see evidence of incidents being reported in relation to missing records. This was detailed on the risk register for the advanced orthopaedic practitioners with actions listed to mitigate this risk, for example the provision of last clinic letters or re-booking of appointments when necessary.
- Records for general outpatient clinics were stored securely behind the locked reception desk until they were required.
- In children's outpatients, we saw that records were stored in an unlocked room. Staff told us this was because the emergency resuscitation grab bag was also stored in this area. Rheumatology also stored notes in an unlocked room and the team told us they were looking at options to have locked notes trolleys. We also noted that in the respiratory medicine clinic, notes were stored in an unlocked area within the main waiting room although we were told a staff member was always present. We did not see any evidence that these notes were unattended.

Outpatients and diagnostic imaging

- The rheumatology team had their own records that were stored at Bolton One. Patients being seen for the first time were seen with their full medical record. Following this, they were seen with the rheumatology record and staff could access clinic letters from the main medical notes electronically.
- Therapy teams created and stored their own paper records specific to that discipline. Records were stored securely in the areas we visited.
- Information governance training, which includes training on records and record keeping, was 97%.
- Records we reviewed were mostly complete although we noted two entries that were unsigned in physiotherapy.

Safeguarding

- Staff were aware of their responsibilities in relation to adult and children's safeguarding. They were able to tell us where to gain advice and how to make a safeguarding referral. The safeguarding team were available for advice during normal working hours and information about how to contact them was clearly displayed in outpatient and diagnostic imaging areas.
- In the elective care division, 96% of staff had completed safeguarding adults level two training which was above the trust target of 95% Safeguarding children level two completion rates were 97%. In radiology, if there were concerns regarding non-accidental injuries to a child, a named radiologist reported the images.
- All nursing staff in children's outpatients had completed safeguarding children level three.
- During our inspection, we observed a member of staff appropriately raising a safeguarding referral in radiology.

Mandatory training

- Mandatory training was a mixture of online learning and face to face sessions. Face to face training was delivered in a half-day session, allowing staff to access this in one session and staffing to be planned effectively.
- At Bolton One, all areas met the trust target of 85% for mandatory training. Outpatients, therapies, radiology and rheumatology were all above 90% training and in the acute paediatric service (which included children's outpatients) mandatory training was 97.5%.

Assessing and responding to patient risk

- Radiology had protocols in place for 'red flag' findings for cancer and unexpected non-cancer findings to ensure results were communicated quickly to the relevant team.
- The advanced orthopaedic practitioner team used an electronic triaging system and identified patients with 'red flag' findings. Patients could be seen within one working day when this was necessary.
- Staff were aware of the procedure to manage unwell patients in outpatient areas. There was a system in place to arrange for patients to be admitted to hospital from clinic if this was necessary. In an emergency, staff were aware of the procedure to call 999 and obtain an emergency grab bag containing vital equipment.

Nursing staffing

- No formal tool had been used to calculate the required nursing staffing. Levels had been determined based on the number of clinics running.
- Nursing staff from the general outpatient's team at Royal Bolton Hospital provided cover for clinics such as urology, pain clinic and endocrinology at Bolton One. Rheumatology, pre-operative assessment and children's outpatients had their own staff.
- Departments used bank or agency nurse staff to fill shifts when required. These staff received a local induction to the department. We saw evidence of completed induction forms during our inspection.
- Between April 2014 and March 2015, nursing bank usage in general outpatients was around 14%, although the rate had halved in the three months from January to March 2015. For paediatrics, the rate was 6%.
- In rheumatology, the service was unable to provide patients with biologic therapy treatment due to a lack of nursing staff trained to deliver this treatment. The service had relied on a bank member of staff to provide these infusions on the Churchill unit at Royal Bolton hospital. At the time of our inspection there were six

patients who had not received their treatment as required to ensure effectiveness and a further two patients were due that week, however the trust had made arrangements for these patients to receive treatment the following week.

- There was a good level of skill mix in outpatient departments. Registered nursing staff were used alongside band 2 and 4 unregistered staff workers.
- There were 1.6 WTE vacancies for band 5 nursing staff in pre-operative assessment and 1.0 WTE band 2 vacancy. In rheumatology there was 1.5 WTE RN vacancies.

Medical staffing

- There was a shortage of radiologists in post at the time of our inspection however; the trust had recently recruited to 2.5 whole time equivalent (WTE) posts.
- Regular medical locum staff were used to supplement the establishment. Trust and local inductions were in place for these to staff to ensure they understood trust and local policies, procedure and systems. From April 2014 to March 2015, locum usage in radiology was 16.3%.
- There were three WTE consultants in post in rheumatology, but the service had recognised that an additional 0.7 WTE consultant cover was required to provide an improved service. A business case was being put forward to apply for funding for additional funding.

Allied health professional staffing

- Podiatry and rheumatology therapy used assistant practitioners and therapy assistants alongside qualified AHPs to support the delivery of care.
- There were 3.87 WTE radiographer vacancies. Four new radiographers had been recruited to commence in post in summer 2016. There were 1.2 WTE vacancies for sonographers. Agency radiographers were used to cover absence such as maternity leave.
- Radiology supported the delivery of care by qualified radiographers with assistant practitioners and radiology assistants.
- The therapy department was actively recruiting to upcoming vacancies to reduce the need to use agency staff or leave posts vacant. There were four physiotherapy vacancies and one podiatrist vacancy across the service. One of the vacant physiotherapy posts and the podiatry post had been recruited to at the time of our inspection.

Major incident awareness and training

- There were business continuity plans in place for each of the outpatient and diagnostic imaging areas we visited. These included contingency plans to be used in the event of staffing shortages and equipment failure or the failure of technology. Staff were aware of the plans and had access to paper copies of the plan.
- There was a trust wide major incident plan and emergency response policy in place.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging:

- Services followed national and local guidelines based on evidence based practice.
- Local audits were completed to monitor performance against local guidelines and patient outcomes.
- Pain relief was discussed and alternatives to medical pain relief were offered.
- Appraisal rates were high and staff were supported to develop extended knowledge and skills.
- The diagnostic imaging service was not participating in the Imaging Services Accreditation Scheme (ISAS) or the Improving Quality in Physiological Services (IQIPS) accreditation scheme.
- Only 73% of clinic letters were sent to GPs within 5 days of the appointment.

Evidence-based care and treatment

- Diagnostic imaging followed national guidelines to prioritise patients based on clinical need
- Policies and procedures were in place locally. Radiology had guidelines in place for the use of contrast media

and to reduce the risk of contrast induced nephropathy. These guidelines followed evidence-based practice. Local pathways were in place in the breast unit, for example breast abscess pathways.

- Guidelines produced by professional bodies such as ENT UK, the Chartered Society of Physiotherapists and NICE guidelines for the management of cardiovascular conditions, diabetes and chronic obstructive pulmonary disease (COPD) were followed.
- AHPs held evidence based practice meetings. These meetings reviewed guidelines, best practice and audits under taken within the team to ensure current best practice was being delivered within the service.
- At the time of our inspection, the rheumatology team was unable to deliver biologic therapy treatment in line with recommended treatment timescales due to nursing staffing issues. Patients were being offered steroid injections as an interim treatment where necessary and there were plans in place to address the immediate staffing difficulties along with medium and long term actions.

Pain relief

- Pain and pain relief was discussed when necessary during outpatient consultations.
- Patients were also offered non-medical pain management treatment such as acupuncture, hydrotherapy and exercise.

Patient outcomes

- The therapy department measured outcomes using a number of patient outcomes measures. The physiotherapy department measured patient outcomes using the EQ5D, a measure of health outcomes. Data showed improved functional outcomes, reduced and reduced pain. All departmental targets for improved outcomes were met in 2015.
- Local audits and reviews were completed to monitor patient outcomes and effectiveness of services. For example, the AOP team had surveyed GPs to establish their perception and knowledge of the spinal service they offered. They identified actions from this survey to improve awareness of the service and provided additional teaching to GPs in musculoskeletal assessment to improve the number and quality of referrals to the team.
- The rheumatology team participated in the British Society of Rheumatologist audits and quality improvement projects which had been presented internationally at conference.
- All patients who were listed for elective surgery in the outpatients department were referred to the smoking cessation team if this was relevant and they agreed. Overall in the smoking cessation service in 2015, 69% of patients had set a quit date and remained smoke free for at least four weeks following this.
- The diagnostic imaging service was not participating in the Imaging Services Accreditation Scheme (ISAS) or the Improving Quality in Physiological Services (IQIPS) accreditation scheme. ISAS acts as a mark of quality and takes approximately 18 months to achieve. IQIPS is a process of self-assessment, improvement and accreditation with the aim of improving quality, care and safety for patients. There were plans to participate in this in the future.

Competent staff

- Staff were supported to develop extended skills in outpatients and diagnostic imaging, including both qualified and unqualified staff. Staff told us there were good training opportunities.
- There were a number of nursing mentors for students in outpatients and radiology also provided education to students from local universities. The thoracic team had recently won an award from a local university for the quality of their student placement.
- There were a number of nurse practitioners and extended scope physiotherapy practitioners at Bolton One. Physiotherapists had been supported to develop skills in steroid injections and acupuncture and nurses and pharmacists had been supported to gain prescribing rights.
- Appraisal rates were 95% for outpatient and diagnostic imaging staff and 99% for acute paediatrics. This was above the trust target of 85%.

Outpatients and diagnostic imaging

- There was a well-established preceptorship programme in the therapy department. In house training was provided to share skills and knowledge within the department. Appraisals had been completed for 92% of therapy staff. Staff were supported to continue their education through additional study at local universities.
- The trust monitored revalidation of medical staff. There were 94 doctors across the trust due for revalidation in 2015/2016. Of these, 86 were revalidated and seven deferred.
- Unqualified staff were supported to undertake national vocation qualifications to develop their skills and knowledge. Some staff had been trained to take blood, perform echocardiograms (ECGs) and teach patients skills in using inhalers and nebulisers.
- Non-medical staff were supported to develop skills to allow them to refer patients for diagnostic imaging. The department maintained a list of these staff, who underwent a competency based programme and IR(ME)R training.
- Staff in the podiatry team rotated through the biomechanics service, podiatry and diabetes service to ensure skill development and a good level of skill mix.
- The thoracic medicine and rheumatology teams had dedicated weekly time for continuing professional development and service development.

Multidisciplinary working

- Outpatient teams at Bolton One working collaboratively with other health and social care professionals. The respiratory team had good links with occupational therapy, physiotherapy, clinical psychology and the palliative care team.
- The rheumatology team worked as a multi-disciplinary team with shared education and governance meetings. They also offered cross discipline clinical supervision.
- The podiatry team had developed shared care pathways with district nurses and the tissue viability team following best practice guidelines.
- Children's outpatients had close links with health visitors and school nurses to ensure information was communicated between services.

Seven-day services

- There were no weekend clinics offered at Bolton One. Some services offered late night or early morning appointments, for example, the thoracic clinic held a clinic until 8pm one day per month and physiotherapy offered sessions from 7.30am until 6pm.
- Access to a respiratory nurse specialist was available seven days a week

Access to information

- There was electronic access to diagnostic results and images throughout the Greater Manchester area. Services at Bolton One could access clinic letters from other specialities via the electronic letter system.
- Only 73% of outpatient clinic letters were sent to GPs within five days of the appointment across the trust. The trust target was that 99% of letters would be sent within this time frame. The target was only met in one month for one speciality at Bolton One

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training was delivered as part of the adult safeguarding mandatory training. This had been completed by 96% of staff in the elective care division. Staff understood the need for consent and had an understanding of the Mental Capacity Act.
- In pre-operative assessment, staff completed a mental capacity assessment proforma if they had concerns that a patient may not be able to consent to the surgical procedure. Staff filled in the reasons for their concerns and pre-alerted the surgeon to these concerns.
- Staff were aware of procedures to obtain consent from a child and described how the Gillick competence was assessed to establish if children had the maturity to make their own decisions and understand the implications of treatment.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

Outpatients and diagnostic imaging

- Patients were treated with dignity and respect. Staff were caring, compassionate and kind.
- Patient feedback about staff was positive. High numbers of patients would recommend outpatient and diagnostic imaging services to their friends and family.
- Patients and their families were involved in their care and treatment. Information was provided in a way that patients could understand and patients had time to ask questions about their care.
- Clinical nurse specialists for a range of health conditions and counsellors were available to provide additional emotional support.

Compassionate care

- Patients told us that staff were caring, friendly and professional, and one relative described staff as "brilliant". Continuity of staff, including after service moves to Bolton One, had a positive impact for patients. One patient told us "familiar staff faces help me cope".
- In the tuberculosis clinic, specialist nurses provided a patient who had no permanent place of residence with food at his appointments to encourage him to attend appointments and therefore receive treatment.
- Chaperones were provided when this was required.
- Patients told us they were happy with the care and treatment they received. Patient satisfaction surveys for therapy services showed that patients felt their privacy and dignity was maintained, and told us that therapists were kind, caring and courteous.
- NHS Friends and family test (FFT) results were displayed in waiting areas. Overall for outpatients, 92% of people would recommend the service to their family or friends. For rheumatology, the overall recommend rate was 87.5% for April 2015 to March 2016. Acute paediatric services (which includes children's outpatients) scored 100% on the most recent FFT results we saw.

Understanding and involvement of patients and those close to them

- Patients told us staff clearly explained planned care, test results or changes to medication, and what will happen next. They said they felt able to ask questions during their consultations and by telephone between consultations. Patients also received copies of the clinic letters that were sent to their GPs.
- Patient information leaflets were available on displays and were also given to patients by health care staff to provide them with additional information about their care and treatment.
- We observed that health care support workers welcomed patients in a warm and friendly manner and ensuring they had access to anything they and their relatives needed.
- In the urology clinic, we saw that nursing staff offered patients additional explanation and time to ask questions after consultation with medical staff.
- In rheumatology, staff directed patients to local patient support groups and provided leaflets produced by national organisations for further advice and support. Self-management plans were provided for patients with rheumatoid arthritis and fibromyalgia.

Emotional support

- Clinical nurse specialists were available to provide additional support in some specialities such as respiratory medicine and rheumatology and ran clinics alongside the medical team. Additional appointment time was given to patients with new diagnoses in rheumatology.
- There was access to a counsellor in the rheumatology team for additional emotional support.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Services had been planned to meet the needs of local people. Patients were given achoice about where they went for their appointment in some specialities and services had been developed to allow direct referral from GPs.

Outpatients and diagnostic imaging

- Diagnostic waiting times had been consistently better than the England average between January 2014 and November 2015.
- Overall, the 95% 18-week target for non-admitted patients was met each month between April 2015 and December 2015.
- The trust had performed consistently better than the England indicators for incomplete pathways referral to treatment times within 18 weeks.
- Individual needs were understood and considered when delivering care and treatment. Adjustments were made to remove barriers to people accessing services.

However,

- Clinics in outpatients sometimes ran late and the trust did not gather sufficient data to monitor whether patients were seen on time.
- The breast screening service was not meeting national targets in relation to the recall of women for mammography. Nearly half of all patients did not receive a timely breast screening service. National targets had been extended locally to allow a recovery plan.

Service planning and delivery to meet the needs of local people

- Some clinics ran from the main Royal Bolton Hospital site as well as at Bolton One and patients were offered a choice of where they would like to attend via the choose and book system.
- Radiology offered plain film x-ray at pre-booked appointments or on a 'walk-in' basis.
- Pre-operative assessment offered telephone appointments when this was appropriate to the patient.
- Musculoskeletal physiotherapy provided treatment sessions on a one to one basis and also as part of groups. There was also an injection clinic where patients were directly referred by their GP for a steroid injection, cutting the need for a referral to a consultant or for a physiotherapy assessment.
- Advanced orthopaedic practitioners accepted referrals direct from GPs as a first line assessment service for patients with orthopaedic problems. These practitioners were able to offer a range of treatments and also order a range of investigations normally limited to medical doctors such as nerve conduction studies and magnetic resonance imaging scans. This meant that patients could access care and treatment more quickly and efficiently, reducing the need for multiple consultations.
- The rheumatology service ran a daily patient advice line. This was staffed by a senior member of the team who provide telephone advice to patients in relation to their care and treatment. They also provided a triage system to identify patients requiring quick access to a consultant appointment. Information was reviewed by a consultant and an appointment could be offered within two or three weeks.
- There was no access to phlebotomy at Bolton One due to shortages of phlebotomy staff. Nurses trained in venepuncture were sometimes able to take patient's bloods, but if this was not possible then patients had to visit the phlebotomy service at the hospital or their GP. We saw that this issue was listed on the risk register for urology at Bolton One as it could potentially cause a delay for patients on cancer pathways and on the rheumatology risk register. At the time of our inspection at review of phlebotomy services was in progress. Actions were being taken to reduce the impact on patients.
- Children's outpatients had recently relocated to Bolton One and were now unable to offer rapid drop in clinics and child protection medical assessments due to the reduced consultant cover available at Bolton One. This meant that children needing these services had to attend Royal Bolton Hospital to access this service. They were also unable to provide an ECG service at Bolton One.

Access and flow

- Diagnostic waiting times had been consistently better than the England average between January 2014 and November 2015. Less than 1% of patients waited over 6 weeks for diagnostic testing.
- Overall, the 95% 18-week target for non-admitted patients was met each month between April 2015 and December 2015. The target for non-admitted colorectal and trauma and orthopaedic patients was however missed in each month.

Outpatients and diagnostic imaging

- The trust had performed consistently better than the England indicators for incomplete pathway referral to treatment times between December 2014 and November 2015.
- Between September 2015 and December 2015, 8.8% of clinics were cancelled less than six weeks before the appointment and 1.7% were cancelled more than six weeks before. The main reasons for cancellations were given as annual leave, study leave, emergency leave and staff sickness.
- One performance measure had failed target each month since November 2014: 'Breast Screening, Quality Assessment Reference Centre (QARC) Round Length'. There was a recovery plan in place that had been agreed by Public Health England and NHS England in January 2016. The target round length (the interval between breast screening) is usually 36 months. This had been temporarily increased to 38 months as part of the recovery plan. The trust had met the extended target in February 2016. However, when the trust is compared to the national target of 36 months, only 52.7% of women were screened within the agreed timeframe. This meant that nearly half of patients did not receive a timely breast screening service. The aim of the recovery plan was to achieve the national target by July 2016 and the trust was on track to achieve this.
- Weekly meetings were held to discuss capacity and demand for outpatient clinics. When necessary, clinics would be modified to accommodate more or less patients.
- Reporting times for diagnostic imaging were monitored against aspirational time frames. Overall performance for reporting within the time frames was 80% between April 2015 and November 2016. The department outsourced some reporting to support in delivering timely reports and prioritised reporting into three categories, critical, urgent and standard, to minimise any risk to patients.
- Did not attend (DNA) rates averaged at 9% at Bolton One which was slightly higher (worse) than the national average of 7%. Rheumatology therapy had high levels of DNA rates averaging at 21%.
- The respiratory team had taken action to reduce DNA rates by undertaking patient surveys, providing patients discharged from the ward at Royal Bolton Hospital with the appointment at the time of discharge and using a text reminder service.
- There was no facility to provide a written update of clinic running times as the trust had been unable to put up additional noticeboards. However, staff informed patients verbally if clinics were running late and patients confirmed this. The trust did not gather sufficient data to assess whether patients were seen on time.
- The average wait time to access rheumatology therapy was 13 weeks. The target set by the trust was 6 weeks. There was a 10 month waiting list to see the counsellor in the rheumatology team, however urgent referrals were seen more quickly or patients could be referred for emotional support through alternative services.
- The trust was not meeting its target to see urgent rheumatology referrals within four weeks. Only 33.8% of patients were seen within this time frame. The target was that 95% of these patients would be seen within four weeks.

Meeting people's individual needs

- There was a dementia lead in place for the trust and a dementia steering group for the trust with an associated action plan including a training needs analysis.
- A learning disabilities nurse was in post and supported staff in the delivery of care to patients with a learning disability. There was an electronic flagging system to identify patients with a learning disability. The specialist nurse had advised staff at Bolton One with specific patients who required additional support.
- In pre-operative assessment staff completed a booklet entitled 'information to keep me safe while I'm in hospital' for any patient with a communication difficulty. This explained specific communication needs, preferences and likes and dislikes.
- Equality and diversity training had been completed by 97% of staff. Translation was provided face to face and there was access to a telephone translation service. This was regularly used in the TB clinic and there was a clinic room set up to facilitate telephone translation

appointments. However, we did speak to one patient's relative who told us they had never been offered translation services and he had been expected to translate for his wife.

- Patients were taught self-needling acupuncture techniques to allow them to manage their own pain better.
- A MacMillan information and support service was being constructed at the time of our inspection.
- There was good wheelchair access within Bolton One, with disabled parking located outside the entrance. Bariatric chairs were available in waiting areas and spare wheelchairs were available for patients who experienced difficulties with mobility. Wheelchair weighing scales were also available.
- In children's outpatients there was a play specialist available. Part of this role was to support children's during appointments with distraction techniques, gather information about any additional needs in advance of an appointment and when necessary carry out pre-visits to the child's home to ensure the child felt comfortable when attending the outpatient department. The play specialist also rotated toys within the department on a regular basis to ensure that children attending multiple times would have a different choice of toys to play with.

Learning from complaints and concerns

- Complaints, compliments and concerns leaflets were available in the areas we inspected. These leaflets outlined how patients could make a complaint about a service.
- Complaints were discussed at quality forum meetings and staff meetings and learning from complaints was also circulated electronically within the trust.
- There had been six complaints about rheumatology between April 2015 and March 2016 and these had all been responded to and closed in less than 35 days. Two of these related to the inability of the service to provide biologic therapy infusions.
- Therapy services monitored formal and informal complaints and also monitored the number of compliments received by the service. Themes from complaints and lessons learned were shared in staff meetings.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Governance systems were in place to support the delivery of high quality care.
- Objectives were aligned with the trust aims and had clear, measureable outcomes.
- Risks were understood and managed to reduce any impact upon the quality of service deliver. Risk registers were reviewed and updated regularly.
- Performance dashboards were comprehensive and shared widely with staff to provide feedback on how services were doing.
- Leaders at all levels were described as supportive. Staff were supported to develop leadership skills.
- Services planned to maintain sustainability in the future and continue to deliver service improvement.

However;

- There were not adequate plans in place to ensure that the rheumatology team had appropriately trained permanent members of staff to deliver the biologic therapy service.

Vision and strategy for this service

- The trust vision was to be "an excellent integrated care provider within Bolton and beyond delivering patient centred, efficient and safe service". Outpatient and diagnostic imaging areas each had separate objectives that were aligned to the trusts six strategic goals and the divisional objectives. This included the trusts strategy to be 'fit for the future' through partnership working and collaboration.
- There was a clear statement of values that were driven by quality and safety. Staff knew and understood the trust vision and values.

Outpatients and diagnostic imaging

Governance, risk management and quality measurement

- Outpatients and diagnostic imaging was managed as part of the elective care division within the trust. Children's outpatients was managed by the families division. There was a standard governance agenda for the division, including health and safety, incidents and policies. each division held monthly governance meetings along with quarterly performance and quality meetings for each speciality.
- There were audit leads within departments. Regular audit and discrepancy meetings were held. These were minuted and shared within the department. Information from these meetings was fed into the elective care division governance structure. In turn, the divisional governance meeting cascaded division and trust wide information relating to risk, audit and serious incidents.
- Following the serious incident, a new breast screening governance group had been introduced to ensure governance was more robust within the breast screening programme.
- A monthly newsletter was circulated trust wide detailing information from incidents and complaints.
- Performance and governance dashboards were in use for each area we visited. These were displayed and shared with staff to ensure they were aware of performance in relation to targets such as appraisals, training, sickness absence and performance targets.
- Separate risk registers were in place for the departments we visited. Any risks scoring 15 or more (high risk) also appeared on the divisional risk register. There were no risks for outpatients held on the divisional register and one risk for diagnostic imaging (radiologist vacancies). We saw that risk registers had been reviewed regularly in most areas and actions taken to reduce and mitigate risks had been completed.
- However, the highest risk on the rheumatology risk register was the risk that the service could not provide the biologic therapy infusion service. This risk had been identified in July 2015. Despite this, we saw that there was no robust plan in place to ensure patients received biologic therapy infusions. There had been a reliance on a bank member of staff for a long period of time with no action being taken to prevent a gap in the service. A short term action plan had been developed during the inspection period to manage patients who were overdue their treatment and leaders of the service were considering longer term options.
- The radiology department double checked 20% of its outsourced reporting and received audit results from the external reporting agency which ensured the quality of this service was being monitored.
- There were radiation protection supervisors in each area where radiation was used. Quarterly meetings were held to discuss IR(ME)R incidents.
- The respiratory team had undertaken a programme of work called the 'model hospital'. This work aimed to reduce inefficiencies and reducing costs. For example, the team had compared the cost of inhalers and introduced educational work to encourage the prescription of more cost effective inhalers with no loss of effectiveness of the treatment.

Leadership of service

- Staff described the leadership of the service as very supportive. Some leaders had an open door policy. Staff described leaders as grounded and never too busy to listen to concerns. Senior staff told us they were well supported by managers and other support functions within the trust such as human resources and finance. Achievement boards were in each area we visited. These provided information to staff and patients about how the area was performing. For example, the boards displayed friends and family test results and performance on local audits.
- In radiology, there were comprehensive staff information boards providing staff with up to date information about performance in relating to key performance indicators, the radiology dashboard and patient experience audit. This meant that staff were informed about how the service was performing and what the key areas for improvement were.

Culture within the service

- There was an open and honest culture in the areas we visited. Some departments described morale as excellent. Staff felt that there had been many improvements in the culture and staff attitude.

Outpatients and diagnostic imaging

- Staff spoke positively about the environment and facilities at Bolton One.
- There was a trust wide duty of candour policy in place and there was access to duty of candour training on a monthly basis.
- In the 2015 staff survey, 78% of staff at the trust said they were enthusiastic about their job and 66% looked forward to going to work. Staff we spoke with were proud of the work they did and enjoyed coming to work.
- Sickness rates for outpatient nursing was 4.75% and acute paediatrics was 5.8% which was higher than the trust target of 4.2% between January and November 2015. In radiology, outpatient therapies and rheumatology, the rate was below (better than) target. The nursing turnover rate for general outpatient nursing was 10.8% and 13.2% for children and families nursing in 2015.

Public engagement

- There were plans to change the provision of podiatry services as a result of a service review and changes in national guidance. The service had anticipated that patients may be unhappy as a result of these changes and had worked with Healthwatch and the CCG to engage the public in these changes and produced literature for them explaining the changes and why they were happening.
- Radiology carried out a quarterly patient experience audit and therapy teams carried out regular patient satisfaction surveys with positive results.
- The thoracic medicine team were taking part in World TB day during the week of our inspection and attended local health events each year to raise awareness of TB.

Staff engagement

- Staff meetings were held monthly and minutes taken for those staff who could not attend. There was a standard agenda template used across the division.
- The team brief was shared with staff and displayed on staff notice boards.
- The vision and values were in the process of being updated at the time of our inspection. Around 200 staff had been involved in a consultation as part of this process.
- In general outpatients, staff felt they were in 'pockets' of areas rather than being part of a team. This was because of the location of clinics and need to cover clinics across two sites.

Innovation, improvement and sustainability

- The radiology department had a managed equipment programme in place. This meant that equipment was serviced, repaired and replaced as part of the contract in a timely way, minimising disruption to services and reducing the need for costly and time consuming business cases when equipment needed replacing.
- Historically there had been long waits to access the fibromyalgia self-management course. The service recognised that continuing to deliver the course in its then format was unsustainable and redesigned the programme to enable patients to access this in a more timely way.
- The rheumatology service had plans in place to improve access to ultrasound in order to confirm diagnoses earlier, diagnose flare ups and guide injections.
- Outcomes of local quality improvement projects had been presented nationally and internationally by the rheumatology team. For example, the team had developed electronic databases to manage patients receiving osteoporosis treatment more effectively. The team were also participating in a multi-centre research trial.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that paper records are stored securely.
- The trust must ensure that appropriately skilled staff are in place to provide a biological therapy treatment service.

Action the hospital SHOULD take to improve

- The trust should ensure that letters are provided to GPs in a timely way.
- The trust should ensure that patients are kept informed about any delays in outpatient and diagnostic imaging services and should monitor how long patients wait to be seen.
- The trust should ensure that the recovery plan for breast screening is completed within agreed timeframes.
- The trust should consider participating in the Imaging Services Accreditation Scheme (ISAS) and the Improving Quality in Physiological Services (IQIPS) accreditation scheme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met; Outpatient services did not maintain secure, accurate and complete records in respect of each service user. Regulation 17(2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met; The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to deliver the biologic therapy service in rheumatology There was not procedures in place to follow in an emergency that make sure sufficient and suitable people are deployed to cover both the emergency and the routine work of the service Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.