

Bolton NHS Foundation Trust

Royal Bolton Hospital










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	
Urgent and emergency services	Requires improvement	
Medical care (including older people's care)	Good	
Surgery	Good	
Critical care	Good	
Maternity and gynaecology	Good	
Services for children and young people	Good	
End of life care	Good	
Outpatients and diagnostic imaging	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Bolton hospital is part of Bolton NHS Foundation Trust, which provides a range of hospital and community health services in the North West Sector of Greater Manchester, delivering services from the Royal Bolton Hospital (RBH) site in Farnworth, in the South West of Bolton, close to the boundaries of Salford, Wigan and Bury; and also providing a wide range of community services from locations within Bolton.

The Royal Bolton hospital site is situated in the town of Farnworth, near Bolton. For services, in particular patients requiring non-elective treatment, it is estimated to have a catchment population of 310-320,000, compared with a resident Bolton population of 270,000.

The Royal Bolton hospital provides a full range of acute and a number of specialist services including urgent and emergency care, general and specialist medicine, general and specialist surgery and full consultant led obstetric and paediatric service for women, children and babies, including level three neonatal care and 24-hour paediatric and consultant-led obstetric services.

Approximately 110,000 people attend the trust for emergency treatment every year and 72,000 patients are admitted. Approximately 310,000 attend the outpatient departments for consultations. The Royal Bolton Hospital has approximately 740 beds and employs 5200 staff.

We visited the hospital on 21-24 March 2016. We also carried out an out-of-hours unannounced visit on 6 April 2016. During this inspection, the team inspected the following core services:

- Urgent and emergency services
- Medical care services
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young people
- End of life
- Outpatients and diagnostic services

Overall, we rated Royal Bolton Hospital as good. We have judged the service as 'good' for effective, caring, responsive and well led. We found that compassionate, caring staff provided services and patients were treated with dignity and respect. However, improvements were needed to ensure that services were safe.

Our key findings were as follows:

Leadership and Management

- There was a positive culture and a sense of pride throughout teams in the hospital, and staff were committed to being part of the trusts vision and strategy going forward.
- There was effective teamwork and clear leadership and communication in services at a local level. Managers and leaders were visible and approachable. Staff felt supported by their managers and there was an open culture of transparency and communication in between teams.
- The hospital was led and managed by an executive team that were approachable and visible. Staff knew the team and felt that they were listened to and concerns were acted upon.

Summary of findings

Access and Flow

- Access and flow remained a challenge, and the emergency department did not at times see, treat, admit or discharge patients within four hours. Between July 2014 and November 2015 the trust met the target to admit, transfer or discharge patients within four hours for six out of 17 months. However, the total average time spent in the emergency department between January 2013 and October 2015 was below the England average, ranging between 50 and 139 minutes.
- Plans were in place to expand the emergency department in order to accommodate the increase in patient attendances, of which notable there had been an increase in patients attending from outside of Bolton and patients being brought in by ambulance.
- There were some pressures with access and flow across the medical and surgical wards, including patients who were medically optimised for discharge, but awaiting further care arrangements to be agreed. Access and flow issues resulted in a number of patients being cared for on a ward outside of their speciality. Between August 2015 and November 2015, data showed there had been 208 medical outliers at the hospital. There were policies and procedures in place outlining the management of these patients to ensure that patients were seen by the appropriate medical teams at the right time.
- The trust had put a number of initiatives in place, including theatre productivity initiatives and opening additional beds to support access and flow through the hospital. There were also established escalation procedures in place, which were supported through regular bed planning meetings.
- The overall hospital-wide bed occupancy rate between July 2013 and December 2015 ranged between 80.8% and 88%, which rose to 91% on medical wards between January and March 2016.
- In spite of pressures, we observed that the average length of stay for elective medicine at the hospital was shorter (better) than the England average at 2.9 days. The England average was 3.8 days. For non-elective (not planned) medicine, it was shorter (better) than the England average at 5.8 days. The England average was 6.8 days.
- NHS England data showed the surgical and gynaecology services consistently performed better than the England average for 18-week referral to treatment standards for admitted (adjusted) patients between November 2014 and January 2016.
- Records between April 2015 and January 2016 showed the surgical services also achieved the historical 90% standard for 18-week referral to treatment standards for admitted (adjusted) patients for general surgery, ENT, ophthalmology, urology and oral surgery during this period. However, the trauma and orthopaedics speciality (84.5%) and oral surgery (77.65) did not perform as well other specialties during this period.
- Most patients were admitted to the intensive care unit within four hours of making the decision to admit them and a consultant assessed 100% of patients within 12 hours of admission.

Cleanliness and Infection control

- Clinical areas at the point of care were visibly clean and trust had infection prevention and control policies in place, which were accessible to staff and staff were knowledgeable on preventing infection.
- There was enough personal protective equipment available, which was accessible for staff and staff used this appropriately.
- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures.
- Between April 2015 and December 2015, the trust reported 19 cases of *Clostridium difficile*, 4 cases of Methicillin-resistant staphylococcus aureus (MRSA) and 18 cases of Methicillin-susceptible staphylococcus aureus (MSSA).
- Lessons from all cases were disseminated to staff for learning across directorates.
- There were established audit programmes in place related to the prevention of cross infection, which included hand hygiene, infections within a central line (a long, thin, flexible tube used to give medicines, fluids, nutrients, or blood products) and methicillin-resistant Staphylococcus Aureus (MRSA).

Summary of findings

Nurse staffing

- The trust undertook biannual nurse staffing establishment reviews as part of mandatory requirements. As part of this, key objectives were set though this work to support safer staffing.
- The trust was in the process of implementing a daily acuity tool to further support safer staffing levels based on patients acuity.
- There were processes in place to ensure ward staffing levels were monitored on a daily basis. Senior nurses and matrons met each week to discuss nurse staffing levels across services to ensure that there were sufficient numbers of staff. Staffing on a day-to-day basis was reviewed as part of the trust bed management meetings.
- However, nurse staffing levels remained a challenge, particularly in emergency, medical and the paediatric department. Nursing staffing was identified on both operational and corporate risk registers. At the time of this inspection there were 50 nursing staff vacancies across the trust and additional posts had been made available in order to support the increased requirements across the across the hospital.
- Staffing levels were maintained by staff regularly working extra shifts and with the use of bank or agency staff. Inductions were in place for new staff in order to mitigate the risk of using staff that were not familiar with the hospital.

Medical staffing

- Whilst most areas had sufficient numbers of medical staff to meet patients needs, which included the use of agency staff, there were pressures within the emergency department due to increased demand.
- Increased activity in the emergency department had meant that emergency department consultants were regularly working in place of middle grade staff to ensure the department continued to function with safe medical staffing levels. We observed that medical staff were committed to maintaining patient safety and ensuring that rotas were covered.
- A recent review by the Royal College of Emergency Medicine had recommended an increase in establishment of consultants of 6.5 WTE, which was being considered at the time of this inspection. In addition, it had been recommended to increase medical middle grade staffing by five WTE. Whilst the shifts we reviewed showed that staffing levels were safe, we were concerned that the current use of consultants to fill middle grade shifts may not be sustainable in the long term.
- Locum doctors were also used to boost medical staffing levels, particularly in the emergency department. Between May 2014 and March 2015, the average rate of locum use in this area was high at 21.5%.
- The trust board had recently authorised recruitment for two middle grade doctors and relaxed the cap on locum use to assist with staffing. However, managers described difficulties recruiting due to the high volume of patients attending the ED compared with other EDs.

Mortality rates

- Mortality and morbidity reviews were held in accordance with trust policies and were underpinned by policies and procedures. All cases were reviewed and appropriate changes made to help to promote the safety of patients. Key learning Information was cascaded to staff appropriately. Monitoring arrangements were in place at board level to ensure that any findings were acted upon.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators, which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. In November 2015, the trust score was 104.

Summary of findings

- The sentinel stroke national audit programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. The latest audit results rated the hospital overall as a grade 'D' which was an improvement from the previous audit results when the hospital was rated as the 'E'. The trust had put in place actions to improve the audit results. These included a dedicated social worker on the stroke unit and further training for staff.

Nutrition and Hydration

- Patients and people close to them attending departments had access to food and drink whilst visiting this hospital, including a café that was open out of hours and vending machines in areas such as the emergency department.
- Patients were able to choose from a wide range of meals, which took account of their individual preferences, including religious and cultural requirements. Most patients felt that the quality of food offered was of a good quality.
- We found that there were policies and procedures in place to support patients nutritional and hydration needs and staff across the hospital knew how to access them.
- The hospital used part of the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. An audit of the completion of the tool was undertaken as part of the food standards assessment and the trust scored an amber rating. Nutrition champions are now in place who undertake regular audits of nutrition and hydration standards.
- We found that patients nutritional needs were risk assessed and results were acted upon appropriately, however on some medical wards, fluid balance charts and nutrition charts had not been completed promptly.
- There was a system in place to identify patient in needs of assistance with eating and drinking. We found that most patients received assistance with eating and drinking as needed.
- Staff and patients had access to specialist nutritional advice from the dietician team who responded promptly to patient referrals.
- Breast feeding support was available for mothers after discharge. Post-natal support for breast-feeding was provided by peer support workers.

We saw several areas of outstanding practice including:

- The emergency department had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The emergency department offered bereavement meetings were offered to those who had lost a loved one, to help them understand what had happened.
- Emergency department Consultants were regularly working in place of middle grade staff to ensure the department continued to function with safe medical staffing levels.
- 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. This was an innovative way of managing high cost equipment.
- The trust were early adopters of the neonatal behaviour evaluation scale (NBES). The scale represents a guide that helps parents, health care providers and researchers understand the newborn's language.
- The neonatal unit were early adopters of volume ventilation.
- The neonatal unit introduced 'Matching Michigan', a two-year programme designed to reduce infections in central lines, before it was rolled out as best practice. The service was nominated for an award from the Health Service Journal (HSJ) for this.
- The neonatal unit introduced the 'fresh eyes initiative', which is where nursing staff look at other nurses' patients at 1am and 1pm to promote things not being missed.

Summary of findings

- There was a visible person-centred culture with caring, compassionate staff who considered the needs of patients nearing their final days or hours and their families. There were systems in place to support this, including the butterfly logo. This was embedded throughout the organisation so that any staff coming into contact with bereaved families could offer care and support where this may be needed.
- The trust had adopted the 'butterfly symbol', which made staff aware of a family in need (identified by the symbol). This ensured that during difficult times families were supported (for example by staff offering drinks etc.). The scheme also ensured that the deceased's property was put into a special bag (with the butterfly symbol on). Relatives were offered a fingerprint, lock of hair and photo (from medical illustration) of the deceased patient.
- We observed nurse interaction with patients living with dementia on the bluebell ward, using a variety of dementia friendly strategies. Staff used aids, for example dolls, computers, karaoke and a piano. Interaction was approached in a caring way, and tailored to support each patients individual needs.

However, there were also areas where the trust needs to make improvements.

Importantly, the trust must:

- Complete mental health assessment forms in the emergency department as soon as practicable and ensure these are distributed and used where appropriate.
- Improve appraisal rates in the emergency department.
- In the emergency department, Improve the focus on audits, ensuring clear action plans are formulated and progress regularly tracked to improve outcomes
- Ensure that robust information is collected, analysed, and recorded to support clinical and operational practice in medical services.
- Must ensure that there are sufficient staff with the appropriate skills on wards.
- Must ensure that records are kept secure at all times so that they are only accessed and amended by staff.
- The trust must ensure that staff are up to date with appraisals and mandatory training in medical wards.
- The trust must ensure that paper and electronic records are stored securely and are complete in outpatients areas.
- The trust must ensure that essential safety checks are completed and records of checks are maintained to provide assurance that all steps are being taken to maintain patient safety in outpatients.

In addition the trust should:

In urgent and emergency care services :

- Ensure building work continues at a suitable pace.
- Improve staffing levels in the emergency department with an aim to reducing agency and locum rates.
- Review the security arrangements for both paediatric entrances to ensure the trust is satisfied the risk is mitigated as far as possible.
- Consider the addition of facilities appropriate for adolescents in the paediatric area
- Review the number of computer terminals in the clinical areas to ensure this meets the needs of staff during peak periods.
- Continue to work to improve figures in relation to Department of Health targets.

In medical care services :

- The trust should ensure that hazardous chemicals are stored appropriately in a locked cupboard when not in use.
- The trust should ensure that patient is discharged as soon as they are fit to do so.
- The trust should wherever possible ensure that patients are cared for on a ward suited to meet their needs.
- The trust should ensure that patients' privacy and dignity is maintained at all times
- The trust should ensure that equipment and facilities in the endoscopy mobile unit are fit for purpose
- The trust should ensure that procedures and assessments in place to provide safe care are completed correctly. Especially comfort round and fluid and nutrition charts and assessments.

Summary of findings

In surgical services :

- Take appropriate actions to minimise the occurrence of never events.
- Take appropriate actions to improve staff appraisal rates.

In Maternity and Gynaecology :

- Consider improving the electronic patient management systems.

Children and young people's services :

- Review the door exit systems on the paediatric and neonatal unit to improve security.
- Ensure all staff working with children and young people have level three safeguarding training.
- Ensure that there is a trained Advanced Paediatric Life Support or European Paediatric Life Support nurse on each shift.
- Ensure there is sufficient staff to match patient acuity on the paediatric unit,
- Ensure that all paediatric staff have a good working understanding of the Mental Capacity Act and how it works in practice.
- Ensure the risk register highlight all risks and controls that are in place and is periodically reviewed.
- Ensure that neonatal practitioners all have current NLS training certification

In end of life services:

In relation to DNA CPR:

- In all cases assess and record patients' mental capacity as part of the DNA CPR assessment.
- Document a summary of communication with the patient, welfare attorney and/or next of kin (NOK).
- Document consent.
- Ensure private rooms are available to break bad news to bereaved family and friends of a deceased patient

In outpatients and diagnostic imaging services :

- The trust should ensure that medical gases are stored safely and securely.
- 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.
- The trust should consider how to meet the need to see patients in the TIA clinic with 24 hours over weekend and bank holiday periods.
- The trust should consider how the privacy and dignity of inpatients can be maintained in the main radiology department.
- The trust should consider how to manage environmental capacity in the eye unit and breast unit.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement



Rating Why have we given this rating?

- The Emergency Department (ED) regularly saw more patients than the infrastructure was built to accommodate. Building work was in progress to expand the ED.
- There was no assigned room for mental health patients to stay whilst in the department and no formal environmental risk assessments to record risks associated with mental health patients or the environment they were placed in. A room was under construction which would reduce the risks posed to patients.
- One of two entrances to the paediatric ED was via an unlocked door, which posed a risk of unauthorised access. There was no area designed for adolescents.
- Patient outcomes were measured through audits at both national and local level. Improvements were evident in audit results relating to sepsis care. However we were less assured about the work done to improve all other national audit results given that the trust had no formal action plans in place.
- Staff described a limited number of computer terminals causing delays during busy periods.
- Whilst some training was up to date, we were less assured about advanced life support training for nurses and competencies for reception staff.
- Annual appraisal rates were below the trust target of 85%.
- Access and flow remained a problem and despite efforts to address this, the ED missed the target to see, treat, admit or discharge patients within four hours over the last two winter seasons. Additionally, the number of patients waiting between four and 12 hours following a decision to admit was above the England average.
- Staff felt supported by leaders in the department. Senior staff felt supported by the trust executive team but reported it had taken some time to establish this.

Summary of findings

- Despite these issues, the department was visibly very clean and tidy.
- Fridges storing medicines requiring low storage were within the correct temperature range and checked regularly. Equipment was stored in an organised way, within expiry date for portable appliance testing.
- A central safeguarding team and safeguarding link nurses with specialist knowledge worked within the ED.
- Records were legible, and included the correct details
- Major incident equipment was in place and equipment for patients suffering viral haemorrhagic fever such as Ebola was fit for purpose and regularly checked. Practice educators worked in the department to ensure other staff competencies were maintained.
- Staff cared for patients using national and local guidelines, policies, protocols and pathways. Pain was checked and managed for patients where necessary. Patients were offered food and refreshment whilst in the department.
- Staff worked together to provide services. These included doctors, nurses, physiotherapists, the safeguarding team, police, the rapid assessment interface discharge (RAID) team, Age UK and other NHS trust's emergency planning teams.
- Staff worked under the principle of implied consent when caring for and treating patients. They knew who to contact to organise assessments of patients under the Mental Capacity Act 2005.
- Patients spoke highly of the care they received, describing staff as friendly, calm and caring, introducing themselves and taking time to listen and explain care.
- Staff invited people who had lost a loved one back to the ED to meet with staff and answer any questions about what happened, to help with the grieving process.
- Staff were familiar with local people and their needs. Language interpretation was available for

Summary of findings

patients or loved ones and Hearing loops were available for people with hearing problems. Loved ones were able to access quiet rooms if they wished.

- Complaints were dealt with at the time they occurred, if possible. Formal complaints were referred to the trust's patient advice and liaison team.
- Staff were aware of the vision and values held by the trust and plans to expand the ED in the future.
- Governance, risk and quality was measured and recorded appropriately.
- Innovative work to assist bereaved relatives took place and the department focused on the new build and community supportive strategies to ensure future sustainability.

Medical care (including older people's care)

Good



We rated medical services as good because :

- Clinical staff had access to information they required, for example diagnostic tests and risk assessments.
- Staff were clear about the procedures in relation to assessing patients for capacity and in the completion of capacity assessments and deprivation of liberty forms.
- The hospital had implemented appropriate schemes to help meet individual patient needs. For example those living with dementia.
- Care was provided in line with national best practice guidance and the level of pain patients were in was monitored effectively
- Staff were committed to delivering good, compassionate care and were motivated to work at the hospital.
- There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was relatively clean and staff followed good hygiene practices.
- Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. Action plans were in place if standards were not being met.

Summary of findings

- We observed care and found this to be compassionate from all grades of support and clinical staff and patients were involved in their care and treatment and could access emotional support if they needed to.
- The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and a red symbol to indicate that a patient was frail or elderly. This helped alert staff to people's needs. Medical services had access to psychiatric liaison services to help support patients who had dementia or a cognitive impairment and who had challenging behaviour
- Medical services captured views of people who used the services with changes made following feedback. A survey showed that people would recommend the hospital to friends or a relative.
- All staff knew the trust vision and behavioural framework and said they felt supported and that morale was good. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

However,

- We found records were left unsecured on a number of wards we visited and there was a risk that personal information was available to members of the public.
- There were standards for record keeping that required improvement but records did include a treatment plan for each patient.
- Oxygen was not being stored in line with guidance and resuscitation equipment was not always being checked. We found occasions where the temperature of fridges used to store medications were not always checked. However, there was good management of safe administration and prescribing of medication.

Summary of findings

- There were concerns in relation to nursing staffing on some of the wards especially at night and there had been a reliance on agency or bank nurses as well as locum doctors.
- We found there was insufficient bed capacity on occasions to meet the needs of people within the hospital but there were systems in place to ensure they were reviewed by the medical team.
- We observed care and found this to be compassionate, however, privacy and dignity was not always being maintained on the discharge lounge.
- There were governance structures in place which included a risk register. Some actions on the register had still not been completed despite being past the target date for completion.

Surgery

Good



We gave the surgical services at the Royal Bolton Hospital an overall rating of good. This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises. Medicines were stored safely and given to patients in a timely manner.
- Most staff had completed their statutory and mandatory training and the hospital's internal targets for training completion were achieved. The staffing levels and skills mix was sufficient to meet patients' needs.
- The surgical services reported four never events between January 2015 and January 2016. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- Remedial actions were taken to learn from these never events and to minimise the risk of reoccurrence. Most remedial actions had been completed and staff were working to implement the remaining actions. There were clear timelines in place for the completion of these actions.

Summary of findings

- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with the England average for most safety and clinical performance measures.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their annual appraisals. However, the hospitals internal target of 85% appraisal completion had not been achieved across all the surgical specialties.
- Patients and their relatives spoke positively about the care and treatment they received. They told us they were kept fully involved in their care and the staff supported them with their emotional and spiritual needs. Patient feedback from the NHS Friends and Family Test showed that most patients were positive about recommending the surgical wards to friends and family.
- Services were planned and delivered to meet the needs of local people. The surgical services achieved the 18 week referral to treatment standards across most specialties.
- The proportion of elective operations cancelled at the hospital was either similar to or slightly worse than the England average from April 2013 to December 2015. However, the services performed better than the England average for the number of patients whose operations were cancelled and were treated within the 28 days.
- Actions taken to improve patient access and flow by opening an additional ward to increase capacity for day surgery and elective admissions. A theatre productivity and safety project was also in place to improve theatre efficiency.
- There were systems in place to support vulnerable patients. The majority of complaints about the services were resolved within the expected time frames and complaints were shared with staff to aid learning.
- The hospitals vision and values had been cascaded across the surgical services. Key risks

Summary of findings

to the services, audit findings and performance was monitored through routine departmental and divisional governance and integrated performance meetings.

- There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers.

Critical care

Good



We gave the critical care services at the Royal Bolton Hospital an overall rating of good. This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises.
- There were plans to build a combined critical care unit by 2019. In the interim, risk assessments had been carried out to minimise the risk to patients. The control measures included visible prompts and floor markings, additional infection control training and monitoring of staff compliance and restricting visitors to a maximum of two per bed.
- Most staff had completed their mandatory training and the hospital's internal targets for training completion were achieved. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks.
- The critical care services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The service performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit.
- Patients received care and treatment by multidisciplinary staff that worked well as a team. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Patients and their relatives spoke positively about the care and treatment they received. They were supported with their emotional and

Summary of findings

spiritual needs. Feedback from surveys showed patients or their relatives were positive about recommending the services to friends and family. There were systems in place to support vulnerable patients.

- There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. Bed occupancy levels were similar to or slightly lower than the England average between March 2015 and February 2016. Most patients were admitted to the ICU within four hours of making the decision to admit and assessed by a consultant within 12 hours of admission.
- Remedial actions were being taken to reduce delayed discharges, including increased consultant presence on the HDU and analysing admission data to predict capacity issues. Staff also took appropriate steps to minimise the impact to patients privacy and dignity.
- The hospitals vision and values had been cascaded across the critical care services. Key risks monitored through routine departmental and governance meetings. There was effective teamwork and clearly visible leadership within the services.
- Staff were positive about the culture within the critical care services and the level of support they received from their managers. The services participated in a safety culture survey during 2015, which showed staff were positive about morale, training and overall safety culture.
- The ICU team received the team of the year award in 2015 following their work on patient diaries, ICU follow up and for their work to facilitate the discharge of three patients that expressed a preference to die in their own home.

However, we also found that: -

- The intensive care unit (ICU) and one bay in the high dependency unit (HDU) did not have sufficient bed space of a minimum of 25.5M2 as outlined in the Department of Health Health Building Note HBN 04-02 (critical care units) guidelines.

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- There were 60 delayed discharges over four hours on the ICU between September 2015 and February 2016. However, there were 246 delayed discharges over four hours on the HDU during this period. The delayed discharges were mainly due to a lack of available ward beds across the hospital.
- The presence of patients with delayed discharges meant there were three mixed sex breaches on the ICU between January 2015 and March 2016. However, there were 40 mixed sex breaches in the HDU during this period; 25 of these breaches occurred between January 2016 and March 2016.

Maternity and gynaecology

Good



Services for children and young people

Good



Overall we rated children and young people's services at Bolton NHS Foundation Trust as good. This was because:

- Processes were in place to use available evidence to achieve good outcomes for children and young people.
- Guidelines were based on national standards of best practice and audits were undertaken to identify compliance with action plans for improvements.
- Systems were in place to support children and young people and their families to provide informed consent to procedures.
- Staff were kind and compassionate in their communications with parents and their children. They were given information in a way they could understand.
- Children and young people felt informed and involved in their treatment options. Regard was given to emotional health and support was provided to promote independence when the child was discharged.
- Children and young people were involved in their care and were aware of their treatment options.

Summary of findings

- Feedback from children and young people who used the service and their families was positive with quotes that the service was ‘excellent’ and that parents were ‘very pleased with the care and the explanations given.’
- Individual needs were considered and needs met wherever possible in a way that did not single people out as different.
- There were strong links with community resources which helped provide continuity of care for patients when they were discharged from hospital.
- Senior staff were represented at trust board level and felt children’s services were listened to and action was taken, where necessary.
- Partnership working and engaging with patients and staff was a priority for the management team.
- Innovation and improvement was encouraged and implemented.

However, there were some concerns, particularly within the safe domain:

- Paediatric nurse staffing did not meet Royal College of Nursing (RCN) guidance in terms of patient to staff ratios in 41 out of 87 shifts (47.1%) over one month that we reviewed.
- Paediatric nurse staffing did not meet RCN guidance in terms of the Advanced Paediatric Life Support (APLS) or European Paediatric Advanced Life Support (EPALS) requirements as there was no suitably trained nurse on shift in 36% of the shifts we reviewed.
- Neonatal nurse staffing was not compliant with British Association of Perinatal Medicine (BAPM) guidance in terms of the patient to staff ratio. Over a three month period the figures varied from 95.4% to 82.9% compliant.

End of life care

Good



We rated End of Life Care as ‘Good’ overall. This was because:

- There were no ‘Never Events’ or serious incidents in the year prior to our inspection, processes were in place to ensure that learning from incidents took place and duty of candour was undertaken when required.

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- End of Life staff were 100% compliant with mandatory training.
- A rapid discharge pathway checklist enabled Pharmacists to process prescriptions quickly.
- The Specialist Palliative Care Team (SPCT) responded promptly when required and worked in line with best practice and national guidelines.
- The partook in the National Care of the Dying Audit and the results showed that they scored above the England average for the majority of indicators.
- There was a proactive and comprehensive end of life care training programme in place.
- There was good evidence of multidisciplinary team working across the hospital and in community settings.
- There was a visible person-centred culture with caring, compassionate staff who considered the needs of patients nearing their final days or hours and their families.
- There was a co-ordinated approach to meeting the needs of the local population and involving other organisations.
- There was a clear work plan in place for end of life care that showed measurable progress.
- There was good leadership with a clear view of strategy.
- Staff told us that the management team worked well together and that they were proud of the service that they provided.
- The mortuary staff had won the 'Non-clinical Team of the Year Award' in 2015 and were very proud of this.

However:

- Consultant cover at the hospital was not at establishment and there was long-term Consultant locum cover at the hospice.
- There was no electronic patient record system in general use in the hospital and patient transfer between services relied on paper-based records.

Summary of findings

- The 'Care After Death' Audit revealed that ward notes did not reveal the trust's bereavement nursing and chaplaincy services being routinely offered to bereaved families or carers.
- The Bereavement Team was being restructured at the time of our inspection and the support offered by them was expected to be undertaken by staff on the wards, overseen by a Band 7 Bereavement Nurse. Staff did not feel supported throughout the consultation period for this and were unclear on what the service would look like going forward.
- There was a lack of private rooms available to break bad news to families and friends.

Outpatients and diagnostic imaging

Good



We rated safe as good because,

- Staff were encouraged to report incidents and lessons were learnt and shared.
- Diagnostic imaging services had established systems and practices in place to protect patients and staff from radiation and radioactive substances.
- 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,

- In the eye unit, audit systems did not provide assurance that safety checks were being carried out following a serious patient safety incident.
- Medical gases were not always stored safely and securely.
- Records were not always stored securely and IT systems were sometimes left logged on and unattended. They were not always well organised or contained minimum patient identifiers and 38% of incidents reported for outpatients and diagnostic imaging related to issues with records.

Summary of findings

- In interventional radiology, the most recent audit of the use of the safer surgery checklist showed this had only been completed in 47% of cases.

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 provided when this was needed, for example interventional radiology and in fracture clinic.
- Appraisal rates were high and staff were supported to develop extended knowledge and skills.
- Ninety-nine per cent of patient records were supplied by health records for outpatient clinics, however, we noted that this figure was based on notes available at the end of clinic rather than at the time of the appointment.
- 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 within 5 days of the appointment and for some specialities this was as low as 36%.

We rated caring as good because:

- 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.

Summary of findings

- Clinical nurse specialists for a range of health conditions were available to provide additional emotional support. Psychologists provided additional emotional support to patients on the breast unit and Churchill Unit.

We rated responsive as good because:

- There were a number of rapid access and one stop shop clinics. Emergency referrals could be seen on the same day in the eye clinic. Services had been planned to meet the needs of local people.
- 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 often ran late and patients were not always informed of delays. 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.
- Diagnostic imaging reporting turnarounds did not meet locally agreed targets.
- The 18-week target for non-admitted colorectal and trauma and orthopaedic patients was missed in each month between April and December 2015.

Summary of findings

- In the main radiology department, there was no separate area for inpatients to wait. This meant that inpatients on trolleys or in beds, usually in nightwear or gowns, waited in the same area as outpatients.
- Some services had outgrown the clinical space available, meaning that areas were frequently overcrowded or additional clinic capacity could not be accommodated.

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,

- In the eye unit, staff felt they were not supported to be innovative. A new business manager was in place following a recent practice review and this change needed further time to embed and provide leadership.
-

Royal Bolton Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Surgery (gynaecology); Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging;

Detailed findings

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Background to Royal Bolton Hospital

The Royal Bolton hospital is part of Bolton NHS Foundation Trust, which provides a range of hospital and community health services in the North West Sector of Greater Manchester. The trust delivers services from the Royal Bolton Hospital (RBH) site in Farnworth, in the South West of Bolton, close to the boundaries of Salford, Wigan and Bury; and also providing a wide range of community services from locations within Bolton.

The Royal Bolton hospital site is situated in the town of Farnworth, near Bolton. The Royal Bolton hospital provides a full range of acute and a number of specialist services including urgent and emergency care, general and specialist medicine, general and specialist surgery and full consultant led obstetric and paediatric service for women, children and babies, including level three neonatal care and 24-hour paediatric and consultant-led obstetric services.

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, 10 CQC inspectors, an inspection planner, an assistant planner, a senior analyst and a variety of specialists including : a non-executive board member, a medical director, a

director of nursing, a senior manager, a governance lead, a safeguarding nurse, a consultant physician, an accident and emergency nurse, an intensive care consultant, an intensive care advanced nurse, and consultant in palliative care, a palliative care nurse, a consultant obstetrician and gynaecologist, a maternity matron, an outpatients nurse, a consultant paediatrician, a nurse consultant in paediatrics, a consultant surgeon, a junior doctor and a student nurse.

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?

Detailed findings

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

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

We held a listening event for people who had experienced care at Bolton NHS Foundation Trust on the 15th and 17th March 2016 in The Royal Bolton Hospital and Bolton One Health Centre. 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 announced inspection of Bolton NHS Foundation Trust 21st – 24th March 2016.

The inspection team inspected the following core services at Royal Bolton NHS Hospital

- Urgent and Emergency Services
- Medical care (including older people's care)
- <>
Intensive/critical care
- Maternity and gynaecology

- Children and young people's services
- Outpatients and Diagnostic Imaging
- End of life care
- Child and Adolescent mental health services

As part of the inspection, we held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters.

We also spoke with staff individually as requested. We talked with patients and staff from all the ward areas and outpatients services. 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 undertook an unannounced inspection between 12pm and 5pm on 6th April 2016 at Royal Bolton hospital. As part of the unannounced inspection, we looked at outpatients and radiology, pharmacy, and medical care wards. 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 at Royal Bolton Hospital.

Facts and data about Royal Bolton Hospital

The Royal Bolton Hospital site is close to the junction of the M60 and M61 motorways and, for non-elective services in particular is estimated to have a catchment population of 310-320,000, compared with a resident Bolton population of 270,000.

Bolton is a major urban region, in which the largest age group is 16-44 (37.9%) as is ranked the 36th most deprived district out of 326 in England in the 2010 Indices of Multiple Deprivation.

The majority of secondary diagnostic, treatment and care services provided from Royal Bolton Hospital are DGH-level emergency and elective specialisms, Royal Bolton hospital also represents a major hub within

Greater Manchester for women's and children's services. In 2011, following implementation of the Greater Manchester-wide Women's and Children's Services reconfiguration Bolton became one of three neonatal level 3 centres and one of eight 24-hour paediatric and consultant-led obstetric providers. The Trust now provides care for approximately 6,000 births p.a.

Approximately 110,000 people attend the trust for emergency treatment every year and 72,000 patients are admitted, of which 84% are non-elective admissions. Approximately 310,000 attend the outpatient departments for consultations. The Royal Bolton Hospital has approximately 740 beds and employs 5200 staff.

Detailed findings






Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Urgent and emergency services

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Good	
Overall	Requires improvement	

Information about the service

Urgent and emergency services are provided at the Royal Bolton Hospital by the emergency department (ED), which is run under Bolton NHS Foundation trust's emergency medicine directorate.

The services operate 24 hours a day, seven days a week. The ED saw 188,768 patients between April 2014 and November 2015 of which 46,032 were children up to the age of 16 years. On average, 315 adults and 76 children attend the ED each day. Approximately 24% of patients arrive by ambulance.

Whilst the emergency department provides care for patients suffering trauma, more severely injured patients will be taken by ambulance or helicopter to the nearest trauma centre at a neighbouring trust, if their condition allows them to travel. If not, they will be stabilised at the Royal Bolton Hospital and then treated or transferred in line with their needs.

There is a designated entrance for patients brought in by ambulance. These patients then wait in the main corridor before being assigned to a suitable area. Ambulatory patients are triaged in one of two cubicles. Patients then receive care and treatment in four main areas: the paediatric area, minor injury/illness, the main 'quadrangle' (majors) and resuscitation bays.

Children wait to be seen in a designated waiting area before being assessed and treated in one of five treatment rooms, two observation bays or two resuscitation bays.

Patients with minor illnesses or injuries are assessed in one of two triage cubicles and treated in one of seven cubicles in the 'minors' area. Patients with more serious illness or injury are seen and treated in the main clinical area ('quadrangle') where there are 12 bays, or in one of four resuscitation bays.

During the inspection we spoke with 10 patients or carers and 30 staff from different disciplines including matrons, senior managers, doctors, nurses, housekeepers, emergency and advanced practitioners, reception and domestic staff. We also reviewed 20 patient records and observed daily activity and clinical practice within the department. Prior to and following our inspection we analysed information about the service which was provided by the trust.

Urgent and emergency services

Summary of findings

We have rated Urgent and Emergency care services at the Royal Bolton Hospital as requires improvement. This is because:

- The ED regularly saw more patients than the infrastructure was built to accommodate. However staff worked hard to ensure patients were accommodated safely, whilst recognising the limitations for dignity and privacy. Building work was in progress to expand the ED.
- At the time of our inspection there was no assigned room for mental health patients to stay whilst in the department. A room was under construction which would be ready in April 2016. However we remained concerned that until the build was completed, mental health patients may be exposed to greater risk.
- There were no formal risk assessments used routinely to record risks associated with mental health patients or the environment they were placed in. Senior staff said risk assessment training had been provided, however despite asking for evidence of this it was not received. We raised this with the matron who assured us staff informally risk assessed areas where mental health patients were being cared for whilst the room was being built.
- One of two entrances to the paediatric ED was via an unlocked door, which posed a risk of unauthorised access. There was no area designed for adolescents in the ED.
- There were no areas of the ED designed for those living with dementia (however the trust confirmed a dementia nurse was advising about adjustments for the new build).
- Patient outcomes were measured through audits at both national and local level. Following poor results for sepsis care, the department had worked to improve care. However we were less assured about work to improve following national audit results given that the trust had no formal action plans in place.

- Staff described having access to the information they needed to provide care and treatment to patients. However they described a limited number of computer terminals causing delays during busy periods.
- Whilst some training was up to date, we were less assured about intermediate life support training for nurses and competencies for reception staff. This was because supporting documentation was incomplete or showed that training had expired.
- Sixty-seven percent of nurses and 79% of doctors were up to date with annual appraisals against a target of 85%. Rates had fallen as staff were called away from line management duties to care for patients in winter months.
- Access and flow remained a problem and despite efforts to address this, the ED missed the target to see, treat, admit or discharge patients within four hours over the last two winter seasons. Additionally, the number of patients waiting between four and 12 hours following a decision to admit was above the England average.
- Staff felt supported by leaders in the department and whilst senior staff also described feeling supported they said it had taken some time to establish this. Receptionists described similar problems with leaders whilst trying to resolve an issue relating to glass screens in the waiting area.

However:

- The department was visibly very clean and tidy. Cleaning records and audit results provided evidence that daily cleaning and infection prevention took place and was of a high standard.
- Fridges storing medicines requiring low storage were within the correct temperature range and checked regularly. Equipment was stored in an organised way, within portable appliance test expiry date. Equipment checklists were completed each day.
- A central safeguarding team and safeguarding link nurses with specialist knowledge worked within the ED.
- Records were paper based. They were legible, and included details of presenting complaint, triage priority, level of pain, and treatment plan.

Urgent and emergency services

- Major incident equipment was stored outside the main ED. Other equipment for use with patients suffering viral haemorrhagic fever such as Ebola was stored around the department. This was fit for purpose and regularly checked. Regular training took place and staff knew what to do should a major incident be declared. Practice educators worked in the department to ensure other staff competencies were maintained.
 - Staff cared for patients using national and local guidelines, policies, protocols and pathways which were readily available for staff in the department. Pain was checked and managed for patients, where necessary. Patients were offered food and refreshment whilst in the department.
 - Staff from a range of disciplines worked together to provide services for patients. These included doctors, nurses, physiotherapists, safeguarding team, police, rapid assessment interface discharge (RAID) team, Age UK and other NHS trusts emergency planning teams. The department were hoping to work more closely with GPs in the future.
 - Staff worked under the principle of implied consent when caring for and treating patients. They knew who to contact to organise assessments of patients under the Mental Capacity Act 2005, and although it was very rare to submit applications under Deprivation of Liberty Safeguards, there was appropriate monitoring of applications made to ensure they were made appropriately.
 - Whilst at times limited space impacted on dignity and privacy, patients spoke highly of the care they received. Staff were described as friendly, calm and caring, introducing themselves and taking time to listen and explain care to patients.
 - Staff proactively cared for family members or those close to patients nearing the end of life. A butterfly symbol was used to highlight that someone close by was dying or had passed away. Staff invited those who had lost a loved one back to the ED to meet with staff and answer any questions to help with the grieving process.
 - The total time patients spent in the ED fluctuated but was consistently below the England average since July 2013.
- Staff were familiar with local people and access to other healthcare provision such as primary care services. Language interpretation was available for those whose first language was not English. Hearing loops were available for people with hearing problems. Loved ones had access to quiet rooms.
 - Complaints were dealt with at the time they occurred, if possible, by way of explanation or reassurance. Formal complaints were referred to the trust's patient advice and liaison team.
 - Staff were aware of the vision and values held by the trust and plans to expand the ED in the future.
 - Governance, risk and quality was measured and recorded appropriately. The department had a risk register in place which contained information such as risk rating, actions to mitigate the risk and dates for review.
 - Innovative work to assist bereaved relatives took place and the department focused on the new build and community supportive strategies to ensure future sustainability.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement 

We have rated urgent and emergency services as requiring improvement for protecting people from abuse and avoidable harm. This is because:

- Systems and processes were not always reliable enough to keep people safe. For example, one of two entrances to the paediatric ED was via an unlocked door, which posed a risk of unauthorised access.
- Building work was in progress to construct a new room suitable for mental health patients. However, until the room was completed, there was no assigned area for mental health patients to stay whilst in the department.
- In the meantime, staff told us they informally risk assessed areas when deciding where to place a mental health patient and that a formal assessment form was in draft almost ready to distribute for use. Senior staff said risk assessment training had been provided, however despite requesting evidence of this we did not receive it. We were concerned that until the build was completed and formal assessment documentation used, mental health patients may be exposed to greater risk.
- The department had frequent staff shortages. Nursing posts were being advertised which would address shortfalls for nurses. In the meantime vacant shifts were covered by agency nurses. There were also vacancies for middle grade doctors which were proving difficult to recruit to. Whilst efforts were made to recruit these doctors, locums and consultants covered the shortfalls.
- Staff completed mandatory training and were able to check requirements for training on line. Compliance with mandatory training in nurses and doctors met the trust target of 85% for some but not all training topics.

However:

- We saw an open culture of reporting and learning from incidents. Monthly mortality and morbidity meetings were held.
- The department was visibly clean and tidy with 100% compliance regularly attained through trust wide audits of cleanliness and hygiene. Records showed that cleaning was done regularly, except for the sterilisation of toys where we found some completion dates missing.

- Equipment, medicines and controlled drugs were stored in an organised way within expiry date. Checklists were used to record equipment stock levels in treatment areas. Controlled drug stocks were checked and correctly recorded. Fridges storing medicines requiring low temperature storage were within the correct temperature range and regularly checked.
- The trust had a central safeguarding team and safeguarding link nurses with specialist knowledge worked in the ED.
- Records were paper based. They were legible and included details of presenting complaint, triage priority, level of pain, and treatment plan.
- Major incident equipment was stored outside the main ED. Other equipment for use with patients suffering viral haemorrhagic fever such as Ebola was stored around the department. This was fit for purpose and regularly checked. Regular training took place and staff knew what to do should a major incident be declared.

Incidents

- There was a culture of reporting and learning from incidents amongst staff.
- Incidents were reported electronically and staff received email receipts following submission. Learning was shared during monthly staff meetings and bi-weekly governance meetings.
- Between January and December 2015 the department reported 749 incidents, 719 of which were reported as low or no harm.
- Fourteen serious incidents were recorded by the trust between January 2015 and January 2016. Ten of these related to patients found to have pressure ulcers upon arrival in the ED, the other four related to a delay in treatment, abuse of a patient, an accident in the department and a fall.
- Practice was changed following incidents to help prevent recurrence. For example, following an incident, staff were encouraged to record a physical description of vulnerable patients to ensure they could be easily identified.
- Senior staff were familiar with the Duty of Candour. The Duty of Candour is a legal duty to inform and apologise to patients if mistakes in their care have led to significant harm. All staff we spoke with demonstrated an open and honest approach to things going wrong and told us they would escalate any incidents to a senior member of staff.

Urgent and emergency services

- Mortality was discussed divisionally on a monthly basis. Reviewing mortality helps promote learning and provides assurance that patients are not dying as a result of unsafe care. We observed a meeting which was well attended and followed an agenda with minutes produced and disseminated to other staff.
- There was a designated ambulance entrance accessible through a secure doorway. There were two entrances to the paediatric area. One of these entrances was locked between 9pm and 9am each night but the other entrance was accessible at all times. This posed a risk of unauthorised access.

Cleanliness, infection control and hygiene

- The areas we inspected were visibly clean and tidy.
- In the CQC Accident and Emergency patient survey 2014 patients rated the department 8.7 out of ten for cleanliness which was about the same as other trusts nationally.
- Monthly hand hygiene audits were conducted which showed that in October, November and December 2015, staff were 100% compliant with hand hygiene practice.
- Monthly environmental audits covering a range of tasks in different areas were also completed. Checks included equipment stocks in public areas and cleanliness of floors, cutlery trays, bathing areas and curtain tracks. Between May 2015 and January 2016, the ED scored an average of 96%.
- We saw stickers on equipment such as commodes and trolleys indicating they had been cleaned.
- Personal protective equipment with instructions for staff were available throughout the department.
- Domestic cleaning staff explained daily cleaning took place when cubicles were empty which was challenging when the department was busy. They kept a record of areas that they had not been able to access so that the next staff member could ensure cleaning took place as a priority. However this practice had only begun in March 2016. There were no historical records available prior to March which meant we could not corroborate what staff told us about cleaning practice each day.
- Cleaning records were kept relating to sterilisation of toys in the paediatric area. Staff told us cleaning took place daily, but records for January showed cleaning was completed on only nine dates in January 2016 and 13 dates in February 2016.
- Colour coded chairs were used to indicate which area patients waited to be seen for initial assessment or care and treatment.
- There was no designated room for mental health patients to receive care or treatment in the ED. However building works were in progress to construct a suitable room with expected completion in April 2016. The room would have a ligature proof ceiling, dual exits and panic facilities. In the meantime, standard cubicles were used and made as safe as possible by removing equipment (such as tubing) that might pose a risk. Staff told us the trust's rapid assessment and interface discharge (RAID) team provided risk assessment training to enable staff to identify these risks in December 2015. However the trust were unable to confirm how many staff had completed this training. We remained concerned that with no designated area or formal risk assessment in place for patients or the environment, there was greater potential for risks or mitigating actions to remain unidentified.
- Inside the paediatric area there were books, toys and children's television. There was no area for adolescents.
- The clinical equipment we checked was stored in an organised way and labelled to ensure accessibility. It was clean, and in date. Checklist records for September, October and November 2015 showed staff reviewed items each day and placed 'use me first' stickers on items approaching expiry to prompt use.
- Major incident equipment was stored securely outside the main ED. The equipment was in date and records showed it was checked regularly.
- Appropriate signage indicated where compressed gas such as oxygen was being stored. Cylinders were checked twice daily by porters with specialist training.
- Two rooms were available for loved ones to wait in a quiet area. There were no refreshment facilities, television, books or toys in these rooms but staff told us they provided drinks for loved ones.

Environment and equipment

- The ED infrastructure was due to be extended in order to cope with the number of patients attending the ED. For example the majors area had 12 bays, which would increase to 16 in November 2016 and to 22 cubicles in a third phase due for completion in November 2017.

Medicines

Urgent and emergency services

- Medicines and controlled drugs stored in the emergency department were within date and stored securely in an organised way.
- Controlled drugs were checked daily and usage was correctly documented.
- Fridges storing medicine at low temperature were within the required temperature range. Records showed that daily temperature checks were completed ensuring an appropriate range was maintained.
- Nursing staff were either trained to prescribe certain medicines or used Patient Group Directives (PGDs). PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available. We checked a sample of these. Whilst some were dated 2013, we saw updates listed at the front of the folder and staff signatures to confirm they had read the up to date directives.
- Link nurses worked within the ED to provide advice and support for staff, as required.
- Training took place to maintain knowledge about safeguarding. Clinical staff received level two safeguarding training for both children and adults, whilst paediatric clinical staff trained in level three. Managers told us that they were hoping to train all staff to level three in the future.
- The trust target for the completion of training was 95%. The trust could not tell us how many ED staff had completed safeguarding training but did provide figures for the division. These showed that administrative staff met the target for non-clinical training (96%), medical staff did not meet the target for children's safeguarding training (80%) but did for adult safeguarding training (97%) and nursing staff met the target for children's safeguarding training (98%) but not for adult safeguarding training (93%).

Records

- Patient records were in paper format and stored securely behind the reception desk in a closed office. Following discharge, records were scanned into the electronic system to be used for future reference. The trust was due to move to an electronic records system in the future.
- We reviewed 20 (including six paediatric) patient records during our inspection. These were legible, with details of the presenting complaint, triage priority, level of pain, and treatment plan. Risk assessments for nutrition, social circumstances, tissue viability, moving and handling and safeguarding were not always completed, but were not always required based upon the patient's medical condition.

Safeguarding

- The trust safeguarding team supported staff between Monday and Friday from 9am until 5pm. Outside of these hours, staff liaised directly with social workers.
- Safeguarding staff told us they visited the department every morning (Monday to Friday) to collect referrals made by staff. Reception staff confirmed this and we observed their attendance during our inspection.
- Children who were taken away from the ED by parents or carers before being seen were flagged by staff to ensure that, where required, assessment care or treatment could still be provided.

Mandatory training

- Mandatory training for conflict resolution, resuscitation, information governance and medicine management was completed by all staff through e-learning. Statutory training was also undertaken by staff and covered fire safety, infection, prevention and control, moving and handling and equality and diversity. Two practice educators were employed in the department to ensure staff received up to date training and staff accessed their on line training account to identify training requirements.
- The trust could not tell us how many ED staff had completed training but did provide figures for the division. These showed that against a target of 85%, 83% of medical and dental staff were up to date with resuscitation and medicine management, 88% with conflict resolution and 70% with information governance training. Of nursing and midwifery staff; 91% were up to date with resuscitation, 86% with conflict resolution, 83% with medicine management and 87% with information governance training.
- We asked the trust to provide statutory training figures for ED staff but they were unable to do this. Instead they provided figures for the division as a whole. These showed that 88% of medical and 90% of nursing staff were up to date with fire safety training with the same figures for infection, prevention and control training.

Urgent and emergency services

Ninety percent of medical and 92% of nursing staff were up to date with moving and handling training and 96% of medical and 93% of nursing staff were up to date with equality and diversity training.

Assessing and responding to patient risk

- Staff managed patient risk by following processes and using tools to triage and assess patients. These included the Manchester Triage System (MTS) and an Early Warning Score (EWS) system. The Manchester Triage System is a clinical risk management tool which standardises the triage process using a red, amber, green rating. EWS systems analyse clinical observations within set parameters to determine how unwell a patient may be. When observations fall outside parameters they produce a higher score, which can indicate a requirement for more urgent clinical care than others.
- Initial triage using the MTS was done for all patients attending the ED and we saw evidence of this in the records we reviewed.
- We reviewed 11 records deemed to require an EWS score during triage and found that nine of them had a score recorded.
- To help mitigate the risks associated with children, some staff were trained in advanced paediatric life support (APLS). The trust confirmed that at least one doctor with APLS training was always on duty.
- Staff used a 'suicide risk assessment' tool to assess the risk of self-harm in some patients. The tool helped define patients as low, medium or high risk. This helped determine the level of observation required.
- The risk of mental health patients harming themselves or others can be managed by having a room designed to reduce the risk of suicide, self-harm or harm to others. At the time of our inspection there was no designated room for mental health patients but construction was in progress with completion expected in April 2016. The matron confirmed that a ligature proof ceiling, dual exits and panic buttons would be incorporated. In the meantime the issue was recorded as a risk along with mitigating actions.
- Staff did not complete formal risk assessments about where to place a mental health patient. Formal environmental risk assessments prompt staff to identify risks such as ligature points, or sharp objects. In the

meantime, a mental health safety form was being devised which, once implemented, would help staff confirm details such as any plans to self-harm or delusions.

- Security staff were based in the department between 6pm and 6am and available upon request at other times. One of their roles involved observation of patients deemed to be vulnerable or at risk. Staff used trust policy to determine the level of observation required. We saw observation in progress during our inspection. Here staff kept a respectful distance whilst monitoring the patient.
- Reception staff alerted nurse colleagues if they had clinical concerns about a patient. For example, those with chest pain. However, the decision to do this was based on experience rather than key descriptors.
- Staff were trialling the use of a yellow wrist band, placed on vulnerable patients. This helped staff identify patients that might need more support or be at greater risk whilst in the department, due to issues such as confusion.
- Calls bells were available for patients to use to summon assistance if required.

Nursing staffing

- A range of nursing staff were assigned to areas of the ED each day in an organised way. These included staff nurses, emergency and advanced nurse practitioners, senior sisters and a matron.
- In total, 46 full time nurses and 14 part time nurses were employed in the department.
- The trust reviewed staffing levels twice a year across the division using a tool devised by the Association of UK University Hospitals. Senior staff explained that establishment levels were due to be recalculated because the infrastructure was expanding and the number of patients being seen had increased beyond expectations since last year.
- At the time of our inspection there were eight vacancies with an additional five staff due to retire in summer 2016. Recruitment was in progress for ten nursing posts.
- Vacancies were reflected in fill rates provided by the trust. Fill rates provide the percentage of staff on duty against establishment. Between September and December 2015 the average fill rate was 87% during the

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day and 93% during the night. The business manager and matron confirmed that the department was able to deliver a safe service at these levels but did require more staff.

- Senior staff sourced agency staff to ensure staffing levels were safe and we saw evidence that agency staff use was approved to cover absence. Between April 2014 and March 2015, 7.9% of staff on duty were sourced from agencies. Staff remained mindful of agency costs being higher at night, weekends or public holidays and rostered core staff during these times as much as possible.
- The trust was unable to provide sickness levels for the ED but did provide the rate for the division as a whole. This was 4.9% between April 2014 and March 2015 which was slightly higher than the average sickness rate for NHS staff in England (4.4% between January and March 2015).
- Nurse handovers were completed twice daily for all staff. We observed a handover where details about each 'majors' patient, number of patients in the department for more than four hours, staff numbers and assigned areas were discussed. Other information was also shared including details about drop in sessions to discuss revalidation, reminders about using nil by mouth signs, completing equipment checks and the use of yellow wrist bands for vulnerable patients.

Medical staffing

- The department was fully staffed with an establishment of 10.5 whole time equivalent consultant staff. However following a recent review, the Royal College of Emergency Medicine had recommended an establishment of 16 consultants in the department. Additionally, trust finance staff had confirmed that, on average, demand exceeded current medical and nurse staffing levels between 9am and 9pm. These findings were being considered at the time of our inspection.
- Seven middle grade doctors were employed in the department. However, 12 were required. The short fall in medical staff was being covered by consultants. Between 7 and 21 March 2016, consultants covered 24 vacant middle grade shifts. Whilst the shifts we reviewed showed that staffing levels were safe, we were concerned that the current use of consultants to fill middle grade shifts may not be sustainable in the long term.

- Locum doctors were also used to boost medical staffing levels. Between May 2014 and March 2015 the average rate of locum use was 21.5%.
- The division had recently authorised recruitment for two middle grade doctors and relaxed the cap on locum use to assist with staffing. However, managers described difficulties recruiting due to the high volume of patients attending the ED compared with other EDs which they felt made it appear a more stressful work environment.
- Consultant cover was provided in the department between 8am and 10pm seven days a week. Outside of these times consultants were available on an on call basis. One consultant specialised in paediatric emergency medicine in line with Royal College of Paediatrics and Child Health (RCPCH) (2007) recommendation.
- The trust was unable to provide sickness levels for the ED but did provide the rate for the division as a whole. This was 0.93% between April 2014 and March 2015, well below the average sickness rate for NHS staff in England (4.4% between January and March 2015).
- Medical handovers took place at 8am, 1pm, 3pm, 5pm and 10pm each day. We observed a handover, which was well attended with an established process where doctors conveyed patient details. General issues were also discussed including reminders about sepsis care, pain scores, early warning scores and identifying vulnerable patients.
- Individual handovers took place between acute medical physicians who maintained a presence in the ED to ensure medical patients were moved away from the ED and onto medical wards as soon as possible.

Major incident awareness and training

- The trust had an up to date policy and plan for managing a major incident as well as business continuity plans to manage service disruption such as fire, or infection outbreaks.
- The department held a security procedure for 'locking down' the department, if required.
- Major incident action cards and equipment were available for staff. Action cards contained clear instructions, roles and responsibilities for staff assigned to different areas. Equipment was stored in an organised way, regularly checked and within expiry date.
- Staff were trained for major or hazardous material (HAZMAT) incidents. Training took place on a monthly

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basis. We saw that in December 2015 and January 2016 19 staff completed training. Large scale training sessions took place every three years, the last of which was a simulated train crash in October 2014.

- Supportive documentation was available for staff caring for patients presenting with infectious diseases such as Ebola or Middle East Respiratory Syndrome (MERS). These are serious diseases originating in Africa and the Middle East. Separate action cards were held to help staff care for suspected patients safely. Specialist protective equipment and equipment for assessing suspected patients such as 'remote' thermometers was stored in triage areas and in good working order.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



We have rated urgent and emergency services as requires improvement for providing effective care for patients. This is because:

- Whilst patient outcomes were measured through audits at both national and local level we had concerns that action was not always taken following national audit findings. This was because the trust had no formal action plans in place to address identified areas for improvement. Senior staff acknowledged there had been a lack of focus in this area but were hopeful this would improve following the appointment of a new lead consultant.
- Despite staff saying they had access to the information they needed to provide care and treatment to patients, they highlighted limited computer terminals which caused delays when the department was very busy.
- Whilst some training to maintain competency was up to date, we were less assured about intermediate life support training for nurses and competencies for reception staff. This was because supporting documentation was incomplete or showed that training had expired.

- Only 67% of nurses and 79% of doctors were up to date with annual appraisals against a target of 85%. Rates had fallen as staff were called away from line management duties to care for patients in winter months.

However:

- Staff cared for patients using national and local guidelines, policies, protocols and pathways which were readily available for staff in the department. Pain was checked and managed for patients, where necessary. Patients were offered food and refreshment whilst in the department.
- Staff from a range of disciplines worked together to provide services for patients. These included doctors, nurses, physiotherapists, safeguarding team, police, rapid assessment interface discharge (RAID) team, Age UK and other NHS trusts emergency planning teams. The department were hoping to work more closely with GPs in the future.
- Staff worked under the principle of implied consent when caring for and treating patients. They knew who to contact to organise assessments of patients under the Mental Capacity Act 2005, and although it was very rare to submit applications under Deprivation of Liberty Safeguards, there was appropriate monitoring of applications made to ensure this was done appropriately.
- Practice educators worked in the department to help ensure staff competencies were maintained.
- Following poor results for sepsis care, the department had worked to improve this through education, screensaver prompts and monthly monitoring. Improvements were evident in audit results.

Evidence-based care and treatment

- Staff followed national guidelines and pathways issued by the National Institute of Health and Care Excellence (NICE) such as managing meningitis (bacterial) and meningococcal septicaemia in under 16s (CG102).
- Staff also used locally devised care pathways, policies and quick reference guides relating to topics such as asthma, sepsis, status epilepticus, tracheostomy management, chaperone use and consent. These were based on national or regional guidance. Other trust policies helped staff manage vulnerable patients or major incidents. Joint protocols with local police helped staff provide care for patients behaving aggressively.

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- Pathways, policies and guidance were available in folders or accessible via the trust intranet. The documents we reviewed were comprehensive, formally approved and within their review date except the guideline for sepsis, which was due for review in July 2015. Senior medical staff told us it was currently undergoing ratification and would be updated as soon as complete. However the trust later confirmed that ratification was already complete, with the new version uploaded to the trust intranet site on March 15 2016.
- Local audits were done to monitor practice in the department including recording clinical observations and sepsis care. Individual audits were also completed for heart attack and head injury patients.
- Results for recording clinical observations showed 91% compliance in January, 99% in February and 98% in March 2016. Results for sepsis showed improvements in the percentage of patients appropriately screened for sepsis between October 2015 (64%) and December 2015 (74%). This was attributed to initiatives such as a 'staff sepsis awareness week' in early December 2015.
- The audit of heart attack patients (December 2015) reviewed seven patients with a specific type of heart attack requiring specific treatment. Results showed staff followed protocol correctly in all cases.
- The audit of head injury in children (2014) showed 96% compliance with NICE guidelines for the management of head injury in 51 children reviewed.
- Results were displayed on noticeboards along with good practice (pressure ulcer risk assessment displayed in March 2016) and areas for improvement (record completion displayed in March 2016).

Pain relief

- The department used a range of medicine to manage pain including paracetamol, codeine and morphine.
- We reviewed ten adult and five paediatric patient records in relation to pain. Four out five paediatric records and nine out of ten adult records showed evidence that pain was assessed, with analgesia provided when required.
- In the CQC A&E survey 2014, the department scored 7.4 out of ten for patients reporting staff did everything they could to help control pain which was about the same as other trusts surveyed in England
- Patients we spoke to confirmed staff asked them if they were in pain and offered analgesia if required.

Equipment

- The department had recently upgraded their IT system. This meant that processes such as generating GP letters were now much quicker. However there were still some issues associated with IT facilities in the department. For example junior doctors described the limited number of terminals in the department (four terminals in the majors area and two mobile computers).

Nutrition and hydration

- There were two vending machines and a hot drinks machine in the waiting area that were fully stocked at the time of our inspection. Additionally, there was a café in the main hospital open from 9am until 2am every day.
- Two housekeepers worked in the department between the hours of 7:30am and 6pm Monday to Friday. They provided breakfast, lunch and dinner for patients in the department.
- In the CQC A&E survey 2014, the department scored 7.3 out of ten for patients being able to get suitable food and drinks which was about the same as other trusts surveyed in England
- Patients we spoke to had been offered regular food and refreshment where appropriate.

Patient outcomes

- The trust participated in national audit programmes by the College of Emergency Medicine (CEM) for severe sepsis and septic shock (2013/14), asthma in children (2013/14), paracetamol overdose (2014/15), management of the fitting child (2014/15) and assessing cognitive impairment in older people (2014/15).
- The severe sepsis and septic shock audit showed that vital signs were measured and recorded in only 32% of patients within 15 minutes of arrival against a target of 100%, high flow oxygen was initiated in the ED in only 12% of patients against a target of 100% and the first intravenous crystalloid fluid bolus was given in the ED within one hour in only 36% of patients against a target of 75%.
- Work had been done to improve knowledge of sepsis among staff. Screensavers were applied to computers with quick reference guides about assessing and treating sepsis, and an awareness week and study day was held in December 2015. Results for sepsis care

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showed improvement. For example, in 2013, antibiotics were given within 120 and 180 minutes following arrival in the ED. By 2015 the time had reduced to within 70-100 minutes.

- The asthma in children audit showed that 86% of children had a respiratory rate and 100% had a pulse rate recorded within 15 minutes of arrival against a target of 100%. However only 6% had a systolic blood pressure and peak flow recorded against targets of 100%.
- The paracetamol overdose audit showed that only 13% of eligible patients received N-acetylcysteine within one hour of arrival against a target of 100% and only 51% received the recommended treatment in relation to the Medicines and Healthcare products Regulatory Agency against a target of 100%.
- The initial management of fitting children audit showed that in all cases reviewed an eye witness history was recorded in line with the target of 100%. However, only 18% of records showed that parents'/carers had been given written safety information during discharge.
- The assessing cognitive impairment audit showed that only 5% had a cognitive assessment completed against a target of 100%.
- We asked the trust to provide evidence of actions taken to address the findings in these audits, but we were told that no action plans were in place.
- Senior staff explained that whilst some of the data required to reach these targets was not always possible or appropriate to obtain they acknowledged there had been a lack of focus on audits recently. They explained that three weeks prior to our inspection, a new lead was identified and a new focus on audit was expected imminently. In the meantime, senior staff sought assurance of good practice by monitoring local audits, complaints and incidents.
- We asked the trust to provide details about mental health patient outcomes for assurance that care was timely. The trust told us they did not record these details. ED staff told us the Rapid Assessment Interface Discharge (RAID) team usually responded within the hour. Figures provided by the trust showed that between April 2015 and February 2016 88% of referrals received a response within one hour of the request being made.
- In addition to audits, the trust monitored the number of patients who unexpectedly re-attended the ED within

seven days of discharge. Between January 2013 and November 2015 the figures were consistently above (worse than) the Department of Health target of 5%, with between 5% and 7% of patients re-attending.

Competent staff

- Two practice educators worked with staff to ensure they were competent in their roles. Whilst medical staff received protected time for training on a weekly basis, nursing staff did not.
- Staff were trained in advanced life support techniques. Out of 11 consultant staff, eight were trained in advanced life support (four were trained as instructors), seven were trained in advanced paediatric life support (three were trained as instructors) and eight were trained in advanced trauma life support (with one trained as an instructor).
- Advanced nurse practitioners audited nurses responsible for triage through observation. Comments were recorded such as missing information or incomplete history taking, along with feedback such as reminders to ensure hand writing was legible.
- The data supplied in relation to advanced life support for nursing staff was more difficult to interpret. For example, for annual intermediate life support training, only four out of 63 adult ED nurses had completion dates within the last 12 months listed. Twenty-six staff had blank spaces which practice educators told us meant training had expired and 28 staff names displayed dates that were older than 12 months old. Findings were clearer for advanced life support where the trust confirmed all advanced nurse practitioners, and seven out of 11 band seven senior nurses were trained. The trust also told us that 11 band six nurses and seven band five nurses were trained but it was not clear how many staff there were in total regarding the latter two figures. In relation to advanced paediatric life support training for 16 paediatric nursing staff, 12 were listed as requiring refresher training. The trust told us that all senior nurses were booked for refresher training over the coming months.
- Study days for topics such as sepsis, non-medical prescribing and meetings relating to revalidation for nurses were held throughout the year and staff were expected to attend.

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- There was a formal induction package in place for new staff. This involved going through a standard trust induction form with details including the trust sickness policy and dress code before working through a series of competencies within different areas of the Department. These included competencies for medical device use, protocols for particular clinical presentations, cannulation and catheterisation. Additionally, practice educators supervised staff who worked on a supernumerary basis for approximately two weeks.
- Medical and nursing staff rotated between the adult and paediatric departments to maintain skills.
- Staff nurses had opportunities to develop professionally to the roles of emergency or advanced nurse practitioner.
- Appraisals took place to allow managers and staff to meet on an individual basis. However, only 67% of nursing staff and 79% of medical staff had received an appraisal within the last 12 months. The matron confirmed that protected time for appraisals had been stopped to allow staff to provide patient care in the department. Rates were expected to improve when new staff were recruited. The appraisal rate for reception and secretarial staff was 35%. We queried this with the supervisor who advised the rate was actually 85% but there had been a delay in sending figures to the Human Resource department.
- Reception staff also had key competencies to work through. These included being competent in preparing for clinic, making clinic appointments, entering data and generating GP letters and making bed requests. However when we checked the folder of 30 staff, only two had entries to show competencies. All the entries for these two staff were dated 15 October 2015.

Multidisciplinary working

- Multi-disciplinary work took place both internally and with colleagues in the wider local community.
- ED staff worked with physiotherapists to provide care for patients and helped each other during training to widen knowledge.
- The department worked closely with the police when police intervention was required. A police liaison officer was based in the department to assist with care and help formulate strategies such as a mental health assessment form and a flow chart for patients displaying violent behaviour. Additionally, the officer reviewed

cases where vulnerable patients left prior to receiving treatment as well as safeguarding issues. Regular multi-agency meetings were held with ED staff, safeguarding agencies and the police.

- Staff worked closely with the trust's Rapid Assessment Interface and Discharge (RAID) team of two psychiatrists, 13 nurses and a psychologist. With availability 24 hours a day, seven days per week, the team attended within a target of one hour to assess mental health patients and provide links social care, substance misuse workers and community services. They told us that 50% of referrals came from the ED with approximately six referrals each day.
- The department worked with Age UK, the local clinical commissioning group and the local council for two specific services. The Admission Avoidance Team offered support to patients to enable them to remain at home rather than attend the ED. The 'Take Home and Tuck up' service ensured that elderly patients discharged from the ED at night were assisted into bed at home, with a follow up welfare call made by Age UK.
- The department was working with the local clinical commissioning group to consider co-locating a GP led service next to the ED. This would allow staff to signpost patients to GPs if they did not require emergency or urgent care.
- The trust emergency planning team formed part of the 'Greater Manchester Acutes Group' where planning teams from local NHS trusts met on a bi-monthly basis.
- Staff worked with health visitors and school nurses in the community to bridge safeguarding links by ensuring copies of all children's records were sent to them for information.

Seven-day services

- The department operated seven days a week 365 days a year. However some services within the ED were not available at all times.
- A&E follow up clinics and housekeeping staff operated between Monday and Friday each week but not evenings or weekends. Housekeepers ensured patients and loved ones received food and refreshments, replaced curtains and ordered stock for the department. Outside of these hours, ED staff fulfilled the role of the housekeeper.
- Porters were based in the department each day until 4am. After this staff had to request central porter services which could take longer.

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- The Admission Avoidance Team were available to assist the department seven days a week between 8am and 10pm but not overnight. This team provided urgent assessments and support for patients over 65 years old to prevent unnecessary hospital admissions. This included short-term treatment such as intravenous antibiotics and fluids.

Access to information

- Reception staff had access to information required to support visitors and staff in the department. For example, bleep numbers for departments such as thoracic, fracture clinic, and neurology were displayed as well as actions in the event of a chemical incident.
- In the paediatric resuscitation area observational charts for a range of ages were displayed for quick reference.
- Staff could source specialist information about topics such as dementia, pain, ophthalmology or safeguarding from link nurses based in the department.
- When improvements were required, the trust increased access to information. For example, sepsis care information was displayed as screensavers to reinforce important information.
- Despite this, staff reported difficulties accessing IT terminals in the department, especially during busy periods. There were four terminal in the majors area and two mobile computer terminals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff explained the process for caring for mental health patients which included referral to a mental health liaison team, requesting security or additional healthcare assistants to provide one to one care or increased monitoring.
- Since January 2016 no Deprivation of Liberty Safeguards applications had been made by the department. Senior staff told us it was extremely rare to make applications with only one made in the last 12 months. However the trust had a process in place to manage and review applications that were made, to ensure they were appropriate.
- Staff worked under the principles of implied consent for much of the care or treatment provided. Implied consent involves compliance with examination or treatment through cooperation, for example, by rolling up a sleeve to have blood pressure taken.

Are urgent and emergency services caring?

Good



We have rated urgent and emergency services as good in the caring domain. This is because:

- Whilst limited space sometimes meant care was provided in an open environment, which impacted on dignity and privacy, feedback from people was positive about the way staff treated people.
- Staff were described as friendly, calm and caring, and spent time talking to people, introducing themselves and taking time to listen and explain care to patients.
- Staff proactively cared for family members or those close to patients nearing the end of life. A butterfly symbol was used to highlight that someone close by was dying or had passed away.
- Staff helped people cope emotionally. They invited people who had lost a loved one back to the ED to meet with staff and answer any questions about what happened, to help with the grieving process.

Compassionate care

- In the CQC A&E patient survey 2014 the department scored nine out of ten for patients feeling they were treated with dignity and respect and 9.1 out of ten for staff not talking to each other as if the patient weren't there. Both these scores were about the same as other trusts surveyed in England.
- We saw staff introduce themselves to patients and build a rapport with them during examination.
- We also saw staff speak with patients and loved ones with a calm and caring manner, particularly when patients looked to be distressed or in pain.
- Patients told us staff were friendly and described feeling safe and very happy with the care provided by staff.
- When the quadrangle (majors) received more patients than could be accommodated, some patients were moved out of bays and into the middle of the room to allow others to be brought in. Those in the middle were not separated by curtains or screens. On multiple occasions we saw patients being cared for in the open.

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Staff described being careful to select clinically appropriate patients but were unhappy about the impact they felt this had on patients' privacy and dignity.

Understanding and involvement of patients and those close to them

- In the CQC A&E patient survey 2014 the department scored nine out of ten for listening to what patients had to say and 7.5 out of ten for family or close friends having the opportunity to talk to a doctor if they wished. The department scored eight out of ten for patients feeling as involved as they wanted to be in their care and treatment. These scores were about the same as other trusts surveyed in England.
- Advice leaflets were available for patients and loved ones to take home following discharge from hospital. They covered a range of topics including burns, knee injury, eye injury, rib injury, road traffic collision incidents and head injury.
- We spoke to six patients who confirmed that everything had been explained to them following their arrival and assessment in the department.

Emotional support

- In the CQC A&E patient survey 2014 the department scored 7.6 out of ten for discussing patients' anxieties or fears with them and 6.7 out of ten for offering reassurance when patients felt distressed in the department. Both these scores were about the same as other trusts surveyed in England.
- The department placed a laminated 'butterfly' symbol on doorways to areas where very sick or recently deceased patients were. This raised awareness that loved ones who had lost or might lose someone were close by.
- The department made a point of contacting those who had lost someone in the ED and offered meetings with staff should they have any questions.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement



We rated urgent and emergency services as requiring improvement for responsiveness. This is because:

- Access and flow remained a problem and despite efforts to address this, the number of patients waiting between four and 12 hours following a decision to admit was above (worse than) the England average. The ED also missed the target to see, treat, admit or discharge patients within four hours over the last two winter seasons.

However:

- The total time patients spent in the ED fluctuated but was consistently below the England average since July 2013.
- Staff were familiar with the needs of local people and the local access to other healthcare provision such as primary care services. Language interpretation was available for patients or loved ones whose first language was not English. Hearing loops were available for people with hearing problems. Loved ones were able to access quiet rooms if they wished.
- Complaints were dealt with at the time they occurred if possible by way of explanation or reassurance. Formal complaints were referred to the trust's patient advice and liaison team.

Service planning and delivery to meet the needs of local people

- Staff were familiar with the needs of the local community and the reasons people attended the ED.
- Interpreter services were available if required and we saw staff start this process for a patient during our inspection.
- There were two rooms for patients' relatives or loved ones to spend time away from the main waiting area. Hot and cold drinks were available upon request but not available in the rooms themselves.
- Play therapists were not based in the ED but were available upon request from the children's ward.

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- Wait times were not displayed for those waiting to be seen. Staff told us this was because they changed frequently and might give inaccurate information to those waiting. To find out about wait times, patients or visitors had to approach reception staff.

Meeting people's individual needs

- A telephone translation service was available for patients or visitors whose first language was not English.
- Adults with mental health needs were cared for by the trust's Rapid Assessment Interface and Discharge (RAID) team who attended to complete dementia screening or mental health assessments for patients in the ED.
- Children and young people with mental health needs were cared for by specialist staff from the local children and adolescent mental health service (CAMHS) who attended upon request. However we were unsure how quickly CAMHS staff attended on average because the trust did not collate this information.
- A hearing loop was installed in the department for patients using hearing aids. Staff also described using written communication for people with limited or no hearing.
- Staff were familiar with patients with learning disabilities or complex needs. They explained that the majority of patients visited with carers and many carried a 'health passport' detailing their condition.
- We noted that none of the areas in the ED were designed as 'dementia friendly'. For example, doorways and floors were not painted to enhance perception. The trust confirmed that a dementia specialist nurse was engaged in helping with environmental adjustments during development of the new build.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. Wait times for admission between four and 12 hours, total time spent in an ED, numbers of patients leaving prior to being seen and ambulance handover times are also monitored.
- Between July 2014 and February 2016 the trust met the target to admit, transfer or discharge patients within four hours for only six out of 17 months. These occasions were during the summer months. Winter

pressures saw average standards drop to 86% from November 2014 to January 2015 and to 84% from November 2015 to February 2016. These figures were slightly below (worse than) the England average.

- The number of patients waiting between four and 12 hours for a decision to admit was higher than the England average during winter months. In January 2015, 19% of patients waited between four and 12 hours for admission. In November 2015 the figure was 14%.
- The total average time spent in the ED between January 2013 and October 2015 was below the England average, ranging between 50 and 139 minutes.
- The percentage of patients leaving prior to being seen was above the England average between July and October 2015. During this time period approximately 3% of patients left the department without being seen.
- Delays in ambulance staff handing over the care of patients was monitored because long delays can increase risk for patients. Ambulance staff experienced delays handing over patients to ED staff, particularly during winter months. For example, in December 2014, there were 1213 delays over 30 minutes and 438 delays over 60 minutes. In January 2015, there were 1158 delays over 30 minutes and 383 delays over 60 minutes.
- Initial assessment was undertaken by nurses rather than medics. The NHS supports early senior assessment for patients which improves patient safety and satisfaction. (Effective approaches in emergency care, paper 2, June 2012).
- In August 2014 the Emergency Care Intensive Support Team (ECIST) reviewed the ED. The team is commissioned by the NHS and provided several recommendations to the trust. One was to 'develop a model to deliver early senior review carried out by a ST4 or above during peak times'. Senior staff described difficulties implementing this model due to current pressures which was supported by the team who state 'implementation can be difficult, particularly in poorly staffed departments'.
- Patients received care in the minors area from emergency nurse practitioners who had received additional training (such as prescribing medicine). The nurses were able to initiate a limited number of investigative tests such as hand, wrist, ankle and foot x-rays or venous blood gases.

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- A nurse coordinator worked in the department at all times and monitored activity and flow in the department. They used an IT system which held details about patients including where they were being cared for, bed requirements and bed availability.
- At times the department became overcrowded. For example at 4pm on a Monday afternoon we observed 27 patients being cared for in the majors quadrangle which was built to cater for a maximum of 12 patients. Here, staff moved four patients into the middle of the room to allow other patients into the bays.
- We also witnessed significant delays for some patients. At 9:12am on one morning we noted that nine patients had been in the department for over eight hours. The following morning at 9:35am we saw five patients who had been in the department for longer than six hours. These patients were all medically fit to leave the ED but were waiting for medical or surgical beds. One patient we saw had been in the department for ten hours 57 minutes. Following review we saw that the patient had received medicines appropriately, had early warning scores and nursing assessments documented, and intentional rounding completed. (Intentional rounding is a structured approach where nurses conduct checks including level of pain, comfort, position and refreshment requirements at set times to manage fundamental care needs).
- Patients brought by ambulance waited in the main corridor until a triage nurse could take over care and locate a cubicle for the patient. The ECIST review identified this as an issue in 2014, stating concerns that 'this issue had become normalised'. Ambulance staff told us delays were frequent.
- Trust bed meetings were held four times daily at 9am, 1pm, 4pm and 7pm. Here, staff from different departments such as pathology, X-ray, ED, and the discharge and flow team, analysed capacity within the hospital. They reviewed actions for maintaining flow such as assessing patients ready for discharge and sourcing extra staff. We observed one meeting and saw that despite this, no discussion took place about where or how soon beds were expected to be available.
- Although the hospital had a Clinical Decisions Unit and an Ambulatory Care Unit, neither of these were run as an adjunct to the emergency department. Instead the areas were used primarily for patients requiring medical care.
- An Admission Avoidance Team worked with the department to support people over the age of 65 to remain at home rather than attend the ED. Nurses took clinical observations and other team members such as physiotherapists, pharmacists or social workers provided therapy or equipment so that patients remained at home safely. During our inspection we saw team members enter the department to identify eligible patients.
- The trust was also part of a trial service called 'Take Home and Tuck Up'. The service enabled elderly patients to be discharged and assisted into bed at home rather than spending the night in hospital.
- The RAID team supported ED staff by identifying and working with patients who frequently attended the department to prevent unnecessary attendance, however response times to the ED were not routinely monitored by the trust.
- Acute medical physicians worked within the ED to identify patients suitable for transfer to medical beds as soon as possible. We saw physicians present and liaise with staff and patients each morning during our inspection.
- Senior nursing staff told us there were no formal descriptors for when to escalate access and flow issues. Instead they used experience to determine when to escalate which we saw in practice during our visit. Despite this, the trust provided us with a draft escalation policy showing indicators such as ambulance handover delays, four hour target breaches and excessive numbers of patients in the majors or resuscitation areas.
- Despite there being no formal escalation policy embedded staff were able to tell us who they escalate to during the day and out of hours.

Learning from complaints and concerns

- The department handled complaints in a number of ways. Reception staff advised they would try to communicate with the complainant before seeking assistance from a senior member of staff. Should someone still wish to complain, staff had leaflets outlining the trust's patient advice and liaison service (PALS). Staff also had access to complaint forms which could be filled in. The form asked for consent to be provided by the patient in line with data protection laws.

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- The numbers of complaints and compliments for the month were displayed on noticeboards in public areas of the department.
- Learning took place following complaints which was documented in a learning log. A learning log was required prior to sending responses to complainants.

Are urgent and emergency services well-led?

Good



We rated services as good for being well led. This is because:

- Staff were aware of and understood the vision, values and strategic goals held by the trust. Staff felt supported by leaders in the department.
- There was an effective and comprehensive process to measure, monitor and address risks. The department had a risk register in place containing information such as risk rating, actions to mitigate the risk and dates for review.
- Governance and quality measurement was evident and there were processes and information available to help staff manage current and future performance. Senior staff had knowledge of quality issues and priorities. Performance issues were escalated to a strategy planning group to help monitor and address issues and risks. However, staffing issues had led to leaders focusing on providing clinical care rather than governance in the past. To address this, a new audit lead consultant had recently been identified and staff felt confident that this would improve the focus on governance and quality measurement.
- Innovative work to assist bereaved relatives took place and the department focused on the new build and community supportive strategies to ensure future sustainability.

However:

- Whilst senior staff felt supported by the trust executive team, they told us this had taken some time.
- Whilst reception staff were kept safe behind glass screens, they experienced difficulties communicating with visitors through the glass and some reported suffering with repetitive strain injury as a result.

Vision and strategy for this service

- Staff were aware of the vision and values held by the trust and described these as 'common sense' approaches to patient care.
- There was a clear strategy in place for expansion of the department. Plans were displayed in the staff room for staff to look at.
- Future strategy also involved improving deflection of patients who could be more appropriately treated elsewhere, and increasing the effectiveness of other pathways of care for ambulance staff, which were more suitable than the ED. A strategy planning group met monthly to monitor and address issues and think about improvements in services.

Governance, risk management and quality measurement

- The department had a risk register in place to ensure issues were captured and reviewed regularly. Each risk had a score, the highest of which was 25 representing significant risk. Review dates, actions and progress were all listed along with a target date for dealing with the risk. The most significant risk listed on the register related to overcapacity in the department and this corresponded with concerns described by senior staff.
- Security staff were based in the department each night from 6pm until 6am and staff had access to panic buttons. Reception staff sat behind glass screens which, although helpful in reducing the risk of violence towards them, had led to communication difficulties and repetitive strain injury because staff had to lean over to communicate more effectively.
- There was evidence of governance and quality measurement. We saw minutes of strategy meetings where issues such as alternative care, quality of care and factors contributing to attendance to the ED were reviewed with actions identified to help the department improve. However, improvement did not always occur following findings of poor performance in areas such as maintaining the four hour target and clinical audit. A new audit lead consultant had been identified and senior clinical managers felt this would improve the focus on measuring quality.
- Weekly 'consultant catch up' meetings took place and minutes showed that quality was regularly discussed.

Leadership of service

Urgent and emergency services

- Staff were happy with their line managers. Senior managers said they had not always felt supported by the executive team describing months of asking for help to manage flow. However the situation had recently improved following a meeting with the executive team.
- Reception staff who had raised concerns with leaders about communication issues due to glass screens felt that their concerns had not been heard by wider managers in the trust until recently. One staff member described the support as 'a long time coming'.

Culture within the service

- Staff told us they felt part of a good team and were positive about colleagues they worked with.
- One staff member spoke highly of the support provided to her by the trust in relation to flexible working.
- Junior doctors described an open culture where staff could 'talk to anyone' and where consultants were active team members. However they also described a very busy department which was stressful at times.

Public engagement

- The trust used posters and web based information to remind the public of the purpose of an ED and alternative care pathways such as the GP, 111 service or pharmacists.
- The department took part in the NHS A&E friends and family test. An average of 20% of patients responded to

the questionnaire and results showed that between March 2015 and January 2016 an average of 85% of patients said they would recommend the department to friends and family.





Staff engagement

- The department was awarded 'team of the year 2015' by the trust.
- Regular staff meetings took place as well as a monthly newsletter which was circulated to all staff by email, noticeboards and in staff toilets. We reviewed the February 2016 newsletter which covered staffing issues, sepsis guidelines, and the clinical management of osteocondritis.
- We asked three nurses about the building plans which were displayed on a wall in the staff room. They told us that although the poster had been placed there, there had been no engagement from senior management in relation to the plans to expand.

Innovation, improvement and sustainability

- The department were hoping to work more closely with GPs in the future to enable patients to receive the most appropriate care in line with their needs. We saw minutes which showed this was already taking place, with plans to recruit more GPs in the future. Talks to develop this service were on going at the time of inspection.

Medical care (including older people's care)

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The medical care services at the hospital provides care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology. The trust serves a population size of approximately of 280,000 people and employs 5,240 staff. There are 332 medical beds at the hospital.

We visited Bolton Hospital as part of our announced inspection on 21 March to 24 March 2016.

During the inspection, we visited wards B1(fraility unit), B3(care of the elderly), C4(general medicine), D1(female medical assessment unit), D2(male assessment unit), D4(respiratory), H3(stoke unit), coronary care unit, ambulatory care, discharge lounge and the endoscopy unit.

We reviewed the environment and staffing levels and looked at 46 care records and ten prescription records. We spoke with 14 family members, 29 patients and 52 staff of different grades, including nurses, doctors, ward managers, occupational therapists, a student nurse, ward clerks, and the senior managers who were responsible for medical services.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust. We observed how care and treatment was provided.

Summary of findings

We rated medical services as good because,

- Clinical staff had access to information they required, for example diagnostic tests and risk assessments.
- Staff were clear about the procedures in relation to assessing patients for capacity and in the completion of capacity assessments and deprivation of liberty forms
- There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was relatively clean and staff followed good hygiene practices.
- Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations where findings were fed back to staff.
- Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. Action plans were in place if standards were not being met.
- We observed care and found this to be compassionate from all grades of support and clinical staff and patients were involved in their care and treatment and could access emotional support if they needed to.

Medical care (including older people's care)

- Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations where findings were fed back to staff.
- The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and a red symbol to indicate that a patient was frail or elderly. This helped alert staff to people's needs. Medical services had access to psychiatric liaison services to help support patients who had dementia or a cognitive impairment and who had challenging behaviour
- Medical services captured views of people who used the services with changes made following feedback. A survey showed that people would recommend the hospital to friends or a relative.
- All staff knew the trust vision and behavioural framework and said they felt supported and that morale was good. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

However,

- We found records were left unsecured on a number of wards we visited and there was a risk that personal information was available to members of the public. There were standards for record keeping that required improvement but records did include a treatment plan for each patient.
- In some areas oxygen was not being stored in line with guidance. We found some occasions when checks to resuscitation equipment and fridge temperature checks were missed.
- There were concerns in relation to nursing staffing on some of the wards especially at night and there had been a reliance on agency or bank nurses as well as locum doctors. Staff were not always implementing trust procedures due to lack of staffing.
- We found there was insufficient bed capacity on occasions to meet the needs of people within the hospital. Some patients had to stay in hospital longer than was needed due to care packages not being in

place when they were ready for discharge. This hospital was working with partner organisations to look at ways to decrease the number of delayed discharges

- Privacy and dignity was not always being maintained on the discharge lounge.
- There were governance structures in place which included a risk register. Some actions on the register had still not been completed despite being past the target date for completion.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement 

We rated medical services as 'requires improvement' for safe because:

- There were some staff vacancies which were noted on the risk register and actions had been identified to mitigate this risk. However, there were still wards where the nurse staffing levels were a challenge and planned shifts were not always filled. This was on wards B1, C1, C4, D1 and D3. However, wards D1 and D3 maintained a ratio of 1 registered nurse to 8 patients between September - December 2015 on every shift. B1 and C1 maintained this ratio on most occasions. Temporary staffing was used to support some wards.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. However on one ward it was unclear at the time of inspection if observations had been completed as the date had not been recorded clearly on four of the eight records we checked.
- The medical wards were overall clean and staff followed good hygiene. There was good monitoring of infections though we did not see any evidence of actions to improve standards. Cleaning chemicals had been left out in an unlocked room on a number of wards which presented a risk to people and there were oxygen cylinders which were not always stored in line with health and safety best practice guidelines.
- There was essential equipment on the endoscopy unit that was no longer going to be supported should it break down and the mobile temporary endoscopy unit was due to be decommissioned, however the trust had plans in place to address this going forward.
- Some of the areas were cramped, especially a side room on ward D1 and the discharge lounge.
- Record trolleys were left unlocked on some of the wards we visited but records we looked at were documented accurately and medical decisions were documented clearly. However there were some standards for record keeping that required improvement.

- Medication requiring cool storage were appropriately stored in fridges but on ward H3 and the coronary care unit fridge temperature checks had not always been completed. Controlled drug checks had not always been completed on D1, H3 and B3.

However,

- There were systems in place to keep people safe from avoidable harm and staff were aware of how to ensure patients' were safeguarded from abuse.
- There were systems in place to manage the safe administration and prescribing of medication. Audits were undertaken and actions had been identified to help staff improve when standards had not been met. None of the medication errors in medical services had been recorded as high risk.
- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures and we observed good hand hygiene practice.
- Early warning indicators were regularly checked and assessed and where there were concerns of patients deteriorating staff had escalated them appropriately.

Incidents

- Staff were familiar with and encouraged to use the trust's policy and procedures for reporting incidents. Incidents were reported through the trust's electronic reporting system and we spoke with a range of staff across the service that were all aware of how to report incidents.
- A root cause analysis tool was used to investigate serious incidents, and we saw where required an action plan was put in place to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions for learning which were shared with clinical teams and the wider Trust.
- There had been no never events reported in medical services (Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented).
- Between January 2015 and December 2015 medical services, including older people's care, reported 2575 incidents. Of these, 2524 resulted in low or no harm to patients. The main cause for incidents was falls followed by staffing and training issues.

Medical care (including older people's care)

- Between January 2015 and January 2016 there were 26 serious incidents reported throughout medical services at the hospital. Information showed pressure ulcers was the most commonly occurring incident followed by slips, trips and falls.
- Senior staff told us general feedback on patient safety information was discussed at ward staff meetings or in staff huddles. On the wards we visited senior staff facilitated time with ward staff to look at lessons learnt from incidents.
- Staff told us they received feedback from incidents they had reported via email and the findings of Investigations was also received from senior staff. Staff were able to describe an example of a change following an incident of a fall where nurses had received additional training in the use of low profiling beds.
- Information about incidents was discussed for as part of the Governance and Quality Board meetings. However, on reviewing the minutes of the meeting for October and December 2015, it was not always clear if learning had been discussed or whether it had already been shared. The number of incidents and that staff needed feedback on incidents was discussed.
- The trust circulated to services a sign up to safety document each month to inform staff of incidents and learning to improve standards.
- Mortality and morbidity meetings were held every two months and themes and trends were discussed. Learning and actions were identified but it was unclear if the timeframe for actions had been identified therefore making it difficult to track progress.
- Senior staff were aware of their responsibilities relating to Duty of Candour legislation and were able to give us examples of when this had been implemented. The trust had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. 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.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance

against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.

- Safety thermometer information for medical services showed that between December 2014 and December 2015, there had been a total of 17 CAUTI's and the total of new pressure ulcers were 27. The total number of falls that resulted in harm was 18.
- The total number of recorded incidents of falls between January 2015 and December 2015 was 750.
- The trust was monitoring incidents of pressure ulcers and falls through their performance dashboard each month.
- Falls and pressure ulcers were on the risk register with actions identified to lower the risk. For example, the development of guidelines for staff regarding the management of patients who are at risk of falls and an audit of compliance on completing risk assessments for pressure ulcers.
- Safety thermometer information was prominently displayed on all of the medical wards and units we visited.

Cleanliness, infection control and hygiene

- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment where appropriate.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas and that appropriate signage, regarding hand washing for staff and visitors, on display.
- Between April 2015 and December 2015 the trust reported 19 cases of *Clostridium difficile*, four cases of Methicillin-resistant staphylococcus aureus (MRSA) and 18 cases of Methicillin-susceptible staphylococcus aureus (MSSA).
- Wards used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Although the majority of wards we visited were visibly clean and free from odour, we observed that cleaning of the environment was not always as thorough as it

Medical care (including older people's care)

should have been. On ward B3 we saw that bathrooms and toilets had not been thoroughly cleaned and there was a dirty sink on the discharge lounge. We pointed this out to senior staff who rectified this.

- Monthly infection control audits were undertaken across all wards which looked at standards such as how clean was patient equipment. The overall score for adult wards was 95%. However, from the information provided by the trust no actions were identified on the audit tool to improve infection control standards despite some of the wards being below 100%.
- The endoscopy unit undertook a full annual environment and infection control audit and an action plan had been put in place to improve standards following the last audit in March 2015.
- Monthly hand hygiene audits were undertaken by staff being observed. Results were mostly around 100% across medical and care of the elderly wards. However, we looked at the results of 11 monthly audits which showed there were wards which were not always achieving 100%. For example in September ward B1 scored 87% and in October ward C2 scored 87% and ward D2 scored 83%. No actions were recorded on the information provided by the trust which showed how they were going to improve standards.
- Patient led assessments of the environment (PLACE) in 2015 showed a standard of 94% in the trust for cleanliness which was slightly below the England average of 98%.
- Side rooms were used where possible as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- We observed the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use.
- Cleaning schedules were in place and had been completed as required. Wards were using the national colour coding scheme for hospital cleaning materials and equipment so that items were not used in multiple areas, therefore reducing the risk of cross infection.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside wards

to identify themselves on arrival before they were able to access the ward and staff had access codes. However, we noted that the doors to D1 had been left open. We alerted the matron to this and the doors were immediately closed.

- Most areas we visited were bright and well organised, however when we visited the discharge lounge it was cramped and felt unwelcoming for patients who may have to sit in the area for a number of hours waiting to be discharged. There was limited space for up to 24 patients a day.
- On ward D1 there was an old examination room that was being utilised as a bedroom. This room was very cramped and had little ventilation.
- Toilets on ward C4 were not labelled as male or female which meant there was a risk that patient's privacy and dignity may not be maintained.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on the majority of wards we visited. However on ward D2 these had not been completed on three occasions during March 2016 and on the Endoscopy unit the weekly checks had not been completed on two occasions in February and one in March 2016. This meant there was a risk that emergency equipment may not be available or in date when required.
- There was an equipped therapy room on the stroke ward which enabled staff provide rehabilitation support to patients.
- There were systems to maintain and service equipment as required. Records indicated defibrillator equipment were checked and hoists were serviced regularly. Portable appliance testing was carried out on electrical equipment regularly and electrical safety certificates were in date. However on the endoscopy unit there was a portable radiator that did not have an up to date certificate.
- Cleaning chemicals were left in an unlocked staff area on ward B3, C4, D1 and the endoscopy unit. These should have been stored securely as the chemicals were potentially hazardous and presented a risk to people's health.

Medical care (including older people's care)

- On ward B3 and D4 the dirty utility room was left unlocked which contained soiled incontinence pads and clinical waste. This meant there was a risk that clinical waste could be accessed by patients and the public.
- On the coronary care unit, ward D4, ward C4 and the endoscopy unit portable oxygen cylinders were not stored in a locked room or secured in a cage or against a wall. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well ventilated storage area or compound when not in use.
- Patient led assessments of the environment (PLACE) in 2015 showed a standard of 90% in the trust for facilities. This was slightly lower than in 2014 which showed a standard of 95%.
- Endoscopy services also used a temporary unit in addition to the main endoscopy suite. The unit was cold and did not have separate recovery areas. There was also uneven floor in the main procedure room. Staff also used the recovery area to make drinks for patients and themselves. Senior staff told us that this unit was due to be decommissioned later this year but could not give us a definite date.
- Endoscopy services had three diathermy machines that were no longer going to be supported by the company who serviced the equipment after July 2016 as spare parts were no longer available. This had been put on the divisional risk register in February 2016 and escalated to trust level to look at funding for further equipment. Senior staff were not aware of any resolution at the time of the inspection.

Medicines

- Between January 2015 and December 2015 there were 219 medication errors reported in medical services. Of those, 32 reported were medicines omitted without reason and 31 were reported as a record keeping error.
- We looked at the prescription and medicine records for 10 patients. We saw arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- Medicines requiring cool storage at temperatures between two and eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were mostly completed on the wards we visited. However, on ward H3 these were not completed in November 2015 on two occasions, on three occasions in December 2015, and on five occasions in January 2016. On the coronary care unit there had been five occasions in March 2016 when they had not been completed. Staff were able to tell us the system identified to follow up if there were gaps in these records.
- Controlled drugs (medicines which are required to be stored and recorded separately) were stored and mostly recorded appropriately. Access was limited to qualified staff employed by the trust. Two nurses were observed following the correct procedures for the recording and administration of controlled drugs for a patient.
- However on ward D1 and H3 we saw that the daily checks were not completed on a number of occasions and on ward B3 they were not completed on two occasions and not had a second check on four occasions in January 2016. However, the trust did audit the storage of medications which included controlled drugs.
- Emergency medicines were available for use and records indicated that these were regularly checked
- We observed medication rounds on ward B1. We heard nurses ask patients their name and date of birth before administering medication. This helped staff to ensure they were giving prescribed medicines to the correct person.
- A pharmacist visited medical wards regularly. Pharmacy staff checked that the medicines patients were taking when they were admitted to the wards were correct and records were up to date.
- Suitable cupboard and cabinets were in place to store medicines. This included a designated room on each ward to store medicines. We sample checked medicines on the wards and found the majority to be in date, indicating there was good stock management systems in place.
- Patients had been provided with a lockable drawer in which to store their medication, enabling them to continue to take their medication at the times they were used to taking the medication at home. This meant that patients were given a choice and steps were taken to maintain their independence.
- The service undertook regular use of antibiotics audits which showed poor recording of the review and stop dates of antibiotics. Actions were identified to improve standards which included wider sharing of results with other trust teams.

Medical care (including older people's care)

- The service undertook audits of the storage of medications and a number of medical wards were not meeting all the standards. Actions were identified to improve performance.

Records

- The trust undertook monthly medical records audit. We reviewed the information from February 2016 results. There were a number of wards who fell below the compliance target. Actions had been put in place which included discussing professional standards at ward meetings and name stamps to be provided for nurses to use when making entries in patient records.
- We reviewed 46 care records. We saw that recent entries were legible, signed and dated. They were not always easy to follow but medical staff had detailed information for patient's care and treatment and all had a completed nursing assessment and a management plan.
- On wards B3, D3 and C4 we saw that there was loose papers containing patient information in ten patient records we reviewed. This meant there was a risk that important information may get mislaid.
- We looked at four records to see if they had been seen by a consultant within 12 hours of admission. Only one patient had not been recorded as being seen in the timeframe. The electronic system captured the time patients were seen by the consultant following admission but the data was not monitored.
- Patient records included a range of risk assessments and care plans were completed on admission and were updated throughout a patient's stay.
- We observed for each patient there were up to three sets of records which were a mixture of paper based records and bedside records. This meant there may be a risk that important information may be difficult to find in an emergency[BL1].[JH2]
- Not all wards had lockable patient note trolleys. On ward D2, D1, C4, H3, and the endoscopy we observed trolleys containing patient notes were left opened and unattended in the corridors or areas of the unit. This increased the potential for patient confidentiality to be breached. On other wards we visited patient notes were kept away from patient and public areas.
- The majority of patient information boards that were visible in ward corridors respected patient confidentiality by patient names being covered up or

not visible by patients and the public. Patient information boards were used to provide at a glance an overview of the key risks, medication and discharge plans for each patient.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding team which provided guidance during the day in the week. Staff had access to advice out of hours and at weekends from the hospital on-call manager.
- Training statistics provided by the trust showed that in medical services 97% of medical staff and 93% of nursing staff had completed safeguarding adult training. 94% of non-medical staff had completed the training. The trust target was 95%
- The trust target for safeguarding children training was 95%. In medical services 98% of nurses had completed the training but only 80% of medical staff were compliant.
- Basic safeguarding training was included in induction training for all temporary staff before commencing work on the wards.
- Staff we spoke to did have a clear understanding of the trust safeguarding policy. We reviewed a safeguarding referral that had been made and this was completed accurately and appropriately.
- Senior management staff had overall awareness of the number of safeguarding referrals that had been submitted to the safeguarding team but they did not receive any feedback from referrals made.
- Staff on the wards told us they did receive feedback from safeguarding referrals that they made and received learning from other safeguarding referrals at team meetings and in safety huddles.

Mandatory training

- Staff received mandatory and statutory training on a rolling annual basis in areas such as infection control, manual handling and fire. The trust target was 95% for statutory training and 85% for mandatory training. Statutory training included areas such as infection control manual handling and fire. Mandatory training included information governance and medicines management.

Medical care (including older people's care)

- At the time of our inspection, 94% of staff in medical services at the hospital had completed their statutory training and 79% had completed their mandatory training.

Assessing and responding to patient risk

- An early warning score system (EWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above). Repeated checks of the early warning scores were documented accurately.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above). Repeated checks of the early warning scores were documented accurately
- However on ward D1 it was unclear at the time of inspection if these had been completed as the date had not been recorded clearly on four of the eight records we checked. We raised this with the Matron who assured us that they had been completed and this was a recording issue which they would raise with staff.
- We raised this with the Matron who assured us that they had been completed and this was a recording issue which they would raise with staff.
- An audit of the EWS system was completed in May 2015. The overall results showed that a number of medical wards had improved s but wards D2, D3, C1, C3 and C4 and showed a downward trend in scores. Recommendations were made for services to identify actions to improve standards, for example additional training for staff.
- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. Patients

at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool or MUST).

- Observational comfort rounds were carried out by nurses every two to four hours depending on individual need to assess patient risk on an ongoing basis. On ward D1 and C4 these had not yet been implemented and on D4 we saw for one bay these had not been completed when we first arrived on the ward but were retrospectively completed when we checked again before leaving the ward. Therefore, it was not clear if these were undertaken.

Nursing staffing

- There was a designated matron who supported ward staffing levels on a daily basis. Senior nurses and matrons met each week to discuss nurse staffing levels across medical services to ensure that there was good allocation of staff and skills were appropriately deployed and shared across all wards. Staffing on a day to day basis was reviewed at the trust bed management meetings. However, we did observe during a bed meeting that staff were unaware that a ward we had just visited did not have the planned number of nurses.
- At the time of inspection there were 50 whole time equivalent nursing vacancies in medical services and this was recorded on the risk register. There were actions identified to mitigate this risk such as a rolling recruitment programme The Trust had implemented a plan to increase staffing levels, the number of staff per shift had been increased since 2013 and in most areas was meeting the newly agreed enhanced staffing levels, however there were some that did not always achieve this.
- The turnover rate for nursing staff in medical services was 6.96%.
- The service used an acuity tool (AUKUH) to measure staffing levels twice a year. They were in the process of implementing a new acuity tool which measured staffing levels on a daily basis.
- From the last review there had been an increase in the number of registered nurses on duty during the night for the respiratory wards. These additional shifts were being filled by temporary staff whilst recruitment for additional nurses was on going to ensure safe staffing levels..

Medical care (including older people's care)

- Staff on the coronary care unit (CCU) looked after patients who needed level one and level two care. They were assessing the acuity of the patients on a regular basis to determine if they were level one or level two patients. This was done to ensure appropriate skill mix of staff. Level two patients require higher levels of care and more detailed observation and intervention.
- We reviewed the use of agency and bank nurses between August 2014 and March 2015 and found that there were a number of areas which used temporary staff quite regularly. For example, ward D1 the average number of shifts filled with temporary staff was 14% and on ward B3 it was 13%. This was for a number of reasons including vacancies and sickness.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- We reviewed the number of shifts filled as planned for medical wards between September 2015 and December 2015 and found these were not always meeting the levels planned. There were particular concerns regarding wards B1 (frailty unit), C1, C4 and D1. However, wards D1 and D3 maintained a ratio of 1 registered nurse to 8 patients between September - December 2015 on every shift. B1 and C1 maintained this ratio on most occasions. Temporary staffing was used to support some wards.
- The average number of shifts filled during the day between September 2015 and December 2014 for B1 was 85%, C1 was 80%, C4 was 75% and D1 was 85%.
- The number of shifts filled as planned during the night were largely good; however there were concerns about ward D1, and D3. Between November 2015 and December 2015 the average number of shifts filled as planned for D1 was 78% and D3 74%.
- The service used the trust escalation procedures if there was a reduction in the number of nursing staff of duty. This included undertaking a risk assessment and escalating the issues to the chief nurse or divisional director.
- Between January 2016 and March 2016 medical services had temporarily closed a total of 44 beds due to staffing shortages. This was done to ensure the wards had safe staffing levels.
- Between January 2015 and December 2015 there had been 201 incidents reported which related to staffing problems.
- At the time of the inspection there were a number of wards which did not have the number of planned nurses on duty. For example on ward B1 there were two shifts on 22 March when there were not enough nurses on duty.
- Senior nurses who were supernumerary (in addition to the planned number of nurses so they could oversee the running of the ward and assist where necessary) often completed shifts due to shortage of staff. This meant that management tasks were often left uncompleted. We observed this on ward C4 where the manager had not been able to implement the new format for comfort rounds as they were covering nursing shifts. Therefore, these had not been completed for this ward.
- Nursing handovers were structured and information handed over to the incoming staff included allergies, mobility of patients, incidents and expected date of discharge. Each member of staff on the ward were given a copy of the handover sheet at the beginning of each shift.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for medical admissions and all medical inpatients across all wards. All medical trainees contributed to this rota. The information we reviewed showed that medical staffing was appropriate at the time of the inspection.
- Patients on some of the wards did not always see a doctor at the weekends, although there was sufficient cover outside normal working hours and at weekends for emergency reviews.
- There was an on call rota which ensured that there was a consultant available 24 hours a day seven days a week for advice.
- The percentage of consultants working in medical services trust wide was 36% which was higher (better) than the England average of 34%. The percentage of registrars was 31% which was below (worse) the England average of 39%. The percentage of junior doctors was 31% which was higher (better) than the England average. Middle grade levels was 3% which was below the England average of 6%

Medical care (including older people's care)

- The total number of medical staff vacancies at the end of December 2015 was 9.71 whole time equivalent doctors. The turnover rate of medical staff was 2%.
- There were still some medical staffing vacancies in medical services and this was on the trust risk register. There were actions identified to mitigate this risk such as a recruitment programme to include possible international recruitment.
- The total number of shifts covered by locum medical staff in medical services between April 2015 and February 2016 was 30%.
- The use of locum staff was for a number of reasons including, vacancies, extra staffing over and above the normal levels and extra ward rounds. Locums were either trust staff working extra shifts or from an agency
- We saw a ward round which was attended by the consultant as well as junior doctors and there was effective verbal communication between each other and the patients.
- We observed a medical handover which was attended by consultants. Patients were discussed but this was not documented which meant there was a risk that important information may not be available for consultants who were not able to attend the meeting.

Major incident awareness and training

- There were documented major incident plans within medical areas and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.

Are medical care services effective?

Good



We rated medical services as 'requires good' for effective because:

- Care was provided in line with national best practice guidelines and medical services participated in the majority of clinical audits where they were eligible to take part. For example the heart failure audit and the stroke audit.

- There was a focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this. There was evidence of providing services seven days a week. Pain was being managed effectively and pain scores were being completed and staff had access to information they needed to support patients.
- We found that staff members' understanding and awareness of assessing people's capacity to make decisions about their care and treatment was largely good. However they did not recognise the principals in relation to the use of bedrails but trust policy was clear about recording consent to the use of bedrails in relation to the mental capacity act, although stated bedrails were not a form of restraint.

However,

- Recent national audits indicated that although there had been progress the service still needed to make improvements to the care and treatment of people who had chronic obstructive pulmonary disease. Nutrition and fluid intake were not always recorded correctly.
- Most staff said they were supported effectively but only 74% of medical staff and 59% of nursing staff had received their annual appraisal which was below the trust target.
- Not all staff were aware of the plans to increase electronic information systems.

Evidence-based care and treatment

- The service used national and best practice guidelines to care for and treat patients. The service were monitoring compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified.
- The service participated in all of the clinical audits for which it was eligible through the advancing quality programme. Where the service was not meeting the appropriate care score target action plans were completed following the clinical audit to address areas identified for improvement. For example an action plan was put in place to improve the results of the chronic obstructive pulmonary disease(COPD). This included implementation of the COPD admission and discharge care pathway and a trust wide rolling training programme.

Medical care (including older people's care)

- Care pathways were in place for managing patients that needed care following a stroke and for patients who received ambulatory care (ambulatory care is medical care provided on an outpatient basis). The ambulatory care pathways included care of patients with cellulitis, pulmonary embolism (PE) and deep vein thrombosis (DVT). The care pathways were based on NICE guidance.
- There were examples of recent local audits that were completed on the wards. These included documentation and completion of assessments audits. Senior staff said they received the results of the audits and any learning was shared with them via email.

Pain relief

- Services undertook a pain score audit in 2015 and 62% of patients reported being asked about their pain, 39% said they were given medication that helped their level of pain and 42% reported that severe pain was managed well. This was a slight improvement from the previous year.
- Pain relief was managed on an individual basis and was regularly monitored. Patients told us that they were consistently asked about their pain and supported to manage it. However, there was an incident on ward D4 where a patient had to wait for over an hour for some pain relief.
- We saw that the level of pain patients had were recorded on early warning scores documentation.
- There was a specialised tool in place to assess pain in those who had a cognitive impairment such as dementia or a learning disability.

Nutrition and hydration

- A coloured tray, cup and jug system was in place to highlight patients that needed assistance with eating and drinking.
- We observed a meal time on two wards and saw that patients who required assistance with eating and drinking were supported appropriately. However, we saw that on ward C4 there were not always enough staff available to help patients on an individual basis and observed one health care support worker assisting four patients at the same time.
- The majority of patients we spoke with said they were happy with the standard and choice of food available. If patients missed a meal as they were not on the ward at the time, staff were able to order a snack for them.

- We saw there was a comprehensive selection of meals available from a menu which was available for patients.
- We observed drinks were available and in reach for all patients.
- The hospital used part of the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. An audit of the completion of the tool was undertaken as part of the food standards assessment and the trust scored an amber rating. Nutrition champions are now in place who undertake regular audits.
- We looked at nutritional charts for six patients and found that only three had been fully completed. Only four of the 12 fluid balance charts we reviewed in records correctly recorded the total amounts for each patient.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. MINAP audit results for 2013/14 for this trust showed the number of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI-a type of heart attack that does not benefit from immediate PCI) seen by a cardiologist prior to discharge was better than the national average at 100%. 65% of patients with an N-STEMI were admitted to a cardiology ward. This was better than the England average of 55%.
- The sentinel stroke national audit programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. The latest audit results rated the hospital overall as a grade 'D' which was an improvement from the previous audit results when the hospital was rated as the 'E'. The trust had put in place actions to improve the audit results. These included a dedicated social worker on the stroke unit and further training for staff.
- The 2013/2014 heart failure audit showed the hospital performed better than average for all four of the clinical (in hospital) indicators and in six of the eight clinical (discharge) indicators. However it was noted that the trust submitted less than 70% of the statistics and the results may not therefore be representative of the patient population.

Medical care (including older people's care)

- The risk of not achieving compliance against the NICE guidance for heart failure was on the risk register. There were actions identified which included a business case for additional staffing.
- In the 2013 national diabetes inpatient audit (NaDIA) the trust was better than the England average in 15 of the 21 indicators. The trust performed worse than the England average for staff knowledge in answering questions.
- The endoscopy unit had been awarded Joint Advisory Group (JAG) accreditation in May 2015. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines.
- The unit was the local provider for Bolton patients in the national Bowel Cancer Screening Programme. The aim of this was to help reduce the incidents of bowel cancer and achieve earlier diagnosis.
- The readmission rates was worse than the England average in all medical specialities including gastroenterology, nephrology, respiratory medicine and clinical haematology.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. In November 2015 the trust score was 104.

Competent staff

- Staff told us they received an annual appraisal. According to trust figures 74% of medical of staff in medical care services across the trust had received their annual appraisal by the end of December 2015 and 59% of nursing staff. The trust target was 85%.
- The trust had a draft clinical supervision policy which had not yet been ratified. The purpose of clinical supervision is to provide a safe and confidential

environment for staff to reflect on and discuss their work and their personal and professional responses to their work. However, nurses told us that they did have regular meetings with their manager and they were able to speak to their manager at any time.

- Staff we spoke with confirmed they had an adequate induction. Newly appointed staff said that their inductions had been planned and delivered well.
- There was a preceptorship programme which supported junior nursing staff and their competency in undertaking care procedures were assessed by qualified staff.
- The trust was involved in the apprenticeship nursing scheme with the skills for health academy. Cadet nurses were undertaking a national vocational qualification in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required.
- Staff in bands 1-4 were offered opportunities to undertake appropriate vocational qualifications and there were a number of staff in medical services which had gained such qualifications.
- Medical services ensured that healthcare support workers undertook the care certificate. 75 healthcare support workers in medical services had begun or completed the qualification. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants.
- We saw that there was a range of specialist nurses, for example a lead for dementia and diabetes. Staff told us they knew how to contact these specialists and felt supported by them.

Multidisciplinary working

- Multidisciplinary team (MDT) working was established on the medical wards. We saw a good example of MDT working on the stoke unit, ward H3. This included nursing staff as well as therapy staff such as a physiotherapist and occupational therapist.
- Ward teams had access to the full range of allied health professionals and team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.

Medical care (including older people's care)

- A psychiatric liaison service was available within the trust which provided advice and support to staff.
- Meetings about bed availability were held up to four times a day to determine priorities, capacity and demand for all specialities. These were attended by both senior managers and senior clinical staff.
- Daily ward meetings were held on most of the wards we visited. These were called board rounds and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge.

Seven-day services

- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.
- Endoscopy services were available seven days a week.
- Consultants were available on site during the day 9am to 9.30pm Monday to Friday and 8am to 5 pm on Saturday. There was an on-site registrar 24 hours a day, seven days a week.
- Physiotherapy and occupational therapy services were only available six days a week.
- Pharmacy services were seven days a week to ensure patients' medication was available on discharge.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and trust information. Policies, protocols and procedures were kept on the trust's intranet which meant staff had access to them when required.
- Staff said that information and processes were largely paper based and electronic systems were being planned but they were unaware of the specific plans being developed in the trust.
- On the majority of wards there were files containing minutes of meetings, ward protocols and audits which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care.

- MCA training was included in safeguarding training. Information provided by the trust showed that compliance rates for this training was 89% for nurses and 80% for doctors.
- Staff understood the principals of capacity assessments. We checked three records of patients who lacked capacity and found they had had a formal capacity assessment recorded.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLs). DoLs are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack capacity. We saw examples of DoLs paperwork completed fully and accurately.
- The trust policy on the safe use of bedrails stated that bed rails were not a form of restraint and staff we spoke to on the wards did not know that the use of bed rails can be seen as a form of restraint as outlined in the Royal College of Nursing (RCN) rights, risk and responsibilities guidance. The policy did state that if a person lacked capacity to consent to the use of bedrails then staff should make the decision in the best interest of the patient and record this in the nursing notes.
- Between April 2014 and March 2015 there had been 550 DoLs applications across the trust which is a significant increase from the previous year where only 94 applications were made. This showed that staff had an increased awareness and understanding of DoLs.
- Staff knew the principles of consent and we saw written records that indicated consent had been obtained from patients prior to procedures or treatment. However the three records we checked in the Endoscopy unit were not dated.

Are medical care services caring?

Good



We rated medical services as 'good' for caring because:

- Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were

Medical care (including older people's care)

person-centred People we spoke with during the inspection were complimentary about the staff that cared for them. Patients received compassionate care and their dignity and respect were maintained.

- Patients were involved in their care and Chaplaincy services were available to provide people with appropriate emotional support.

However,

- There was limited staff interaction with patients on wards during our visit.

Compassionate care

- Medical services were delivered by, caring and compassionate staff. We observed staff treating patients with dignity and respect
- We spoke to 29 patients throughout our inspection. All the patients we spoke with were positive about their care and treatment. Comments included 'staff have been brilliant', 'anything you want they get for you' and 'treated with respect'. Patients said staff always introduced themselves. However there were comments from patients and relatives that there did not always seem to be enough staff on the wards and they were always very busy.
- We observed that during our time on the wards there was limited interaction between the patients and staff and patients were either in bed or sitting by their bed with no activity taking place. On ward B1 there was a bay with no bedside televisions and patient's told us they did 'get bored at times'.
- The friends and family test (FFT) average response rate was 52% which was higher than the England average of 34%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. 96% of patients in November 2015 said they would recommend medical services at the hospital.
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust performed in the top 20% of all trusts for 22 of the 34 areas. These included 'always treated with respect and dignity, 'staff explained how operation had gone in understandable way' and 'doctors did not talk in front of them as if they were not there'. The trust did not fall in the bottom 20% of trusts for any of the area.
- We saw people had access to call bells and staff responded promptly.

- The trust was performing around the same as the England average in all four parts of the patient-led assessments of the care environment (PLACE). These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey.

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients were aware of this and on the wards we visited; they were displayed on a board above the bed. Patients said they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients said they felt safe on the ward and had been orientated to the ward area on admission.
- Family members said they were kept well informed about how their relative was progressing.
- Patients we spoke with said they had received good information about their condition and treatment.

Emotional support

- Some staff felt they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workloads meant that this did not always happen.
- We received Information from patients and those close to them before the inspection at listening events and through share your experience forms. This told us staff did not always have the time to offer support to patients and were often left for long periods of time.
- Visiting times for the wards met the needs of the friends/relatives we spoke to. Open visiting times were available if patients needed support from their relatives.
- Patients and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to.
- Chaplaincy services were available for patients and relatives if required

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Are medical care services responsive?

Good



We rated medical services as 'good' for responsive because:

- During November 2014 and November 2015 referral to treatment times (RTT) for all medical specialities including cardiology and gastroenterology were above (better) the England average and the trust target of above 95%. Thoracic medicine and geriatric medicine were 100% compliant with the 18 week RTT.
- The average length of stay for elective medicine at the hospital was shorter (better) than the England average at 2.9 days. The England average was 3.8 days. For non-elective (not planned) medicine it was shorter (better) than the England average at 5.8 days. The England average was 6.8 days.
- Complaints were investigated and lessons learnt were communicated to staff and improvements made. Improvements had been made in complaint response times from the previous year.
- The discharge lounge was temporarily located in a ward setting, however plans had been drawn for a purpose built area to support increasing demand. This was due to be opened in November 2016.
- There were specialist nurses who provided support and advice to staff and the service was mostly meeting individual needs for patients who had dementia or a learning disability.
- Services took into account the needs of the local people. There were good ambulatory care services and the trust was part of the healthier together programme. People were supported to raise a concern or a complaint.

However,

- There were times when there was insufficient bed capacity in medical services to meet the needs of patients, but there were systems in place for the management of these patients to ensure they were seen appropriately by a member of the medical team.

- Some patients were experiencing delayed discharges because they were waiting for packages of care.
- There were a number of patients who could not be transferred back to the hospital following treatment elsewhere due to beds not being available. There was high occupancy levels on the wards.
- Patient's privacy and dignity was not always being maintained on the discharge lounge whilst waiting to be discharged. Plans were in place to relocate the discharge lounge to a purpose built unit in November 2016.

Service planning and delivery to meet the needs of local people

- The hospital was part of the Greater Manchester health and social care devolution programme to provide a partnership approach to care and the healthier together programme. This was to reconfigure services across Greater Manchester into a small number of specialist centres to help meet the needs of patients together with integrated neighbourhood teams.
- The trust were working with local commissioners with a number of work streams to improve access and flow and improve bed availability, which included medical services.
- Medical services had a designated ambulatory care unit. This unit saw patients on an outpatient basis for further tests or follow up assessments to avoid unnecessary admission or a longer stay in hospital. Referrals were from GP's and the accident and emergency department. It was open 7.30 am to 10.00pm Monday to Friday and 11.00am to 7.00pm Saturday and Sunday. There was a clear standard operating procedure which included inclusion and exclusion criteria for the types of patients suitable for the service to ensure they received the best care available.
- The facilities and premises in medical care services were appropriate for the majority of services that were planned and delivered. However, the design of the coronary care unit meant there were occasions when male and female patients were in line of sight of each

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other. However, on raising this with senior staff on the unit, they said they would look into how patient's privacy and dignity could be maintained at all times without compromising clinical treatment.

- The discharge lounge was temporarily located in a ward setting, however plans had been drawn for a purpose built area to support increasing demand. This was due to be opened in November 2016.

Access and flow

- Between 13 December 2015 and 6 March 2016 the average occupancy rate of medical wards was 91%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- The average length of stay for elective medicine at the hospital was shorter (better) than the England average at 2.9 days. The England average was 3.8 days. For non-elective (not planned) medicine it was shorter (better) than the England average at 5.8 days. The England average was 6.8 days.
- Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). Between August 2015 and November 2015, data showed there had been 208 medical outliers at the hospital. There was a policy outlining the management of these patients.
- At the time of our inspection, senior staff said there were 12 medical outliers. Patients who were outliers were reviewed on a daily basis by a member of the medical team. We reviewed the record four patients who were outlying and found they were seen by the medical team on a daily basis.
- A separate bay of six beds had been opened for medical outliers. Staff said this had been opened intermittently since October 2015. We saw this was open at the time of the inspection and was being reviewed on daily basis.
- Between December 2014 and December 2015, 55.4% of patients had no ward moves during their stay. 42.0% of patients moved once, however, this included admission to an assessment unit or critical care unit. 2.7% of patients moved more than once to another type of ward, but the average number of ward moves was low at 1.2% for this period.
- Information provided by the trust showed that between July 2015 and November 2015, the number of patients on medical wards that were transferred to another ward after 10pm at night was relatively low at 141 across all medical wards. The information showing the reasons why these moves had taken place during the night was not available.
- The hospital held bed management meetings five times a day seven days a week. Bed co-ordinators supported these meetings by providing up to date information to plan bed capacity and respond to acute bed availability pressures.
- There was a clear focus on effective discharge planning for patients and wards. Staff discussed discharges at the bed management meeting. We observed a bed management meeting which was attended by matrons, the bed management team and a senior manager. Delayed discharges were not always discussed at bed management meetings, however information from meetings related to patients who were experiencing delayed transfers for care was available and reported upon at each bed meeting.
- Senior managers did discuss delayed discharges on a weekly basis as part of multi disciplinary meetings and actions were logged. Information was recorded in a database, which was accessible to all staff involved in discharge processes and available in the bed meeting.
- There was a discharge team who supported patient discharges that were complex or required rapid discharge. Discharge co-ordinator's were allocated to medical wards to support the process. However the discharge team was not currently fully integrated with social care. Medical services were piloting an integrated health and social care discharge team and would evaluate the findings to inform future service planning.
- Hospital episode statistics showed that discharges at the trust were often delayed due to waiting for further care outside the hospital at 32%. 28% was due to family choice which was worse than the England average of 13% and 23% were delayed waiting for

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completion of care assessments. This was in line with similar organisations in the region. They were working with partner organisations to ensure that patients were discharged as soon as possible.

- To support this the trust had access to community beds in care homes which were used for patients who were fit for discharge but were waiting for care packages or equipment to be put in place.
- At the time of the inspection staff said there were 26 delayed discharges across medical services at the hospital. Between September 2015 and February 2016 there had been a total of 4699 bed days lost due to delayed discharges on medical wards.
- At the time of the inspection there were five patients who were not able to be transferred back to Bolton Hospital from neighbouring hospital due to no beds being available on the stroke unit. There was a target of 72 hours but this was not being monitored by the trust.
- Timely discharges were identified as an area of risk in medical services and was on the risk register with actions identified to mitigate the risk. These included ensuring discharge medications were available for patients and the effective use of the discharge lounge.
- The time of discharges were monitored on a monthly basis. Between April November 2016, 21% of patients ready for discharge were discharged before midday against a target of 25% and 58% before 4.00pm against a target of 60%. This meant there was a risk that bed availability was delayed.
- The hospital had a discharge lounge which operated between the hours of 7.30am and 8.00pm Monday to Friday and 10.00am to 6.00 pm at weekends.
- Between December 2015 and March 2016, 1196 patients that were transferred to the discharge lounge. Data from the trust showed that 678 patients were transferred before midday and 947 by 2pm. We did however observe that between 7th March 2016 and 23 March 2016. 60% of patients were not sent down to the discharge lounge until the afternoon which meant there was an impact of bed availability. This was also evident from the discussions at the bed management meeting observed at the time of the inspection.

- During November 2014 and November 2015 referral to treatment times (RTT) for all medical specialities including cardiology and gastroenterology were above (better) the England average and the trust target of above 95%. Thoracic medicine and geriatric medicine were 100% compliant with the 18 week RTT.

Meeting people's individual needs

- The trust used a red symbol of a person falling to indicate that a patient was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made.
- There was a specialist nurse who was the clinical lead for dementia. They provided support for staff and a central point for queries. The trust also had access to a psychiatric liaison team who saw and assessed appropriate patients with a cognitive impairment.
- The hospital had implemented the 'forget-me-not' sticker scheme. This was a discrete flower symbol used as visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.
- On admission patients were assessed for dementia against a set criteria. Support and further assessments were identified if required.
- The back of bed boards had 'what matters to me' information so that staff knew how patients with a cognitive impairment liked to be supported.
- Ward B3 had been adapted to be a dementia friendly environment, including dementia friendly signage, paintwork and flooring. The ward had a reminiscence area which was decorated as a café. Medical services had access to a number of IT systems which had specific programmes to support people living with dementia. For example music and events from days gone by.
- The service had an action plan in place to implement the recommendations outlined in the national dementia strategy. This included developing support for carers and the wider public and protocols to promote early intervention.

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- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities.
- Care plans we saw were not always personalised to identify individual needs but did contain the necessary information to ensure that patients were not at risk and their care managed safely.
- There was a nurse specialist for diabetes who offered specialist advice to staff caring for people with this condition.
- The discharge lounge was split into separate areas for male and female patients who required a bed and one mixed seated area. However we observed on several occasions during the inspection a female patient in nightclothes in a bed which was in the same area as the chaired area which had both female and male patients. The other separate bedded area was empty. This meant that patient's privacy and dignity was maintained in this instance.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint. Leaflets detailing how to make a complaint were readily available in all areas. Notice boards within the clinical areas included information about the number of complaints and any comments for improvement.
- The trust recorded complaints electronically on the trust-wide system. The local ward managers and matrons were responsible for investigating complaints in their areas. Ward managers told us how they were working to achieve 'on the spot' resolutions of concerns where possible.

- Information provided by the service showed that there had been 182 complaints received raised across medical services at the hospital between March 2015 and March 2016 which was a reduction in the number of complaints by 37 from the previous year.
- The trust target for responding to complaints had been reduced from 41 days to 35 days in December 2015 as part of a trust initiative to improve complaint response times. As part of this all complaints that breached 35 days were reviewed by the chief executive of the trust.
- Between March 2015 and March 2016, of 183 complaints, 163 were responded to within 35 days. Of the 19 cases that had breached 35 days, 15 were responded to within 42 days, and 4 between 43 and 74 days. This showed improvement from the previous year where 60 complaints were responded to between 65 and 75 days.
- An example of learning from a complaint was to provide matron's business cards to enable staff provide contact details to patients and families if required to help with communication.
- Complaints were discussed at governance meetings which also outlined key lessons learnt to be shared with staff. Staff told us managers discussed information about complaints during staff meetings to facilitate learning.

Are medical care services well-led?

Good



We rated medical services as 'good' for well-led because:

- Medical care services were generally well led with evidence of effective communication within staff teams. The visibility of senior management was good and there were information boards to highlight each ward's performance displayed on each ward area. Medical services had key objectives to support the overall trust operational plan and there was full engagement in the trust over strategy and plans.
- Staff felt supported and able to speak up if they had concerns although the number of staff who felt valued was higher than the England average. Medical services

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captured views of people who used the services with learning highlighted to make changes to the care provided. People would recommend the hospital to friends or a relative.

- There was good staff engagement with staff being involved in making improvements for services. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital

However,

- There was a clear governance structure but there was limited evidence of learning discussed at key meetings and there was low attendance by some clinicians. Risk registers were in place and had actions identified, however, there were actions on the risk register still to be completed after the target date for completion. This meant we were not assured that risks were being managed in a timely way.

Vision and strategy for this service

- The trust's vision was summarised as better care together. The values was to put patients and staff at the heart of everything they did, to be respected, valued and proud. Staff were aware of the vision and they were displayed on the notice boards.
- The Trust's strategic objectives were based on this vision and these objectives cascaded down to service and individual objectives for staff.
- Medical services had outlined key objectives to support the overall trust operation plan. These included the drive in improvement in length of stay and improved support for the care of the elderly.
- NHS staff survey results for 2015 showed that 89% of staff said they had clear planned goals and objectives. The number of responses was 334.

Governance, risk management and quality measurement

- The risk register highlighted risks across medical services and actions were in place to address concerns for example failure to meet National Institute of Clinical Excellence (NICE) guidelines.
- Risk were reviewed regularly, however, we were not assured that risks were being managed in a timely way as there were actions identified which were still being completed after the target date for completion.

- Senior staff knew there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- There was a clear governance reporting structure in medical services and the main governance and quality meeting was held on a monthly basis. During the meeting a review of the risk register, incident, infection, audits, complaints and feedback from services were undertaken. Actions were identified but it was not clear when the date the action was to have been completed.
- The meetings were attended by senior members of staff, however there were a number of staff who had only attended a couple of times over the previous 10 months, for example some matrons and clinical leads. Therefore it was not clear if any learning was being cascaded effectively through these members of staff.
- Staff were unable to tell us how their ward performance was monitored, though they were aware that data was collected and discussed at governance meetings.
- Staff said that multidisciplinary team meetings were held regularly on each medical ward. There was evidence on wards that regular team meeting took place and these were recorded and cascaded to staff via email. There was also a copy of the minutes in a file on the ward for staff to read.
- There was a ward accreditation scheme in place which looked at ward performance, for example patients feel satisfied with their care, equipment and the learning environment for staff. Wards were audited then given an award ranging from one to four stars for outstanding. Not all junior staff on the wards we spoke to understood the accreditation scheme.

Leadership of service

- Staff reported there was clear visibility of members of the trust board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff.
- All nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within all teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.
- Medical services had recently supported staff to undertake the leadership development programme.

Culture within the service

Medical care (including older people's care)

- The majority of staff said they felt supported and able to speak up if they had concerns.
- 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. These scores were about the national average.
- The latest staff survey results for 2015 showed that 73% of staff would recommend the organisation as a place to be treated. 62% of staff would recommend the organisation as a place to work. There were 370 responses from a total of 5240 staff to these two questions.
- 88% of staff in medical services believed that the organisation provided equal opportunities for career progression.
- The trust celebrated the achievements of staff at an annual event. At the last event medical services had had a number of staff nominated for their work at the trust.
- Staff participated in the 2015 staff survey. This included how staff felt about the organisation and their personal development. 80% of staff at the trust felt the training and development they had undertaken had helped them to deliver a better patient experience and 85% felt it had helped them to do the job more effectively. 76% felt that they were valued by their manager. These scores were all better than the national averages.
- An analysis of the 2015 staff survey results showed 67% of staff in medical services, who responded, felt they were able to make suggestions to improve the work of their team/department. This was worse than the national average of 75%.
- The survey also showed that 76% of staff said they had frequent opportunities to show initiative in their role. 57% of staff said they were involved in deciding on changes to improve services for patients. This was slightly better than the national average of 53%.

Public engagement







- Services participated in better listening Friday event which involved staff talking with patients to learn about their experience. Information was collated and passed down to services to review. However, we could not see any evidence from governance meetings that this was discussed in medical services, although patient stories was an agenda item.
- Cancer services compiled life stories of patients to help inform future services.
- The hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. 51% of patients would recommend medical services at the hospital to friends or a relative. This was better than the national average of 34%.

Staff engagement

Innovation, improvement and sustainability

- Medical services were planning to implement an in-house electronic referral form with an inbuilt audit tool which will be used to inform future service delivery in the endoscopy unit.
- The Endoscopy unit were working with Bolton University to develop an accredited course for assistant practitioners.
- Care of the elderly wards were using the ibleep system. This provided on call doctors with critical patient information gathered by ward based staff which was sent via a mobile device, such as a smart phone. This allowed doctors to prioritise calls.

Surgery

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The Royal Bolton Hospital provides a range of elective and unplanned surgical services, including trauma and orthopaedics, ear, nose and throat (ENT) surgery, urology, plastic surgery, elective vascular surgery, oral surgery, ophthalmology and general surgery (such as colorectal and gastro-intestinal surgery).

The hospital has seven surgical wards with approximately 162 inpatient surgical beds. The main theatres have eight operating theatres. The hospital has a separate day case unit with two theatres and a treatment room. The ophthalmology unit has two theatres. There is also an additional urology theatre.

There were 30,417 surgical procedures carried out at the hospital between September 2014 and August 2015. Records showed that 61% of patients had day surgery, 13% had elective surgery and 26% were emergency surgical patients.

We visited the Royal Bolton Hospital as part of our announced inspection during 21 to 24 March 2016.

As part of the inspection, we visited the main theatres, the day case unit, the ophthalmology unit (H2) and theatres the surgical assessment unit (ward F3), the general surgical wards (F4, E3 and E4), the trauma and orthopaedics wards (G3, G4 and G5) and the temporary elective and day case ward (ward R1).

We spoke with 11 patients and the relatives of another four patients. We observed care and treatment and looked at five care records. We also spoke with a range of staff at

different grades including nurses, doctors, consultants, ward managers, practice educators, healthcare assistants, porters, domestic staff, housekeepers, matrons, theatres staff and the clinical head of division, the patient experience and safety lead, the divisional nurse director and the divisional director of operations. We received comments from our listening event and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

Surgery

Summary of findings

We gave the surgical services at the Royal Bolton Hospital an overall rating of good. This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises. Medicines were stored safely and given to patients in a timely manner.
- Most staff had completed their statutory and mandatory training and the hospitals internal targets for training completion were achieved. The staffing levels and skills mix was sufficient to meet patients needs.
- The surgical services reported four never events between January 2015 and January 2016. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- Remedial actions were taken to learn from these never events and to minimise the risk of reoccurrence. Most remedial actions had been completed and staff were working to implement the remaining actions. There were clear timelines in place for the completion of these actions.
- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with the England average for most safety and clinical performance measures.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their annual appraisals. However, the hospitals internal target of 85% appraisal completion had not been achieved across all the surgical specialties.
- Patients and their relatives spoke positively about the care and treatment they received. They told us they were kept fully involved in their care and the staff supported them with their emotional and

spiritual needs. Patient feedback from the NHS Friends and Family Test showed that most patients were positive about recommending the surgical wards to friends and family.

- Services were planned and delivered to meet the needs of local people. The surgical services achieved the 18 week referral to treatment standards across most specialties.
- The proportion of elective operations cancelled at the hospital was either similar to or slightly worse than the England average from April 2013 to December 2015. However, the services performed better than the England average for the number of patients whose operations were cancelled and were treated within the 28 days.
- Actions taken to improve patient access and flow by opening an additional ward to increase capacity for day surgery and elective admissions. A theatre productivity and safety project was also in place to improve theatre efficiency.
- There were systems in place to support vulnerable patients. The majority of complaints about the services were resolved within the expected time frames and complaints were shared with staff to aid learning.
- The hospitals vision and values had been cascaded across the surgical services. Key risks to the services, audit findings and performance was monitored through routine departmental and divisional governance and integrated performance meetings.
- There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers.

Surgery

Are surgery services safe?

Good



We rated the surgical services at the Royal Bolton Hospital as Good for being safe. This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients.
- Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately.
- Most staff had completed their statutory and mandatory training and the hospitals internal targets for training completion were achieved.
- The staffing levels and skills mix was sufficient to meet patients needs. Staff assessed and responded to patients risks and used an early warning score system.
- The surgical services reported four never events between January 2015 and January 2016. The majority of remedial actions taken to learn from these events had been completed. A number of minor actions (e.g. providing human factors training) were still on-going and there were clear timelines for the completion of these actions.

Incidents

- The surgical services reported four never events between January 2015 and January 2016. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- The four reported never events related to the extraction of a wrong tooth (wrong site surgery) in January 2015, an incorrect orthopaedic (hip) implant in February 2015, a retained item (throat pack) in September 2015 and a retained item (vessel sling) that occurred in April 2014 but was identified and reported in June 2015.
- The never events occurred across a number of surgical specialties so there was no specific trend. Each incident was investigated to determine the root cause. The investigation reports highlighted that these incidents

were caused by a number of factors such as poor staff communication and staff not following the hospitals standard operating procedures and the five steps to safer surgery procedures correctly.

- The hospital invited the Royal College of Surgeons to carry out an external review of operating theatre processes in July 2015. The review concluded that the World Health Organization (WHO) checklist process was not being taken sufficiently seriously at all levels within the surgical services. The review team also considered that there was not universal acceptance of the importance of the five steps to surgical safety.
- A theatre safety culture action plan was put in place in November 2015 based on the recommendations from the Royal College of Surgeons review. Individual action plans were also put in place following each never event in order to minimise reoccurrence of these incidents.
- Remedial actions included updating hospital procedures and WHO checklists to include appropriate checks, retraining of staff in hospital procedures and WHO guidelines, prompts for surgical teams to confirm specific checks have been completed and quality monitoring and audits to check staff compliance.
- We looked at the individual action plans and the theatre safety culture action plan. These showed that as of March 2016 the majority of remedial actions (12 out of 18) had been completed and learning from these incidents had been shared across the surgical services. However, the following actions had not yet been fully completed: -
 - The WHO checklist forms had been updated and ratified and the updated WHO in-brief documents were in use. However, the updated WHO sign out and time out records were still being printed at the time of our inspection. These were planned to be available for use during April 2016.
 - An action for all theatre and medical Staff to complete human factors training was on-going. As of March 2016, 27% of theatre staff had completed this training and further training was scheduled in April 2016 (including for medical staff).
 - An action for all staff to receive training in the Manchester Patient Safety Framework (MaPSaF) was on-going. A training session had already been undertaken in September 2015 and further sessions were scheduled during 2016. MaPSaF is a tool to help NHS organisations assess their progress in developing a safety culture.

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- An action to develop a theatre code of conduct and etiquette involving the theatre teams and medical staff was on-going. A draft code of conduct had been created and this was awaiting approval by the hospitals clinical executive committee.
 - An action to develop patient safety champion roles in theatres was on-going. Six staff had completed the Advancing Quality Alliance (AQuA) training to become patient safety Champions during January 2016.
 - The Strategic Executive Information System data showed there were nine serious patient safety incidents reported by the surgical services between January 2015 and January 2016. This included four instances of pressure ulcers, three falls with harm, one incident of sub-optimal care of the deteriorating patient and a surgical procedure incident.
 - We saw evidence that incidents were investigated and remedial actions were implemented to improve patient care.
 - Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
 - Incidents logged on the system were reviewed and investigated to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matron or lead consultant.
 - Incidents and complaints were discussed during daily safety huddles and weekly and monthly staff meetings so shared learning could take place. Learning from incidents was also shared through hospital-wide alerts and monthly newsletters.
 - The incident reporting system provided prompts for staff to apply 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.
 - The serious incident reports we looked at showed that duty of candour principles were applied including a formal apology and explanation to the patient or their representatives from the clinician involved in their care and treatment.
 - Patient deaths were reviewed by individual consultants. These were also presented and reviewed during monthly mortality and morbidity meetings and monthly governance meetings.
- ## Safety thermometer
- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
 - Safety Thermometer information between December 2014 and December 2015 showed there were eight pressure ulcers, 10 falls with harm and four catheter urinary tract infections reported by the hospital relating to surgical services.
 - Information relating to this was clearly displayed in the wards and theatre areas we inspected.
- ## Cleanliness, infection control and hygiene
- There had been one MRSA bacteraemia infection and five Clostridium difficile (C. diff) infections relating to surgery at the hospital between January 2015 and December 2015.
 - We looked at the investigation reports and action plans for the MRSA incident (September 2015) and one C. diff incident on ward G4 from December 2015. These showed that the incidents had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trusts infection control team.
 - Public Health England data for surgical site infections between October 2014 and September 2015 showed there were no surgical site infections reported following total hip replacement surgery, compared with an average infection rate of 1.1%.
 - The infection rate following fractured neck of femur (hip) surgery was 1.1% compared with a national average of 1.5% during this period. The infection rate following total knee replacement surgery was 0.8% compared with a national average of 1.6%. This showed the hospital performed better than the national average for the proportion of patients that acquired surgical site infections following orthopaedic surgery.
 - The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

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- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Visitors were encouraged to wash their hands.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.
- Hand hygiene audits were carried out on a weekly basis across the wards and theatre areas. Audit results from January 2015 to January 2016 showed high levels of hand hygiene compliance by staff (94% to 100%). Where hand hygiene issues were identified this was discussed with individual staff members to improve compliance.
- Staff carried out weekly and monthly infection control audits to check the cleanliness of the general environment and equipment, including mattresses. Audit results showed compliance levels of 95% and above were consistently achieved in most ward and theatre areas. Where compliance was not fully achieved, additional steps such as deep cleaning took place to minimise the risk of spread of infection.
- Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit and theatre staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments used for surgery.
- There was sufficient storage space in the theatres and we saw that items such as surgical procedure packs were appropriately stored in a tidy and organised manner.
- We found there was a sufficient number of anaesthetic machines and capnography equipment (for monitoring carbon dioxide levels in patients) within the theatre and recovery areas. Staff carried out daily checks of the anaesthetic equipment.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately.
- We saw that medicines that required storage at temperatures below 8C were appropriately stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- A pharmacist carried out daily reviews on each ward. The pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.
- We looked at the medication charts for five patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- Staff used paper patient records and these were securely stored in each area we inspected.
- We looked at the records for five patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and these were reviewed and updated on a regular basis.

Environment and equipment

- The wards and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment was appropriately checked and cleaned regularly and the equipment we saw had service stickers displayed and these were within date. Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Equipment needed for surgery was readily available and any faulty equipment could be replaced from the hospital's equipment store.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.

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- Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received statutory training in the safeguarding of vulnerable adults and children. Records from March 2016 showed the majority of staff across the surgical services had completed training in safeguarding adults (95%) and safeguarding children (98%).
- Staff were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and children's safeguarding concerns was displayed in the areas we inspected. Each area also had safeguarding link nurses in place. Staff were aware they could seek advice and support from the hospital-wide safeguarding team.
- Safeguarding incidents were reviewed by the departmental leads and also by the hospitals safeguarding committee, which held meetings every two months to review individual incidents and to look for trends.

Mandatory training

- Mandatory and statutory training was delivered on a rolling programme and monitored on a monthly basis. We saw that information on mandatory training performance was displayed on notice boards in each area we inspected.
- Statutory training included key topics such as fire safety, blood transfusion, Infection prevention and control, moving and handling, equality and diversity and safeguarding of vulnerable adults and children. The hospitals target for statutory training completion was 95%.
- Mandatory training included key topics such as resuscitation, medicines management, and conflict resolution and information governance. The hospitals target for mandatory training completion was 85%.
- Records up to March 2016 showed that overall training compliance for staff across the surgical services was 92% for mandatory training and 95% for statutory training.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues and there was daily involvement by ward managers and matrons to address these risks.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care.
- Staff used national early warning score systems (NEWS) and carried out routine monitoring based on patients individual needs to ensure any changes to their medical condition could be promptly identified. If a patients health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- A NEWS audit was carried out during April / May 2015 and the findings were based on a review 414 records across the surgical wards. The audit showed that NEWS was recorded with every set of observations on 85% of occasions and NEWS was recorded accurately on 93% of occasions.
- The NEWS audit also showed five of the seven surgical wards showed improved compliance against the audit standards compared with 2014.
- The NEWS audit report listed a number of actions to further improve compliance, including additional monitoring of staff by ward managers, monitoring of compliance through monthly ward accreditation checks and improved observation charts to support clearer documentation.
- We observed five theatre teams undertaking the five steps to safer surgery procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the five steps to safer surgery procedures.
- A WHO checklist documentation audit was carried out on a monthly basis across the theatre departments. The audit included a review of completed WHO checklist records to check information was correctly documented for in-brief, sign in, sign out and time out stages.

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- Records showed average compliance was 99% in the main theatres and 100% across the day surgery, ophthalmology and urology theatres between April 2015 and February 2016.
- An observational audit of the theatre teams conducting the five steps to safer surgery had commenced since February 2016. The audit was carried out by the interim quality assurance lead for theatres and involved observing a theatre list session (approximately four patients) for half a day per week across a different theatre each week.
- The observational audit had not yet been carried out across all the theatres but findings from this audit showed compliance over most aspects of the audit. Findings from the audit and common themes (such as which member of staff leads the in-brief session) were shared with the theatre teams during daily safety briefs to aid learning.

Nursing staffing

- Nurse staffing levels were reviewed against minimum compliance standards and acuity was based on the Shelford Safer Nursing Care Tool. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The ward managers and matrons carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. There was also a weekly meeting on a Monday to highlight and address any staffing issues for the coming week.
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- There were approximately 16 whole time equivalent (wte) band 5 nursing vacancies and approximately 10 wte healthcare assistant vacancies across the surgical wards. The matrons told us recruitment for these posts was on-going and six nurses had been appointed and were due to commence employment at the end of March 2016.
- There were 6.84 whole time equivalent (wte) anaesthetic nurse vacancies in the main theatres and a 0.88 wte scrub nurse vacancy in the day care unit. Recruitment for these posts was on-going.
- Staffing levels were maintained by staff working overtime, staff cross covering wards and with the use of

agency staff. The matrons and ward managers told us they tried to use existing staff or regular agency staff that were familiar with policies and procedures. Agency staff underwent induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment.

- The majority of agency staff working in the theatres were long-term agency staff that had undergone induction training and were familiar with the theatre departments policies and procedures.
- Records showed that average bank and agency staff usage across all the surgical wards and theatres ranged between zero and 7.9% (average 4.6%) between April 2015 and February 2016.
- Nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues. Patients spoke positively about the staff and did not highlight any concerns relating to staffing levels.

Surgical staffing

- The wards and theatres we inspected had sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The proportion of consultants, middle career doctors and junior doctors was greater than the England average. The proportion of registrars was below the England average (28% compared with the England average of 37%).
- There were separate medical rotas in place to cover specific surgical specialties, such as general surgery, urology, trauma and orthopaedics and anaesthetics. Staff rotas showed there was sufficient on-site junior and middle grade medical cover across each specialty over a 24-hour period.
- We found there was sufficient on-site and on-call consultant cover over a 24-hour period including cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they

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understood the hospitals policies and procedures. The majority of locum and agency doctors had worked at the hospital on extended contracts so they were familiar with the hospitals policies and procedures.

- The ward and theatre staff told us they received good support from the consultants and ward-based doctors.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident procedure within the surgical services and this listed key risks that could affect the provision of care and treatment.
- There were clear instructions for staff to follow in the event of a fire or other major incident.
- Records showed 96% of staff across the surgical services had completed resuscitation training and staff had guidelines in place for dealing with medical emergencies such as a patient going into cardiac arrest.

Are surgery services effective?

Good



We rated the surgical services at the Royal Bolton Hospital as Good for being effective. This was because: -

- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.
- The services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken to improve compliance in audits such as the national emergency laparotomy audit.
- The services performed in line with the England average for average length of patient stay and for the proportion of patients readmitted to the hospital following discharge.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had

completed their annual appraisals. However, the hospitals internal target of 85% appraisal completion had not been achieved across all the surgical specialties.

- Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.

Evidence-based care and treatment

- Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE). Emergency surgery was managed in accordance with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery.
- Staff provided care in line with Recognition of and response to acute illness in adults in hospital (NICE clinical guideline 50) and Rehabilitation after critical illness (NICE clinical guideline 83).
- Enhanced recovery pathways were used in a number of surgical specialities, such as colorectal surgery. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery.
- The trusts strategic plan 2014-2019 included objective to implement enhanced recovery pathways across further surgical procedures in order to improve patient experience and reduce patient length of stay.
- During 2014/15 the hospital participated in 100% of the national clinical audits and national confidential enquiries which it was eligible to participate in. The surgical services registered 23 clinical audits during April 2016 to June 2016 and 19 clinical audits between July 2016 and September 2016.
- Findings from clinical audits were reviewed at bi-monthly audit meetings and monthly governance meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trusts intranet. We looked at a selection of the hospitals policies and procedures and these were up to date and reflected national guidelines.

Pain Relief

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- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort. Patients told us staff gave them pain relief medication in a timely manner.
- There was an acute pain team within the hospital and staff knew how to contact them for advice and treatment when required.
- The lung cancer audit 2015 showed the hospital achieved the 80% standard and performed better than the England average for the percentage of patients seen by a nurse specialist (86.1% compared to the England average of 77.5%). The hospital performed slightly worse than the England average for the percentage of patients receiving surgery in all cases (13.3% compared with the average of 15.4%).
- The lung cancer audit also showed the hospital performed slightly worse than the England average for the number of cases discussed at multidisciplinary meetings (91.8% compared with the average of 93.6%).
- The national bowel cancer audit of 2015 showed that the hospital was performing better than the England average for case ascertainment rate and data completeness. The hospital performed slightly worse than the average for the percentage of patients that were seen by a nurse specialist (91% compared with the average of 93%).

Nutrition and hydration

- Patient records included assessments of patients nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Patient records showed fluid balance charts were in place and these were complete and up to date. The records also showed that there was regular dietician involvement with patients who were identified as being at risk.
- Patients with difficulties eating and drinking were placed on special diets. We also saw that the surgical wards used a red tray system so patients needing assistance with feeding could be identified and supported by staff during mealtimes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Patient Outcomes

- The national hip fracture audit 2015, reporting on all of 2014, showed that the hospital performed better than the England average for six out of the eight indicators, including the number of patients admitted to orthopaedic care within four hours, the number of patients developing pressure ulcers, the number of patients that were assessed by an orthopaedic geriatrician, bone health and falls assessments and the total the length of patient stay at the hospital.
- The 2015 hip fracture report also highlighted that the hospital performed slightly worse than the England average for the number of patients having surgery on the day of or after day of admission and for mean length of acute stay.
- The national emergency laparotomy audit (NELA) 2015 showed that the hospital performed well and achieved five out of the 11 standards. The hospital did not achieve three out of the 11 standards including case ascertainment, timely consultant surgeon review and assessment by a medicine for care of the older person (MCOP) specialist.
- There was an action plan in place to improve against the NELA standards that had not been achieved, such as discussions with the acute adult division (medicine) to support the standard for routine daily input from elderly medicine and to implement multidisciplinary mortality and morbidity reviews for all emergency laparotomy patients.
- The national joint registry (NJR) data between April 2003 and July 2015 showed that hip and knee mortality rates at the hospital were within the national average.
- Performance reported outcomes measures (PROMs) data between April 2014 and March 2015 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was similar to the England average. The proportion of patients with worsening outcomes was also lower than the England average.

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- The number of patients that had elective and non-elective surgery and were readmitted to hospital following discharge was similar to or better than the England average for all specialties except for non-elective ear, nose and throat (ENT).
- The trust reported that the main reason for the higher ENT readmission rates was due to the incorrect recording of data on the ward. It was identified that a number of patients who come back to the hospital as part of their planned post-operative care were recorded incorrectly and this could impact the readmission rate and distort the number of genuine readmissions.
- A number of actions were planned to address the discrepancy, such as a retrospective audit of readmissions over the past 12 months to assess the validity of current figures and to formally review readmission rates on a monthly basis as part of the routine governance arrangements.
- The average length of stay for elective and non-elective patients across all specialties was either similar to or better than the England average.

Competent staff

- Newly appointed staff had an induction for up to two weeks and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- The theatres department had two practice educators that oversaw training processes and carried out competency assessments based on national competency guidelines.
- Staff told us they routinely received supervision and annual appraisals. Records up to March 2016 showed appraisal rates across the surgical specialties, including general surgery (52%), anaesthetics (83%), ear, nose and throat (ENT) and audiology (79%) and ophthalmology (78%), trauma and orthopaedics (82%), theatres and day case unit (89%), oral surgery (92%) and urology (92%).
- This showed that although the majority of staff had completed their annual appraisals, the hospitals internal target of 85% appraisal completion had not been achieved across all the surgical specialties.
- Records showed all eligible medical staff in the surgical services that had reached their General Medical Council revalidation date had been reviewed and recommendations had been completed.

- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and safety huddles were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The ward staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.
- The ward and theatre staff told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists as well as diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover.
- At weekends, newly admitted patients were seen by a consultant, and existing patients on the surgical wards were seen by the ward-based doctors or the registrar.
- There was a 24 hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be operated on promptly.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The dispensary was also open for a limited number of hours on Saturdays. Staff could also access the emergency drugs cupboard if needed during weekends.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

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Access to information

- Staff across the surgical services used paper patient records. These contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.
- Notice boards detailed information relating to staffing levels and identified patients with specific needs. Information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected.
- Staff told us the information about patients they cared for was easily accessible. Staff could access information such as policies and procedures from the trusts intranet.
- The theatres department used an electronic system to capture information about patient scheduling and theatre performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Patient records showed that consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- Consent records showed the risks and benefits of the specified surgical procedure were clearly documented and had been explained to the patient.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patients behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patients representatives and other healthcare professionals. We saw evidence of this in the patient records we looked at.
- Patient records showed that staff carried out mental capacity assessments for patients that lacked capacity to make an informed decision about their treatment. We looked at a patient record where a DoLS application had been made and the records for this had been completed correctly.

- There was a hospital-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and DoLS applications.

Are surgery services caring?

Good



We rated the surgical services at the Royal Bolton Hospital as Good for being caring. This was because: -

- We spoke with 11 patients and the relatives of another four patients. They all spoke positively about the care and treatment they received. They told us they were treated with dignity and compassion and their privacy was respected.
- Patients and their relatives were kept fully involved in their care and the staff supported them with their emotional and spiritual needs.
- Patient feedback from the NHS Friends and Family Test between September 2014 and November 2015 showed that five of the seven surgical inpatient wards had an average score above 98% and the remaining two wards averaged above 95%. This showed that most patients were positive about recommending the surgical wards to friends and family.

Compassionate care

- We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner in the wards and theatre areas.
- Patients bed curtains were drawn when providing care and treatment and staff spoke with patients in private to maintain confidentiality.
- Patients could also be transferred to side rooms to provide privacy and to respect their dignity. The privacy and dignity of patients being transferred to the theatre areas was maintained and patients were provided with gowns and blankets.
- We spoke with 11 patients and the relatives of another four patients. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: staff are well trained, the nurses are brilliant and I have been really well looked after.

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- The NHS Friends and Family Test is a satisfaction survey that measures patients satisfaction with the healthcare they have received. The test data between September 2014 and November 2015 showed that five of the seven surgical inpatient wards had an average score above 98% and the remaining two wards averaged above 95%.
- The surgical wards scored consistently better the England average during this period and the survey scores indicated that most patients were positive about recommending these wards to friends and family.
- The average response rate (the percentage of patients that completed the survey out of all eligible patients) was less than the England average of 35.5% across three of the surgical wards. There were plans to introduce tablet computers across the surgical wards to make the process for completing the survey easier for patients.
- A review of data from the CQCs adult inpatient survey 2014 showed that the trust was about the same compared with other trusts for all 10 sections, based on 399 responses received from patients.
- Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. Patient comments included feel safe to be treated at the hospital and the staff have made me feel comfortable.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Patients relatives were also provided with a bereavement booklet if needed. Staff told us they were supported by the hospitals palliative (end of life care) team for support and advice during bereavement.

Are surgery services responsive?

Good



We rated the surgical services at the Royal Bolton Hospital as Good for being responsive to patients needs. This was because: -

Understanding and involvement of patients and those close to them

- Patient records included pre-admission and pre-operative assessments that took individual patient preferences into account.
- Staff respected patients rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand. Staff were respectful and sought permission from patients before they delivered care or treatment.
- Patients and their relatives told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. The comments received included staff are very good; doctors explain everything and was given information about discharge following surgery.

Emotional support

- The staff we spoke with understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients.

- Services were planned and delivered to meet the needs of local people. There was sufficient bed space in the wards and theatres so patients could be appropriately cared for before and after surgery.
- The surgical services achieved the 18 week referral to treatment standards across most specialties. The services performed better than the England average for the number of patients whose operations were cancelled and were treated within the 28 days.
- Actions were taken to improve patient access and flow including opening ward R1 to increase capacity for day surgery and elective admissions. A theatre productivity and safety project was in place to improve theatre efficiency and redesign the theatre timetable to meet the demand for surgical services.
- There were systems in place to support vulnerable patients. The majority of complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- Hospital episode statistics data showed 30,417 surgical procedures took place at the hospital between

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September 2014 and August 2015. The data showed that 61% of patients had day case procedures, 13% had elective surgery and 26% were emergency surgical patients.

- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, oral surgery, ear, nose and throat (ENT) surgery, breast surgery, ophthalmology, plastic surgery and general surgery (such as colorectal and upper gastro-intestinal surgery).
- There were arrangements in place with neighbouring hospitals to allow the transfer of patients for surgical specialties not provided by the hospital, such as neurosurgery.
- The surgical services carried out elective vascular surgery procedures at the hospital. Patients requiring non-elective out-of-hours vascular surgery were transferred to another local hospital.
- The ward and theatre areas we inspected were compliant with same-sex accommodation guidelines.
- There were daily meetings with the bed management team so patient flow could be maintained and to identify and resolve any issues relating to the admission or discharge of patients.
- The surgical services had an ambulatory care unit, which operated from 10am to 8pm during weekdays. Patients that attended through the emergency department or via general practitioner (GP) referral with minor ailments were assessed and treated so they could be discharged without unnecessary admittance to the surgical wards.
- The surgical assessment unit (ward F3) included an admissions area with a sitting area for up to eight patients. This was used to assess patients admitted via the emergency department and referral patients during out of hours and on weekends. There was a treatment room and patients were initially seen by a nurse, followed by a junior doctor to determine whether they could be treated and discharged without being admitted to the ward.
- Patients undergoing day surgery were given morning and afternoon appointment times. As part of the winter escalation plan, ward R1 was being used as an expansion of the day surgery unit and the elective admissions ward (ward F4). This ward had capacity for nine beds. The ward operated from 7.30am until 8pm on weekdays with no overnight patients.

- The R1 ward was originally planned to remain in place until the end of March 2016. However, the divisional director of operations told us this may remain in use until May 2016 as the additional capacity would allow the surgical services to admit and treat more day case and short-stay elective surgery and achieve waiting time targets.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patients stay at the hospital.
- The overall hospital-wide bed occupancy rate between July 2013 and December 2015 ranged between 80.8% and 88%. This was reflected in the surgical wards we visited as we found that most available beds were occupied. Bed management meetings took place at least three times per day to monitor patient flow and bed availability.
- We did not see significant numbers of medical patients admitted to the surgical wards (medical outliers) during the inspection. Records showed that between August 2015 and November 2015 there were a total of 176 patients that were medical outliers across the surgical wards. Staff on the surgical wards told us medical outlier patients were seen daily by medical doctors.
- The matrons told us it was very rare for a surgical patient to be placed on a medical ward. However, there were instances where surgical patients were placed in

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another surgical specialty ward. Where this was the case, the surgical consultants and doctors had a list of patients that were placed in other wards so these patients could be reviewed daily.

- Patient records showed that patients were reviewed by doctors on a daily basis. We identified an orthopaedic surgical patient on ward E3 (general surgical ward) and this patient was seen by an orthopaedic specialty doctor.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation. There was a designated bay in the main theatres recovery area for critically ill patients that required stabilising prior to transfer to the intensive care or high dependency units.
- Since June 2015, the incomplete pathway is the standard for measuring referral to treatment waiting times. The incomplete standard is that at least 92% of patients should have to wait less than or equal to 18 weeks of referral for their treatment.
- Hospital records between March 2015 and February 2016 showed the 92% incomplete pathway standard was achieved across all surgical specialties, except paediatric surgery which averaged 90.4% during this period.
- Records between April 2015 and January 2016 showed the surgical services also achieved the historical 90% standard for 18 week referral to treatment standards for admitted (adjusted) patients for general surgery, ENT, ophthalmology, urology and oral surgery. However, the trauma and orthopaedics specialty (84.5%) and oral surgery (77.65) did not perform as well other specialties during this period.
- The divisional director of operations told us there had been an increase in demand for services due to an increased bed pressures, especially since the beginning of 2016. This could impact on referral to treatment performance.
- A number of additional steps were being taken in order to deliver safe and timely care to patients. This included putting on additional theatre lists (such as on weekends) where possible, outsourcing some low risk day case surgery to local independent hospitals and the use of ward R1 to provide additional capacity for day surgery.
- There was a daily of review of surgical lists and these were planned based on bed availability to reduce unnecessary cancellations. The divisional director of operations also told us they carried out a weekly review involving the divisional leads to review patient tracking / waiting lists and to monitor performance within each specialty.
- NHS England data showed the proportion of elective operations cancelled at the hospital was either similar to or slightly worse than the England average from April 2013 to December 2015. However, the hospital performed much better than the England average for the number of patients whose operations were cancelled and were treated within the 28 days.
- There were 340 last minute elective operations cancelled for non-clinical reasons between January 2015 and December 2015. There were six patients whose operations were cancelled and were not treated within 28 days during this period. The main reason for cancelled elective operations was due to bed availability and capacity constraints across the hospital.
- Records for the period between September 2015 and November 2015 showed the average theatre utilisation (efficiency) across 15 operating theatres ranged between 50% and 99%, with overall average of 86% utilisation. The hospital target of 90% utilisation was achieved by eight of the 15 theatres during this period.
- The average utilisation for theatre one was the lowest at 50% during this period. However, this was the dedicated emergency theatre so was only used for when needed.
- The theatre productivity and safety project commenced in May 2015 with specific objectives around improving theatre efficiency and a planned redesign of the current theatre timetable aligned to demand and infrastructure requirements.
- The first phase of the project targeted improvements in the day case unit. Records up to November 2015 showed there were improvements made as a result of booking rules, booking forms and amendments to scheduling process/meeting. This resulted in improved theatre utilisation (82.1% compared to 81% prior to improvements); an increase in the number of operations carried out per session (3.64 compared with 3.5% previously) and a reduction in short notice cancellations (0.27% compared to 0.31% previously).
- The second phase of the project targeted the remaining theatre areas and commenced in January 2016. This included specific actions such as moving from consultant-specific theatre sessions to sessions at specialty level, to assess the viability of closing urology theatre and transfer activity to the main theatres and

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the creation of a theatre template aligned to demand and reduce the number of cancelled sessions as a result of opening the equivalent of 52 weeks worth of sessions based on the current 42 week capacity template.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- The areas we inspected had dementia link nurses in place. Staff also used a passport document for patients admitted to the hospital with dementia or a learning disability. This was completed by the patient or their representatives and included key information such as the patients likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Staff could also contact the hospital-wide safeguarding team for advice and support for dealing with patients living with dementia. There was a hospital-wide lead nurse that provided staff with guidance and support when caring for patients with learning disabilities.
- Staff could also contact the rapid assessment, interface and discharge (RAID) team for support and advice when treating patient with mental health conditions. The RAID service was based at the hospital but provided by a neighbouring mental health trust.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- The recovery area in the main theatres could accommodate up to paediatric patients. However, these were located within the main recovery area, which meant segregation was only maintained through the use of bed-side curtains.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.

- The clinical leads and the ward and theatre matrons were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team. Staff assigned to investigate complaints were allocated up to 21 days to investigate and respond to the central team. As part of the process, they were also required to submit a lessons learned document to demonstrate what learning had taken place following the complaint.
- Staff told us that information about complaints was discussed during daily safety huddles and at routine staff meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.
- Records showed there were 43 complaints raised across the surgical services between April 2015 and March 2016. The most frequent reasons for complaints were due to decisions about clinical treatment (17 complaints) and complications of surgery / procedure (11 complaints).
- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 35 working days for routine formal complaints.
- Records showed there were only three complaints that were not resolved within these timelines between April 2015 and March 2016. This meant the majority of complaints about the surgical services were responded to in a timely manner.

Are surgery services well-led?

Good



We rated the surgical services at the Royal Bolton Hospital as Good for being well-led. This was because: -

- The hospitals vision and values had been cascaded across the surgical services and staff had a clear understanding of what these involved. Key risks to the services, audit findings and quality and performance was monitored through routine departmental and divisional governance and integrated performance meetings.
- There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers.

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- There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the services and how to resolve these.

Vision and strategy for this service

- The hospital's vision was based around the slogan better care together. This was underpinned by a number of values including; placing patients and staff at the heart of everything, to be respected, to be valued and to be proud.
- The elective care divisional objectives 2015/16 incorporated the trust values and included key objectives relating to improving quality, safety and patient experience, improving the delivery of services, staff engagement, governance, financial performance and future strategy of the service.
- The values and objectives had been cascaded to staff across the surgical wards and theatre areas and staff had a good understanding of these.

Governance, risk management and quality measurement

- There were monthly divisional quality and governance meetings, monthly integrated performance meetings and monthly departmental staff meetings across the surgical services. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Risks were documented and escalated by the service appropriately. The risk register for elective the elective care division listed risks relating to surgical services and this showed that key risks had been identified and assessed.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- The surgical services had heat maps and clinical dashboards in place that showed performance against key targets including patient safety, audit compliance and staffing levels and training. These were displayed on notice boards in the areas we inspected.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives and this was discussed during routine meetings.

Leadership of service

- The surgical services provided at the hospital were part of the elective care division. The overall lead for the services was the clinical head of elective care, who was supported by the divisional director of operations and the divisional nurse director.
- The surgical services were divided into clinical directorates based on specific surgical specialties and each speciality had a clinical lead, a matron and an operational business manager.
- The surgical wards were led by ward managers that reported to the matrons. The matron for theatres oversaw the main theatres, day care unit and urology theatres.
- The theatres and ward based staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and who provided good support.

Culture within the service

- The staff we spoke with was proud, highly motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- Records showed the staff turnover rate across the elective care division was 10.8% between January 2015 and December 2015.
- The staff sickness rate across the elective care division was 5.8% between January 2015 and December 2015. The sickness levels were higher (worse) than national averages during this period. Staff sickness levels were reviewed daily in the wards and theatres and staffing levels were maintained through the use of overtime for existing staff and bank and agency staff.

Public engagement

- Staff across the surgical services told us they routinely engaged with patients and their relatives to gain feedback from them. This was done formally through participation in the NHS Friends and Family test and by conducting ad hoc patient feedback surveys.
- Staff told us the most recent patient feedback survey was currently in progress and they were awaiting the results of the survey to be published.

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- The ward managers and matrons told us they sought feedback from patients through daily walk rounds.
- The surgical services had also created patient stories as part of the engagement and these were shared with staff to promote service improvement.

Staff engagement







- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The medical and nursing staff participated in ad hoc training days included that included engagement, training and discussions around improvements to clinical processes.
- The NHS staff survey 2014 15 showed the trust performed better than the national averages for the majority of indicators, including for overall staff engagement.

Innovation, improvement and sustainability

- The theatre productivity and safety project work in the day case unit had resulted in improved theatre

- efficiency. The project was rolled out across the remaining theatre areas in January 2016 and improvement measures such as moving from consultant-specific theatre sessions to sessions at specialty level were regarded as innovative.
- The surgical wards had been assessed as part of the hospitals exemplar star system of accreditation (ESSA) framework. This accreditation was based on a number of nursing standards and five of the seven surgical wards had achieved the highest three star rating. The remaining two wards achieved two stars, which meant the surgical wards had either met or exceeded the hospitals ward accreditation standards.
 - All the staff we spoke with were confident about the sustainability of the surgical services at the hospital. They felt there was a strong, skilled workforce that provided a good standard of care and treatment.
 - The divisional director of operations, the divisional nurse director and the surgical matrons told us the key risks to the service were around maintaining nursing staff levels and their ability to meet performance targets, such as the 18 week referral to treatment standards. However, they were aware of how to address these issues and were confident about the future of the services.

Critical care

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The critical care services are based at the Royal Bolton Hospital. The intensive care unit (ICU) provides care for up to eight level 3 (intensive care) patients. The high dependency unit (HDU) provides care for up to 10 level 2 (high dependency) patients.

The services are consultant-led and provided specialist care and treatment to adult patients with a range of serious life-threatening illnesses from Bolton and the surrounding areas. Patients could be admitted to the critical care services via the emergency department or from within the wards and departments across the trust. There were 1,459 admissions to critical care between April 2014 and March 2015.

We visited the Royal Bolton Hospital as part of our announced inspection during 21 to 24 March 2016. As part of our visit, we inspected the intensive care unit and the high dependency unit.

We spoke with seven patients and the relatives of another two patients. We observed care and treatment and looked at nine care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, a pharmacy technician, the pharmacist, the practice educator, the medical device trainer, healthcare assistants, outreach specialist nurses, a dietitian, the ward managers, the matron for critical care and the consultant lead for intensive care. We received comments from our patient engagement event and from people who contacted us to tell us about their experiences. We reviewed performance information about the services.

Summary of findings

We gave the critical care services at the Royal Bolton Hospital an overall rating of good. This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises.
- There were plans to build a combined critical care unit by 2019. In the interim, risk assessments had been carried out to minimise the risk to patients. The control measures included visible prompts and floor markings, additional infection control training and monitoring of staff compliance and restricting visitors to a maximum of two per bed.
- Most staff had completed their mandatory training and the hospital's internal targets for training completion were achieved. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks.
- The critical care services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The service performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit.
- Patients received care and treatment by multidisciplinary staff that worked well as a team. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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- Patients and their relatives spoke positively about the care and treatment they received. They were supported with their emotional and spiritual needs. Feedback from surveys showed patients or their relatives were positive about recommending the services to friends and family. There were systems in place to support vulnerable patients.
- There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. Bed occupancy levels were similar to or slightly lower than the England average between March 2015 and February 2016. Most patients were admitted to the ICU within four hours of making the decision to admit and assessed by a consultant within 12 hours of admission.
- Remedial actions were being taken to reduce delayed discharges, including increased consultant presence on the HDU and analysing admission data to predict capacity issues. Staff also took appropriate steps to minimise the impact to patients privacy and dignity.
- The hospitals vision and values had been cascaded across the critical care services. Key risks monitored through routine departmental and governance meetings. There was effective teamwork and clearly visible leadership within the services.
- Staff were positive about the culture within the critical care services and the level of support they received from their managers. The services participated in a safety culture survey during 2015, which showed staff were positive about morale, training and overall safety culture.
- The ICU team received the team of the year award in 2015 following their work on patient diaries, ICU follow up and for their work to facilitate the discharge of three patients that expressed a preference to die in their own home.

However, we also found that: -

- The intensive care unit (ICU) and one bay in the high dependency unit (HDU) did not have sufficient bed space of a minimum of 25.5M² as outlined in the Department of Health 'Health Building Note' HBN 04-02 (critical care units) guidelines.
- There were 60 delayed discharges over four hours on the ICU between September 2015 and February 2016.

However, there were 246 delayed discharges over four hours on the HDU during this period. The delayed discharges were mainly due to a lack of available ward beds across the hospital.

- The presence of patients with delayed discharges meant there were three mixed sex breaches on the ICU between January 2015 and March 2016. However, there were 40 mixed sex breaches in the HDU during this period; 25 of these breaches occurred between January 2016 and March 2016.

Critical care

Are critical care services safe?

Good



We rated the critical care services at the Royal Bolton Hospital as Good for being safe. This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. The majority of staff had completed their statutory and mandatory training and the hospitals internal targets for training completion were achieved. Staff were aware of how to access guidance in the event of a major incident.
- Medicines were stored and administered appropriately. The staffing levels and skills mix was sufficient to meet patients needs and staff assessed and responded to patients risks. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating.
- Patients received care in safe, clean and suitably maintained premises. Patients care was supported with the right equipment.
- There were plans in place to build a combined critical care unit that was due for completion by 2019. In the interim, risk assessments had been carried out to minimise the risk to patients. The control measures included visible prompts and floor markings, additional infection control training and monitoring of staff compliance and restricting visitors to a maximum of two per bed.

However, we also found that: -

- The intensive care unit (ICU) and one bay in the high dependency unit (HDU) did not have sufficient bed space of a minimum of 25.5M² as outlined in the Department of Health 'Health Building' Note HBN 04-02 (critical care units) guidelines.

Incidents

- There had been no 'never events' reported by the hospital relating to the critical care services between January 2015 and March 2016. A 'never event' is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.

- The Strategic Executive Information System data showed there were no serious patient safety incidents reported by the critical care services January 2015 and January 2016.
- The critical care services reported 281 incidents to the 'National Reporting and Learning System' between February 2015 and January 2016. The majority of these incidents had resulted in no or low patient harm.
- The most frequent reason for incidents was bed availability in critical care, followed by clinical care incidents and admission and discharge issues. We saw evidence that incidents were investigated and remedial actions were implemented to improve patient care.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated to identify learning and prevent reoccurrence. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matron or lead consultant.
- Incidents and complaints were discussed during weekly and monthly staff meetings so shared learning could take place. Learning from incidents was also shared through a 'highlights sheet' during staff handovers and through hospital-wide alerts and monthly newsletters.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. The incident reporting system provided prompts for staff to apply duty of candour.
- Patient deaths were reviewed by individual consultants. These were also presented and reviewed during monthly consultant meetings and monthly governance meetings.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- The critical care services had low levels of falls with harm, infections and pressure ulcers. Safety Thermometer information showed there were no catheter urinary tract infections, one pressure ulcer and two falls with harm reported by the critical care services between December 2014 and December 2015.

Critical care

- Information relating to the safety thermometer outcomes was clearly displayed on notice boards within the intensive care unit (ICU) and the high dependency unit (HDU).

Cleanliness, infection control and hygiene

- There were no cases of Meticillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C.diff) infections reported between January 2015 and December 2015 across the critical care services.
- Intensive Care National Audit and Research Centre (ICNARC) data also showed that infection rates were within expected levels compared to the England average.
- All patients admitted to the critical care services underwent MRSA screening procedures. Patients identified as at risk were also screened for Carbapenemase-producing enterobacteriaceae (CPE) infections.
- There were 17 incidents of ventilator-associated pneumonia (VAP) identified in the ICU between January 2015 and January 2016. Patients identified with VAP received safe and appropriate treatment through the use of a recognised ventilator care pathway. Staff also used recognised care pathways for patients with sepsis (blood poisoning).
- The ICU and HDU were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. Visitors were encouraged to wash their hands.
- Patients identified with an infection could be isolated in the two side rooms located in the ICU. We saw that appropriate signage was used to protect staff and visitors. The HDU did not have any side rooms so patients that required isolation were routinely transferred to the ICU.
- We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.
- Hand hygiene audits were carried out on a weekly basis across the services. Audit results from January 2015 to

January 2016 showed average hand hygiene compliance was 97.2% in the HDU and 99.8% in the ICU. Where poor hand hygiene compliance was identified, this was discussed with individual staff members to improve compliance.

- Infection control audits were carried out monthly and annually to check the cleanliness of the general environment and equipment. Audit results showed compliance levels of 98% and above were consistently achieved across the HDU and ICU between June 2015 and December 2015. Where compliance was not fully achieved, action plans were in place and these were followed up during the next scheduled audit to minimise the risk of spread of infection.
- Staff in the ICU developed a Major Infection Control Transgressions (MICT) audit as a way to support staff in reducing and managing infection transmission. A major transgression is defined as physical/hand contact with a patient and their connected items (such as bedding, lines, ventilator tubing and drains) followed by physical/hand contact with another person (staff or patient) without doing something in between to stop transmission (such as gloves, gel and hand washing).
- The MICT audit was carried out on a weekly basis to observe and improve staff behaviours in order to reduce the spread of infection from one patient to another. Audit results from January 2014 to March 2015 showed there had been consistent reduction in the number of transgressions observed which showed the MICT process had led to sustained improvement in staff practice within the ICU.
- Records from March 2016 showed 99% of critical care staff had completed infection prevention and control training.

Environment and equipment

- The environment and equipment in the ICU and HDU was visibly clean and well maintained. The clinical areas were tidy and free from clutter. Each patient bed area had an equipment trolley containing all the equipment required to treat the patient.
- The critical care services had identified that the current facilities in the ICU and HDU did not fully comply with the Department of Health 'Health Building Note' HBN 04-02 (critical care units) guidelines. The ICU and one bay within the HDU did not have sufficient bed space of a minimum of 25.5M² as outlined in the HBN 04-02 standards.

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- Risk assessments had been carried out and control measures were put in place to minimise the risk to patients as a result of the reduced bed space. The control measures included visible prompts and floor markings, infection control training for staff, increased infection control monitoring and audit, use of aseptic non-touch technique and restricting visitors to a maximum of two per bed.
- The long-term solution to address this issue was to build a new combined critical care unit. Funding for the new unit had been agreed and the unit was scheduled for completion by 2019.
- Equipment was appropriately checked and cleaned regularly and the equipment we saw had service stickers displayed and these were within date. Equipment was serviced by the hospitals maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.
- There were sufficient quantities of specialist equipment available, such as capnography equipment (for monitoring carbon dioxide levels in patients).
- Staff told us that all items of equipment were readily available and bed spaces were equipped with the right equipment needed to treat patients, such as ventilators and intubation equipment (for placement of tube in patients airways).
- Emergency resuscitation equipment was available and checked on a daily basis by staff.

Medicines

- Medicines, including controlled medicines, were securely stored. Staff carried out daily checks on controlled medicines and medication stocks to ensure that medicines were reconciled correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately. A pharmacy technician carried out daily visits during weekdays to check stock levels and medication expiry dates.
- We saw that medicines that required storage at temperatures below 8C were stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- The ICU did not have a dedicated critical care-trained pharmacist, as outlined in the intensive care society (ICS) best practice guidelines. Recruitment for this role was on-going. However, a pharmacist was present in the

units and carried out daily reviews during weekdays. The pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.

- We looked at the medication charts for six patients across both units and found these to be complete, up to date and reviewed on a regular basis.

Records

- We looked at the records for nine patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for venous thromboembolism (VTE), pressure care or nutrition and these were completed correctly.
- The records showed timely assessments by nurses and daily consultant reviews took place.
- Standardised nursing documentation was kept at the end of patients beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received statutory training in the safeguarding of vulnerable adults and children. Records from March 2016 showed 99% of critical care staff had completed safeguarding adults training and 99% had completed safeguarding children training.
- Staff were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and children's safeguarding concerns was displayed in the areas we inspected. There were safeguarding link nurses in place. Staff were aware they could seek advice and support from the hospital-wide safeguarding team.
- Safeguarding incidents were reviewed during monthly governance meetings and also by the hospitals safeguarding committee, which held meetings every two months to review individual incidents and to look for trends.

Mandatory training

- Mandatory and statutory training was delivered on a rolling programme and monitored on a monthly basis. We saw that information on mandatory training performance was displayed on notice boards in the ICU and HDU.
- Statutory training included key topics such as fire safety, blood transfusion, Infection prevention and control,

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moving and handling, equality and diversity and safeguarding of vulnerable adults and children. The hospitals target for statutory training completion was 95%.

- Mandatory training included topics such as resuscitation, medicines management and conflict resolution and information governance. The hospitals target for mandatory training completion was 85%.
- Records up to March 2016 showed that overall training compliance for staff across the critical care services was 97.3% for mandatory training and 98.9% for statutory training.

Assessing and responding to patient risk

- Critical care staff carried out routine monitoring based on the patients individual needs to ensure any changes to their medical condition could be promptly identified.
- Patient records showed that staff escalated concerns correctly, and repeat observations were taken within necessary time frames to support patient safety.
- Ward staff across the hospital used early warning scores. If a patients health deteriorated, staff were supported with medical input and could access the critical care outreach team.
- The critical care outreach team provided cover for the wards and theatre recovery areas across the hospital over seven days between 7am and 8pm. Outside of these hours the hospital at night team nurse practitioners received handover from the outreach team. Staff spoke positively about the support they received from the outreach team.
- The outreach team followed up all patients that had been discharged from the critical care services within 24 hours of discharge. Records between September 2015 and February 2016 showed 100% of patients discharged from the ICU and HDU received a follow up review by the outreach team within 24 hours of discharge.

Nursing staffing

- Nurse staffing levels were reviewed against minimum compliance standards and acuity was based on Intensive Care Society (ICS) guidelines. The expected and actual staffing levels were displayed on notice boards in the ICU and HDU units and these were updated on a daily basis.
- Nursing staff handovers occurred three times a day and included discussions around patient needs and any staffing or capacity issues.

- We found the critical care services had sufficient numbers of qualified nursing and support staff with an appropriate skills mix on each shift to ensure that patients received the right level of care.
- The ICU provided care for up to eight level 3 (intensive care) patients. These patients were nursed 1:1 in accordance with ICS guidelines.
- There were seven patients in the ICU during the inspection. The staffing establishment was for at least eight trained nurses and two healthcare assistants during the morning and evening shifts and eight trained nurses during the night.
- There was a matron for the critical care services as set out in the ICS standards. The ICU was overseen by two ward managers that worked alternate shifts. There was also a lead nurse on each shift in the ICU. However, the shift leader was not always supernumerary (i.e. additional to the staffing establishment) as recommended by ICS guidelines.
- The matron for critical care told us the low bed occupancy levels in the unit meant the shift lead nurse was able to carry out their additional duties with minimal impact to patient safety. The trust reported that healthcare assistants on the unit had received additional competency-based training and could provide support to the shift leader when they were not supernumerary.
- The HDU provided care for up to 10 level 2 (high dependency) patients. These patients were nursed 1:2 in accordance with ICS guidelines.
- There were eight patients in the HDU during the inspection. The staffing establishment was for at least six trained nurses and two healthcare assistants during the morning and evening shifts and five trained nurses during the night. The HDU was managed by a supernumerary ward manager during normal weekday hours.
- Records between January 2016 and March 2016 showed the proportion of nurses and healthcare assistants across each shift (shift fill rate) was either to the expected establishment (100%) or routinely exceeding the expected staffing numbers.
- There were minimal vacancies across the critical care services and external agency staff were not routinely used. The majority of cover for staff leave or sickness was provided by the existing nursing team.

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- Records between April 2015 and February 2016 showed external agency staff use in the ICU and HDU was less than 1% and so was within levels recommended by ICS guidelines (less than 20% agency staff on any one shift).
- The critical care outreach team included four nurses and an outreach lead nurse. The team was also supported by a consultant during weekdays.

Medical staffing

- During our inspection we found the critical care services had a sufficient number of medical staff with an appropriate skills mix to ensure that patients received the right level of care.
- There was a designated lead consultant for intensive care as set out in the ICS standards.
- There were 13 critical care consultants with a rota pattern for four consultants to cover the service for a four week period. This meant the same individual consultants covered the ICU and HDU for a significant period of time allowing for better continuity of care for patients.
- During weekdays, at least one consultant was based on the ICU from 8am to 8pm and at least one consultant was based on the HDU between 8am and 5pm. The HDU consultant also supported the critical care outreach team during the mornings.
- The same level of consultant cover was available on weekends as during weekdays. During out of hours there was at least one on-call consultant. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- The consultants were supported by a team of registrar grade doctors (including anaesthetic / critical care trainees and non-consultant grade doctors that were trained in airways management) and foundation year junior doctors.
- There was at least one junior and registrar grade doctor resident on the ICU and HDU at all times, based on a 12-hour shift pattern.
- The consultant to patient ratio in the ICU did not exceed 1:8 during weekdays and 1:15 during out-of-hours service in line with ICS standards. There were no medical staff vacancies or locum doctors used within the critical care services.
- We saw that daily medical handovers took place during shift changes and these included discussions about specific patient needs. Medical staff across the different grades participated in the medical handovers.

Major incident awareness and training

- There was a documented major incident procedure within the critical care services and this listed key risks that could affect the provision of care and treatment.
- There were clear instructions for staff to follow in the event of a fire or other major incident.
- Records showed 98% of staff had completed resuscitation training and staff had guidelines in place for dealing with medical emergencies such as a patient going into cardiac arrest.

Are critical care services effective?

Good



We rated the critical care services at the Royal Bolton Hospital as Good for being effective. This was because: -

- The services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit.
- ICNARC audit data up to September 2015 showed the intensive care unit was within the expected range for mortality when compared with similar units nationally. The data showed that performance was within expected levels for mean length of stay, non-clinical transfers out and for unplanned readmissions.
- Patients received care and treatment by multidisciplinary staff that worked well as a team. A consultant-led ward round took place twice a day across the intensive care and high dependency units with daily input from nursing, pharmacy, microbiology and physiotherapy. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The majority of staff across critical care had completed their appraisals and the hospitals target of 85% completion had been achieved.
- Records showed 80% of nursing staff had completed the post registration award in critical care nursing, which met the Intensive Care Society (ICS) standard for at least 50% of staff to have completed this training.

Critical care

- All the critical care consultants were trained to Faculty of Intensive Care Medicine (FFICM) standards or equivalent.

However, we also found that: -

- The HDU did not participate in the ICNARC audit. The department was in the process of recruiting a clerical officer to provide the administrative support needed to take part in the audit. The clerical officer was expected to be in place by June 2016.

Evidence-based care and treatment

- Staff followed policies and procedures based on national guidelines, such as the Intensive Care Society (ICS), National Institute for Health and Care Excellence (NICE), National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations as well as guidance published by the relevant medical bodies such as the Royal Colleges and British Medical Association.
- The critical care services participated in quality audits as part of the 'risk over network' (RICON) project in collaboration with the Greater Manchester Critical Care Network. The service participated in six quality audits, including medicine safety, communication, patient access, lung protective ventilation and airway safety.
- The critical care audit plan 2016 showed planned participation in nine national clinical audits and four local audits.
- Findings from clinical audits were reviewed for any changes to guidance and the impact that it would have on practice was discussed during consultant meetings and clinical governance meetings that took place on a monthly basis. Audit findings were also shared with the critical care network to look for improvements to the service.

Pain relief

- The critical care staff had guidance available about the medicines used for analgesia. Medical staff confirmed that analgesia was a routine part of sedation management. Pain was assessed as part of the overall patient assessment and was accompanied by sedation scoring where relevant.
- There was a dedicated pain team within the hospital and staff knew how to contact them for advice and treatment when required.

- Patient records showed that patients that required pain relief were treated in a way that met their needs and reduced discomfort.

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements. Patient records showed that where patients were identified as 'at risk', there were fluid balance and food charts in place and these were reviewed and updated by the staff.
- A dietician provided routine input during weekdays and was available to participate in daily ward rounds if needed.

Patient outcomes

- ICNARC audit data up to September 2015 showed the intensive care unit was within the expected range for the ICNARC (2013) and APACHE II (2013) mortality ratio when compared with similar units nationally. The unit was within the expected mortality ratio of 1.0 between April 2015 and September 2015, which meant the actual deaths on the unit were similar to or less than the anticipated number.
- The ICNARC data showed the ICU performed better than other similar units for out-of-hours discharges and delayed discharges greater than four hours. The data also showed that performance was within expected levels for mean length of stay, non-clinical transfers out and for unplanned readmissions.
- Staff carried out a daily assessment of delirium (acute confusion) in patients using the 'Confusion Assessment Method for intensive care' (CAM-ICU) guidelines.
- An audit was undertaken to monitor the use of the B@EASE pre-intubation checklist for improving safety during airway management in critically ill patients. The audit was carried out in January 2016 and involved a retrospective review of 30 patient records where patients were intubated.
- The results showed the B@EASE checklist was used on 87% of occasions, which was better than the 80% standard.
- A single day audit to check that patients with acute respiratory distress syndrome (ARDS) were correctly diagnosed and ventilated was undertaken in January 2016 as part of the critical care network. The audit involved a review of the eight patients in the ICU on the day. The results showed three patients met the criteria for ARDS and they all had a documented diagnosis.

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- The HDU did not participate in the ICNARC audit. This was identified as a risk on the HDU risk register. The department was in the process of recruiting a clerical officer to provide the administrative support needed to take part in the audit, such as inputting data. The clerical officer was expected to be in place by June 2016.

Competent staff

- The critical care service had a practice educator that oversaw training processes and carried out competency assessments.
- Newly appointed staff had an induction and their competency was assessed over a period of two months before working unsupervised. This was followed by further training until staff were deemed competent to be placed on a post graduate critical care course.
- Records showed approximately 80% of staff had completed the post registration award in critical care nursing, which met the ICS standard for at least 50% of staff to have completed this training.
- All the critical care consultants were trained to Faculty of Intensive Care Medicine (FFICM) standards or equivalent.
- Staff told us they routinely received supervision and annual appraisals. Records up to March 2016 showed 95% of staff across the critical care services had completed their appraisals and the hospitals target of 85% appraisal completion had been achieved.
- Records showed all eligible medical staff in the critical care services that had reached their General Medical Council revalidation date had been reviewed and recommendations had been completed.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the critical care services. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- A consultant-led ward round took place twice a day with input from nursing, pharmacy and physiotherapy. A

daily microbiologist ward round also took place separately on each unit. The nursing staff told us they had a good relationship with consultants and ward-based doctors.

- There were routine team meetings that involved staff from the different specialties. Patient records showed that there was routine input from nursing and medical staff and allied health professionals.
- Staff told us they received good support from pharmacists, dieticians, speech and language therapists and physiotherapists as well as diagnostic support such as for x-rays and scans.
- The critical care outreach team joined the hospital at night team so that support and training for ward staff in the management of acutely ill and deteriorating patients was available 24 hours per day.
- The critical care outreach team was supported by a consultant who carried out follow up clinics for patients that had a long term stay in critical care. Patients were offered a follow up appointment four months after their discharge.

Seven-day services

- Staff rotas showed that nursing staff levels were appropriately maintained outside normal working hours and at weekends to meet patients needs.
- We found that sufficient out-of-hours medical cover was provided to patients by junior and registrar grade doctors as well as on-site and on-call consultant cover. Patients admitted to critical care were seen daily by a consultant.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. Physiotherapy support was also available on the unit during the day on Saturdays and Sundays.
- On-call dietician support was available during weekdays but not on weekends. A business case had been submitted with a proposal to increase dietician cover to six days.
- Staff based in the ICU and HDU told us they received good support outside normal working hours and at weekends.

Access to information

Critical care

- Staff used paper based patient records that contained detailed patient information from arrival to the ICU or HDU through to discharge or admission to the wards. This meant that staff could access all the information needed about the patient at any time.
- Staff told us the information about patients they cared for was easily accessible, such as test results, nursing and medical records. Notice boards were used to highlight where patients were located within the ICU and HDU and to identify high risk patients.
- We saw that information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the hospital's intranet.

Consent and Mental Capacity Act

- Staff understood how to seek consent from patients and understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- We looked at one patient record where a DoLS application had been made and this had been completed correctly.
- Staff followed guidelines on the appropriate use of restraints such as the use of 'mitts' (equipment used to prevent a patient pulling out intravenous lines while unconscious).
- There was a trust-wide safeguarding lead that provided support and guidance for staff for mental capacity assessments, best interest meetings and DoLS applications.

- Patients and their relatives spoke positively about the care and treatment they received. They told us they were treated with dignity, empathy and compassion. Patients or their relatives were kept fully updated and were given opportunities to have all their questions answered.
- Patient feedback from the NHS Friends and Family Test in the high dependency unit (HDU) showed most all the patients that responded were positive about recommending the services to friends and family.
- Staff prepared patient diaries that would be useful to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition.
- Patients and their relatives told us the staff supported them with their emotional and spiritual needs. They told us they were able to voice any concerns or anxieties. There were facilities to provide overnight accommodation for the relatives of patients.
- During the past year, staff in the intensive care unit (ICU) facilitated the discharge of three patients that expressed a preference to die in their own home to allow them to receive end of life care at their preferred place of care.

Compassionate care

- We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a kind and respectful manner. The patients we saw were well positioned and their dignity was maintained.
- We spoke with seven patients and the relatives of another two patients. They told us the staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that patient dignity was maintained. The comments received included "very pleased with care", "treated with care and respect" and "would always speak highly of the hospital".
- We saw that in the majority of cases, patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to a side room to provide privacy and to respect their dignity.
- The intensive care unit (ICU) did not participate in the NHS Friends and Family test, which asks patients how likely they are to recommend a hospital after treatment. This was because patients were discharged to other wards and not discharged home directly from the unit.

Are critical care services caring?

Good



We rated the critical care services at the Royal Bolton Hospital as Good for being caring. This was because: -

Critical care

- The high dependency unit (HDU) participated in the NHS Friends and Family test. Results from April 2015 to February 2016 showed 100% of patients would recommend the unit to their friends and family. This was based on responses from 30 patients (out of 54 eligible patients) with an overall response rate of approximately 60%.
- A review of data from the CQC's adult inpatient survey 2014 showed that the trust was about the same compared with other trusts for all 10 sections, based on 399 responses received from patients.

Understanding and involvement of patients and those close to them

- Due to the nature of the care provided in critical care, patients could not always be directly involved in their care. Where possible the views and preferences of patients were taken into account and this was documented in their records. Relatives of patients told us staff had asked them about patient preferences and likes and dislikes.
- Patients and relatives spoke positively about the support received from staff. They told us they were seen daily by a consultant or doctor and the medical staff had clearly explained their medical condition and their care and treatment to them. Patients' relatives told us they had been kept fully updated and were given opportunities to have all their questions answered.
- Staff prepared patient diaries that would be useful to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties. Patients and their relatives told us they were supported with their emotional needs.
- The relatives rooms provided drinks facilities and an overnight bed if needed. Staff provided patients with headphones for their television and there was a DVD

library for patient use. The trust reported that critical care staff also raised money in order to provide additional comfort items for patients, such as shampoo, deodorants, ear plugs, eye masks and TV/DVD players.

- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Patient's relatives were also provided with a bereavement booklet if needed. Staff told us they were supported by the hospital's palliative (end of life care) team for support and advice during bereavement.
- ICU staff had developed their own procedures for supporting patients receiving end of life care. This included supporting patients that expressed a preference to die in their own home. During the past year, the ICU staff facilitated the discharge of three patients from the ICU to allow them to receive end of life care at their preferred place of care.

Are critical care services responsive?

Good



We rated the critical care services at the Royal Bolton Hospital as Good for being responsive to patients needs. This was because: -

- There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. Bed occupancy levels ranged between 56.9% and 94% in the ICU and between 62.9% and 89% in the HDU between March 2015 and February 2016. This was similar to or slightly lower than the England average during this period.
- Most patients were admitted to the ICU within four hours of making the decision to admit them. Records showed 100% of patients were assessed by a consultant within 12 hours of admission to the ICU between October 2015 and February 2016.
- ICNARC data up to September 2015 showed the ICU performed within expected levels for non-clinical transfers out, out-of-hours discharges and for delayed discharges greater than four hours.
- The main theatres theatre recovery area included a dedicated critical care recovery bay that was used for

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critically patients awaiting admission to critical care.

The recovery bay had appropriate equipment and patients received 1:1 care by trained nurses with critical care consultant and anaesthetist support.

- There were 26 instances where ventilated patients were kept in the theatre recovery bay between January 2015 and December 2015. There were only three instances where patients were kept in recovery longer than 12 hours.
- A number of actions were being taken to reduce delayed discharges, including increased consultant presence on the HDU and analysing admission data to predict capacity issues.
- Steps were also taken to minimise the impact to patients privacy and dignity by ensuring curtains were drawn, transferring patients awaiting discharge to a side room or allowing patients that were fit enough to wait in the hospitals discharge lounge.
- There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There had only been one formal complaint relating to critical care services between August 2014 and July 2015.

However, we also found that: -

- There were 60 delayed discharges over four hours on the ICU between September 2015 and February 2016. However, there were 246 delayed discharges over four hours on the HDU during this period. The delayed discharges were mainly due to a lack of available ward beds across the hospital.
- The presence of patients with delayed discharges in critical care meant there was an increased likelihood of mixed sex breaches. There were three mixed sex breaches on the ICU between January 2015 and March 2016. However, there were 40 mixed sex breaches in the HDU during this period; 25 of these breaches occurred between January 2016 and March 2016.

Service planning and delivery to meet the needs of local people

- The intensive care unit (ICU) had eight intensive care beds. The high dependency unit (HDU) had 10 high dependency care beds.
- The units provided critical care services for adults over the age of 16 years. There were 1,459 admissions to critical care between April 2014 and March 2015. There were 158 deaths in critical care during this period.

- The main theatres theatre recovery area included a dedicated critical care recovery bay that was used for critically patients awaiting admission to critical care. Records showed there were 26 instances where ventilated patients were kept in the theatre recovery bay between January 2015 and December 2015.
- These patients were transferred from the wards or emergency department requiring stabilisation or from the operating theatres with complications following surgery and were awaiting a critical care bed. There were three instances where patients were kept in recovery longer than 12 hours and the longest stay was 15.5 hours. We saw the theatre recovery area had appropriate equipment and patients received 1:1 care by trained nurses with critical care consultant and anaesthetist support.
- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues. There was daily involvement by the matron to address and manage these risks.
- There were daily meetings with the bed management team to ensure patient flow was maintained and to identify and resolve any issues relating to the admission or discharge of patients.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- The critical care services had dementia link nurses in place. Staff also used a passport document for patients admitted to the hospital with dementia or a learning disability. This was completed by the patient or their representatives and included key information such as the patients likes and dislikes. The additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Staff could contact the hospital-wide safeguarding team for advice and support for dealing with patients living with dementia. There was also a hospital-wide lead nurse that provided staff with guidance and support when caring for patients with learning disabilities.

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- Staff could also contact the rapid assessment, interface and discharge (RAID) team for support and advice when treating patient with mental health conditions. The RAID service was based at the hospital but provided by a neighbouring mental health trust.
- Staff could access appropriate equipment to support the moving and handling of bariatric patients (patients with obesity) admitted to the critical care services.

Access and flow

- Records showed bed occupancy levels between March 2015 and February 2016 were similar to or slightly lower than the England average (of approximately 80%). Bed occupancy levels ranged between 56.9% and 94% in the ICU and between 62.9% and 89% in the HDU during this period. During the inspection, we saw that a number of beds in both units were unoccupied.
- Most patients were admitted to the ICU within four hours of making the decision to admit them. Records between September 2015 and February 2016 showed there were 13 instances where admission to the ICU took longer than four hours.
- Records showed 100% of patients were assessed by a consultant within 12 hours of admission to the ICU between October 2015 and February 2016, in accordance with ICS guidelines.
- ICNARC data showed the ICU performed within expected levels for non-clinical transfers out, out-of-hours discharges and for delayed discharges greater than four hours.
- There were six instances where patients were discharged from the ICU during out of hours (10pm to 7am) and there were 19 out of hours discharges from the HDU between September 2015 and February 2016. Patients were seen by a consultant and only discharged if it was clinically safe to do so.
- There were 60 delayed discharges over four hours on the ICU between September 2015 and February 2016. However, there were 246 delayed discharges over four hours on the HDU during this period. The main reason for delayed discharges was due to a lack of available ward beds across the hospital.
- A number of actions were being taken to reduce the number of delayed discharges, including increased consultant presence on the HDU to facilitate discharges and analysing admission data to look at the profile of

critical care admissions across the week. This would allow staff to predict capacity issues through the week and address these as part of the daily bed management process.

- Patients with delayed discharges were safe as they were still in the care of the staff on the units. Performance data showed the delayed discharges did not have a significant impact on patients awaiting admission to critical care. However, the presence of these patients on the units meant there was an increased likelihood of mixed sex breaches (i.e. occurrences of unjustified mixing).
- Records showed there were three mixed sex breaches on the ICU between January 2015 and March 2016. However, there were 40 mixed sex breaches in the HDU during this period; 25 of these breaches occurred between January 2016 and March 2016.
- The HDU ward manager told us the mixed sex breaches were mainly as a result of the delayed discharges.
- The HDU ward manager also told us they took additional steps to minimise the impact to patients privacy and dignity by ensuring curtains were drawn, transferring patients awaiting discharge to a side room or allowing patients that were fit enough to wait in the hospital's discharge lounge.
- NHS England data between April 2015 and March 2016 showed there were no urgent surgery cancellations due to a lack of critical care beds at the hospital.

Learning from complaints and concerns

- The ICU and HDU had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.
- Senior staff such as the ward managers, matron and lead consultant were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team. Staff responsible for investigating complaints were allocated up to 21 days to investigate and respond to the central team. As part of the process, they were also required to submit a lessons learned document to demonstrate what learning had taken place following the complaint.

Critical care

- Staff told us that information about complaints was discussed during routine staff meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.
- The complaints policy stated that complaints would be acknowledged within three working days and investigated and responded to within 35 working days for routine formal complaints.
- Records showed there had been one formal complaint relating to the critical care services between August 2014 and July 2015. This was raised in September 2015 in relation to a medication issue in the ICU. The complaint was resolved within the hospitals specified timelines.

Are critical care services well-led?

Good



We rated the critical care services at the Royal Bolton Hospital as Good for being well-led. This was because: -

- The hospitals vision and values had been cascaded across the critical care services and staff had a clear understanding of what these involved. Key risks to the services, audit findings and quality and performance was monitored through routine departmental and critical care governance meetings.
- There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within the critical care services and the level of support they received from their managers.
- The services participated in a safety culture survey during 2015. The survey showed staff were positive about key areas such as morale, training and overall safety culture. The ICU team received the team of the year award in 2015 following their work on patient diaries, ICU follow up and for their work to facilitate three discharges from ICU for end of life care.

Vision and strategy for this service

- The hospital's vision was based around the slogan 'better care together'. This was underpinned by a number of values including; placing patients and staff at the heart of everything, to be respected, to be valued and to be proud.
- The critical care services had developed their own mission statement and this was displayed on notice

boards in the ICU and HDU. This stated that the service aimed to provide the best care to any critically ill patient in the hospital through immediate recognition, providing the right care at the right time, providing comfort and care, by applying the most up-to-date knowledge and technology and through working as a team.

- There was no strategy document specifically for the critical care services. However, the strategy for the critical care services had been incorporated into the elective care divisional objectives 2015/16, which included specific performance targets and actions relating to improving quality, safety and patient experience, improving the delivery of services, staff engagement, governance and financial performance.
- The hospital's vision, values and objectives had been cascaded to staff across the critical care services and staff had a clear understanding of what these involved.

Governance, risk management and quality measurement

- There were monthly critical care governance meetings, ward staff meetings and consultants meetings across the critical care services. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Key issues were also discussed at the divisional quality and governance meetings and monthly integrated performance meetings.
- The senior nursing and medical staff also held monthly 5Cs meetings to discuss critical incidents, complaints, cardiac arrests, coroners inquests and cadavers (patient deaths).
- Risks were documented and escalated by the service appropriately. The HDU and ICU had separate departmental risk registers that were also incorporated into the risk register for the elective care division. We looked at the risk registers which showed that key risks had been identified and assessed.
- We saw that routine audit and monitoring of key processes took place across the ICU and HDU to monitor performance against objectives and this was discussed during routine meetings.

Critical care

- The critical care services had heat maps and clinical dashboards in place that showed performance against key performance targets including patient safety, audit compliance and staffing levels and training. These were displayed on notice boards in the areas we inspected.
- The critical care services were routinely peer reviewed through the Greater Manchester Critical Care Network to assess compliance against national standards. The last peer review was carried out in May 2015 and showed the unit complied with most of the applicable standards.

Leadership of service

- The critical care services were part of the elective care division. There were clearly defined and visible leadership roles within the critical care services.
- There was a designated lead consultant for intensive care that oversaw the critical care services. The nursing staff were managed by ward managers, who reported to the matron for critical care. They were also supported by an operational business manager.
- The staff we spoke with told us they understood the reporting structures clearly and that they received good management support.

Culture within the service

- Staff were highly motivated and positive about their work. They described the senior nursing and medical staff as approachable, visible, provided them with good support and made them feel valued.
- Staff told us there was a friendly and open culture. Trainee medical and nursing staff told us that they felt supported and described the service as a 'family' culture.
- Records showed average sickness rate for ICU staff was 4.3% between September 2015 and February 2016. Sickness rates were similar to the national average but higher than the hospital's internal target of less than 3.75% sickness.
- The average sickness rate for HDU staff was 1.1% between September 2015 and February 2016. This was much better than the national average and the hospital's internal target of 3.75%.
- The staff turnover rate was 9.7% in the ICU and 5.4% in the HDU between September 2014 and August 2015. The staff sickness and turnover rates were generally low and demonstrated a positive culture within the service.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Patients that had previously stayed on the ICU and their relatives were invited to attend a follow up appointment and share their experiences.
- Patients in the ICU were sedated due to the nature of the care provided in critical care. This meant staff in the ICU were not able to gain feedback directly from patients. However, staff sought feedback from patients' relatives by asking them to complete a feedback survey. The survey covered key areas such as patient care, dignity and respect, facilities and environment, care of friends and relatives and staff communication. The information was used to look for improvements to the services.
- Survey results between April 2015 and September 2015 showed feedback from patients' relatives was very positive, based on 25 responses across the ICU and HDU.

Staff engagement







- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings in the HDU and ICU. The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The NHS staff survey 2014 – 15 showed the trust performed better than the national averages for the majority of indicators, including for overall staff engagement.
- The critical care services participated in a safety culture survey during 2015 as part of the Greater Manchester Critical Care Network. The survey asked staff about key areas such as communication, training, morale, unit management, whether they would be treated there and whether they were tired at work.
- The survey received responses from 149 staff across the ICU and HDU and the services scored the highest for seven out of the 10 indicators compared with 14 other units across the network. This showed staff felt positive about key areas such as morale, training and overall safety culture.
- The ICU team received the 'team of the year' award in 2015 from the trust. The team was nominated for their work on patient diaries, ICU follow up and for their work to facilitate three discharges from ICU for end of life care.

Critical care

Innovation, improvement and sustainability

- Staff across the critical care services had implemented a number of innovative processes to improve patient care. This included participation in the enhanced skills for nursing staff (e.g. insertion of arterial lines, non-medical prescribing and nurse-led discharge).
- The critical care services had been assessed as part of the hospital's based on a number of nursing standards and the HDU and ICU both achieved the highest 'three star' rating. This meant the critical care services had met or exceeded the hospital's ward accreditation standards.
- All the staff we spoke with were confident about the future of the critical care services at the hospital. They felt there was a strong, stable workforce that provided a good standard of care and treatment. They identified the general environment in ICU and HDU as the main area for improvement. A combined ICU / HDU unit was planned for completion by 2019.

Maternity and gynaecology

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The trust provides maternity and gynaecology services to the populations of Bolton, Wigan, Bury and Salford. Maternity services are based at the Princess Anne Maternity Unit, Royal Bolton Hospital, and midwives also work in the local community. The service has a number of specialist midwives in post, including a consultant midwife in normal birth, an infant feeding lead, antenatal screening co-ordinator, bereavement midwives, a team of advanced midwifery practitioners, outreach midwives attached to each community midwifery team, practice education midwives, standards midwives, an IT midwife, parent education midwife and midwives providing hypnobirth services. Gynaecology clinic is supported by a colposcopy nurse. The Early Pregnancy Unit is supported by midwife sonographers who provide a holistic service to women.

All services are located on the ground and first floors of the hospital. The early pregnancy assessment unit is based alongside the Gynaecology assessment unit and Gynaecology ward and is situated on the first floor.. A team of community midwives deliver antenatal and postnatal care in women's homes, clinics and GP locations in the Bolton area. Gynaecological services are also provided by the trust and included termination of pregnancy (ToP) and the Early Pregnancy Assessment Unit (EPAU).

As part of our inspection we visited the maternity and gynaecology services, which included the EPAU, gynaecology ward, antenatal clinic, antenatal day unit, antenatal and postnatal ward, the birthing centre, labour suite and obstetric theatre. We spoke with nine women who used the service, and 23 staff, including midwives,

doctors, consultants and senior managers. We also held staff focus group meetings to hear the views of staff about the service they provide. We observed care and treatment, inspected 12 sets of care records and we reviewed the trust's audits and performance data.

We reviewed information about the population of Bolton and found it was in the 20% most deprived areas in the country.

Between January and December 2015, Bolton maternity services delivered 5,942 babies.

Maternity and gynaecology

Summary of findings

We rated the service as good overall because :

- Women received care according to professional best practice clinical guidelines. Maternity services provided individualised care to people using the service and they were treated with privacy, dignity and respect.
- The trust had specialist midwives in bereavement who provided support, compassion and care for women and their families in time of bereavement.
- Staff in maternity and gynaecology were up to date with adult basic life support training. The systems for checking emergency equipment such as that used for resuscitation, provided assurance that equipment was in full working order.
- Staff were encouraged to report incidents and systems were in place following investigation to help rapidly disseminate learning.
- Both nursing and medical staffing levels were in line with national guidelines.
- 97.3% of staff had completed mandatory training overall and this was in line with the trust target. We saw evidence of how the trust had recently addressed gaps in statutory training and although there were some areas that did not meet the trust target, divisional managers had identified further training days to address shortfalls.
- There was a system for monitoring patient outcomes in the maternity and gynaecology division. This was used to assess the quality of service delivery.
- The maternity service was managed by a cohesive team who understood the challenges of providing good care. They were aware of their areas of concern and had taken steps to address them.
- Staff were encouraged to drive service improvement and used creative and innovative ways to try to ensure they met the needs of women who used the service and the organisation.
- Staff across a wide range of disciplines, had been included in discussions and felt they were being kept aware of potential changes or issues relating to in the service.

- Staff spoke positively about the leadership in their immediate area and in the wider trust. Staff described an open culture with a sense of pride in the service they provided. Mechanisms were in place for engagement with users of the service.
- All of the patients we spoke with were complimentary about the attitude of staff and the way care was provided. Patients on the post-natal wards told us they had received timely pain relief.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good 

We rated services as good for safe because :

- Staff were encouraged to report incidents and systems were in place following investigation to help rapidly disseminate learning.
- Both nursing and medical staffing were in line with national guidelines.
- There were effective systems in place to monitor infection control.
- There was a good standard of record keeping however; staff had experienced issues with the implementation of the electronic records to record patient care.
- The systems for checking emergency equipment such as that used for resuscitation, provided assurance that equipment would be in full working order with all items present if required.
- The division was 97.3% compliant for mandatory training overall, this was in line with the trust target of 98% overall. We saw evidence that confirmed the trust had addressed training gaps in relation to statutory training, and although there were some areas within the division which did not fully meet the trust target, the trust had identified further training days to address any shortfalls.

Incidents

- There was one never event reported between January and December 2015. Never events are serious, wholly preventable safety incidents that should not occur if the available preventive measures have been implemented.
- Between January and December 2015 there had been 1882 reported incidents; 1336 (99%) of these were reported as no harm caused, 533 were reported as low harm, and 12 as moderate harm and 1 as severe harm. This indicated a positive culture towards incident reporting. Incidents were investigated appropriately and findings were acted upon.
- Data received from the trust confirmed that incident reporting for maternity and gynaecology had remained relatively stable from January to December 2015.
- Records we reviewed showed that learning from incidents was cascaded to the division through

divisional governance arrangements. This was supported by staff we spoke with who confirmed that trust wide, learning was shared via SBAR alerts and a monthly learning set.

- The mortality rates at Bolton NHS Foundation Trust were monitored monthly by the trust board within the performance board report. These were open to all doctors, midwives and students. Doctors of all grades were encouraged to present their own cases which were discussed. These included all patients who had returned to theatre, had a post-partum haemorrhage or any emergency during or post-delivery.
- Between January and December 2015 there was one serious incident reported in the division. We saw this related to an intrapartum death [the death of a baby during birth after 24 or more weeks of pregnancy]. Data showed that the incident was subject to a serious incident investigation. This was then reviewed by the trust board to ensure actions had been taken to address the incident. We noted that the board review had taken place in December 2015 as part of the trust's overarching mortality review. Maternity and gynaecology services held meetings that sat underneath this and reported up to the board.
- Midwifery and nursing staff told us they were encouraged to report incidents and were able to explain the procedure.
- Within each of the areas we visited we noted that there was information relating to the Duty of Candour. For example we saw in the antenatal day unit a display of the information and how the trust was open and honest when things went wrong. 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. This gave assurance that the trust was open and transparent with patients about their care and treatment when things went wrong.
- There was no data relating to incidents that were specific to termination of pregnancy services [TOPs]. However we noted that the trust only performed a relatively small number of TOPs annually.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms

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and 'harm free' care. This information was clearly displayed in each ward we visited. It included information about venous thromboembolism (VTE), catheter acquired urinary tract infections and pressure ulcers. Where issues had been identified staff throughout the service were made aware through briefing sessions, this included learning and preventative measures where appropriate.

- Between January and December 2015 data showed the delivery suite were 100% compliant for completion of VTE risk assessments. This meant that they had performed better than the trust target of 95% for VTE risk assessment completion.
- The maternity theatres' safety dashboard for the period from January 2015 to January 2016, showed between 99 and 100% compliance with the World Health Organisation [WHO] safer surgery checklist.

Cleanliness, infection control and hygiene

- The trust had an infection control policy in place. All of the staff we spoke with were able to clearly define the policy, in addition they all knew where to locate a copy of the infection control policy if required.
- We observed staff following trust policies in relation to infection control; such as the use of hand gel, personal protective equipment [PPE] and 'bare below the elbow' dress code
- Contract cleaners provided the cleaning services at the trust. Each area we visited had a cleaning manual which contained information on the Control of Substances Hazardous to Health (COSHH) Regulations 2002. We saw the cleaning products had been stored correctly as stated in the guidance.
- We reviewed a sample of cleaning records for January 2016 on the antenatal ward and noted that there were no gaps in the record.
- Data provided by the trust, prior to inspection, showed that there had not been any reported incidents of Methicillin-resistant staphylococcus aureus (MRSA) bacterial infection cases during the period between January to December 2015.

Environment and equipment

- Access to the delivery suite and wards was through an intercom system and staff were able to monitor people visiting and leaving these areas.
- We were told by the lead midwife that shift leaders carried out daily checks of equipment, to ensure it had

been maintained in line with current guidelines, was in good working order and fit for purpose. For example, the checks on the antenatal and postnatal ward included the new-born life support equipment, post-partum haemorrhage (PPH) trolley, breast pump, and the sharps bins.

- There were three theatres for use by obstetric service. One is used for elective obstetric operations and there were two emergency obstetric theatres which were staffed for use 24 hours per day, seven days per week.
- Staff told us the equipment for resuscitation of the new-born had been checked daily in line with the trust's policy and records we reviewed confirmed this.

Medicines

- Medicines were safely stored in locked cupboards and trolleys in all of the clinical areas and wards.
- Records showed the administration of controlled drugs (CD) were subject to a second check in line with best practice. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded. Records we reviewed confirmed that shift leaders carried out daily checks of controlled drug records to ensure they had been completed correctly.
- Ordering and disposal of medicines was in line with current guidance and regulations.
- Medicine refrigerators were kept locked; the temperature was monitored daily and was within the recommended range.

Records

- There were clear plans of care for patients in medical and nursing records. These included antenatal assessments, referrals to other centres for specialist consultations, discussions with patients and families, discharge notes to secondary care providers and communication notes from community midwives.
- Staff told us documentation audits were undertaken monthly and the results fed back to the lead midwife. For example in June 2015, the audit for gynaecology inpatients identified the division specific consent audit was 100% compliant, whilst the patient specific was 92% compliant. We saw the action plan that had written

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to address identified shortfalls. We noted that it included how documentation was to be standardised, together with the timescale and date for proposed completion.

- Risk assessments had been completed and reviewed for both maternity and gynaecology patients. These included those for venous thrombosis and to identify high risk patients such as those with a raised body mass index [BMI].
- Within the labour suite we were shown an electronic system to record patient observations. The system had a series of features to alert staff to overdue observations or anomalies which required further actions.
- There was duplication of some records in the inpatient antenatal and postnatal wards and the community. This was due to the electronic patient record system not yet being fully implemented. Staff discussed how this was time consuming and there was a risk of important information being stored incorrectly or overlooked unless both systems were used. However in discussion with us, staff could clearly demonstrate how they ensured essential information was shared throughout the division.
- Records were securely stored and any displays of information that could identify patients were designed to protect their confidentiality.

Safeguarding

- Data received from the trust prior to inspection confirmed that all staff were linked to the appropriate level of training on the trust's electronic training system. Training compliance was then routinely monitored by service managers and the safeguarding committee.
- The compliance for level 1 and level 2 training was over 90%. Level 3 training was monitored by exception reporting on a quarterly basis. Training and updates were provided in a variety of ways to meet the needs of all staff. Safeguarding was included in induction training for all new staff.
- All staff we spoke with were able to explain the procedure for reporting allegations or suspected incidents of abuse, including adults and children and confirmed they had received training.
- There was a system in place for staff to identify potential concerns for the safety of a patient or baby. This

included prompts on the electronic patient record system for known substance misuse and previous mental health problems as well as easily identifiable paper records.

- There was a named lead midwife, and a safeguarding link midwife on each ward and unit. This information was displayed on a notice board at the entrance to each ward/area. In the antenatal clinic there was a separate safeguarding children notice board, which included information about abuse through child 'trafficking.'

Mandatory training

- All staff we spoke with including clerical staff told us they were given time to complete their mandatory and statutory training.
- The trust target for mandatory training was 80% and data provided by the trust showed the overall training compliance within the maternity and gynaecology division was 93.4% [maternity] and 96.9% [gynaecology] as of December 2015.
- Junior doctors completed all the mandatory training prior to starting work at the trust.

Assessing and responding to patient risk

- The service used the National Early Warning Score [NEWS]. This assessment tool enabled staff to identify and respond to the need for additional medical support if required. The NEWS included directions for how to escalate concerns, and staff were aware of the appropriate action to take if patients scored higher than expected. We looked at completed charts, and noted that the documentation had been completed and escalated appropriately.
- Delivery suite had the capacity and equipment to care for three high dependency patients with advice and support from the critical care team. There were guidelines for admission to the high dependency unit and transfer to the intensive care unit. The guidelines had been reviewed and updated 29 June 2015 to ensure they were in date and fit for use. The roles and responsibilities of staff were clearly documented, as was the criteria for admission to the unit and transfer to another unit where appropriate.
- The delivery suite had three theatres, one primarily used for elective procedures, the other two being available for emergency procedures. Theatre staff including an Anaesthetist were available 24 hours per day. There was

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a standard operating procedure (SOP) for the management of all three theatres and a record was maintained and monitored of the time it took for a patient to receive treatment in theatres.

- We observed all steps in the safer surgical checklist being completed. The team members introduced themselves by name and role. This is done to ensure every specialist required is present prior to the start of the procedure.
- We observed a patient who was conscious, identifying themselves by confirming their own details. This gave assurance that appropriate steps were taken to ensure the correct patient was in situ prior to the start of the procedure.
- Records we reviewed confirmed there were audits of the use of the safer surgery checklist, undertaken regularly, to assess compliance. Audits showed a high level of compliance.

Midwifery staffing

- Staffing levels were in line with national guidance of a births to midwife ratio of 1:28. Data received from the trust confirmed that the ratio of supervisory midwives to midwives was 1:19, which is in line with recommendations from Royal College of Obstetricians and Gynaecologists [RCOG] and the Royal College of Midwives [RCM].
- Birth rate plus acuity tool was used to assess the necessary staffing numbers for the maternity service. To assess the acuity on an on-going basis the clinical lead midwife or the bleep holder for the service checked the roster for the service at 8am including any sickness then did a walk around the unit including the gynaecology ward, to ensure there were sufficient staff with the necessary skills and experience to meet the needs of the patients.
- The trust used an electronic (e-rostering) system for recording staff duty. We saw and were told duty rosters were created four weeks in advance to ensure the levels and skill mix of the nursing staff on duty were appropriate for providing safe and effective care.
- Planned and actual staffing numbers and grades of staff were displayed on all the wards we visited.
- Women told us they had received continuity of care and one to one support from a midwife during labour. Trust data showed women received 1:1 care in labour between 97% and 99% of the time.

Nurse Staffing

- Gynaecological wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- We observed handover on the gynaecology ward, delivery suite and the antenatal/postnatal wards. We noted that clear information was shared amongst staff and included: plans for investigations, tests and procedures; care, compassion and any emotional support required by the individual patient.

Medical staffing

- We observed the medical staff handover on the delivery suite which was attended by the consultant, junior medical staff, anaesthetist and the lead midwife. The handover included feedback on women on the unit who may have caused concern for example, women undergoing induction of labour.
- Staff reported the consultant obstetricians were available when needed and also reported antenatal patients were seen each day in line with current guidance. Patients told us they received consultant and medical care which met their needs.
- A consultant anaesthetist was present Monday to Friday 8am to 6pm. Outside of these hours there was one on call. There was a speciality doctor available 24 hours per day who would request the support and assistance of the consultant on call if required.
- Junior doctors we spoke with told us that when they were on call they were supported by more senior doctors. All of the junior doctors we spoke with told us they received good support that was always available when needed.
- Data from the trust prior to inspection showed there was a consistent level of consultant cover across the division. This was supported by staff we spoke with, both medical and nursing, who confirmed that consultant cover ran at 98 hours per week.

Major incident awareness and training

- A business continuity plan for maternity services was in place; dated July 2015. It included the risks specific to each clinical area and the actions and resources required to support recovery.

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- There were clear escalation processes to activate plans during a major incident or internal critical incidents such as shortfalls in staffing levels or bed shortages.

Are maternity and gynaecology services effective?

Good



We rated services as good for effective because :

- Policies and procedures were up to date, easily accessible and in line with National Institute for Clinical Excellence (NICE) and other guidelines such as the Royal College of Obstetrics and Gynaecology (RCOG).
- There was a system for monitoring patient outcomes in maternity services to assess the quality of service delivered. We noted that information gathered was used to benchmark performance against other trusts or national targets.
- Patients received timely pain relief.
- Systems were in place to offer good support for mothers who wished to breast feed. There were supportive systems for patients to have midwifery led care and home births.
- There were examples of effective multi-disciplinary working in obstetrics and gynaecology services. Access to services seven days per week included emergency gynaecology, early pregnancy and diagnostic services.
- Consent to care and treatment was obtained and recorded accurately including that required for termination of pregnancy (ToP).
- Information about outcomes for women was routinely monitored and action taken to improve patient experience. Staff had the skills, knowledge and experience to carry out their role.

Evidence-based care and treatment

- The delivery of care and treatment was based on guidance issued by professional and expert bodies. The maternity services used a combination of National Institute for Health and Care Excellence (NICE) guidelines (for example, QS22, QS32 and QS37) and Royal College of Obstetricians and Gynaecologists

(RCOG) guidelines (for example, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) to determine the treatment they provided.

- The trust policies and procedures were in line with NICE guidance. This included the induction of labour, intra partum care and for caesarean sections. Staff in all areas knew how to access policies and procedures and they were available in both written form and on the intranet.
- The provision of the midwifery led birth centre offered patients a choice of less clinical childbirth. Midwives attended the North West network for normality to share good practice and learn from others.

Pain relief

- Pain relief was available to labouring women and this included Entonox [gas and air] epidural and drug free methods such as use of the birthing pool.
- Patient controlled analgesia (PCA) was offered to patients within risk assessment guidelines. This is any method of allowing a person in pain to administer their own pain relief. The anaesthetist set up the pump to ensure the correct medicine was prescribed. It was popular with patients who could be more independent in their management of pain.
- All of the patients we spoke with told us they received the pain relief of choice, in a timely way. We saw staff assessed patients' pain verbally.
- Anaesthetist support meant a doctor was available to administer epidural pain relief within 30 minutes of request which met NICE guidance.

Nutrition and hydration

- We reviewed menus available to patients and noted that women had a choice of meals that took account of individual preferences, including religious and cultural requirements.
- Mothers who chose to breast feed had a follow up within 48 hours of discharge to offer support if required. An appointment for a home visit would be arranged at this time if needed. Post-natal support for breast feeding was provided by peer support workers.
- There was a patients' kitchen on each ward where patients and partners could make hot and cold drinks and snacks. A café was available on the ground floor of the hospital which provided hot and cold snacks.

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- Patients told us the food provided was sufficient in quantity and was good. Special diets were catered for and snacks were available between meals if required.

Patient outcomes

- Between January and December 2015 the total number of births at Bolton maternity unit was 5,942. The normal delivery rate was 62%, which was slightly higher (better) than the national average of 60%. Data relating to the numbers of 3rd and 4th degree tears following delivery showed that since March 2015 the trust had remained below the trust target of 5%.
- The elective lower segment caesarean (LSCS) rate was 9%, against the national average of 11%, and the emergency LSCS rate was 14% which was slightly lower than the national average of 15%. This showed the service achieved better overall outcomes for women in relation to interventions during labour and birth, in comparison with the national average.
- Royal College of Obstetrics and Gynaecology (RCOG) compare maternity services nationally against 11 quality indicators. The most recent report [March 2016] reviewed proportion of induced labours; this showed that between 2013 and 2014 the trust had a lower level of induced labour for women having their first child. With trust recorded rate at 27% against the national average of 30%
- However during the same time period, unplanned maternal readmission to hospital within 42 days of delivery was higher than the national average at 2% against a national average of 1% for women who had undergone a vaginal delivery.

Competent staff

- Midwives rotated between the maternity wards and the delivery suite to maintain their skills and competence. There was no formal pattern for this as midwives discussed the need for updating their skills during supervision when agreement would be reached about their rotation. They told us they were never required to carry out duties for which they were not competent and the shift leaders allocated work according to their knowledge and experience.
- Midwives received statutory supervision of their practice, and had access to a supervisor of midwives for advice and support 24 hours a day.

- Staff we spoke with across maternity and gynaecology services, confirmed they had annual appraisals of their practice; this was supported by data received from the trust which showed 99% of staff had received an appraisal between January and December 2015.

Multidisciplinary working

- We saw evidence of multidisciplinary working in the minutes for the governance and risk committee meeting which took place in June and in morbidity and mortality meetings which took place monthly.
- We reviewed documentation that confirmed that midwives within both the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- We reviewed a copy of the discharge information sent to GP's, we noted that the letter was comprehensive and included important and relevant information relating to the patient.
- Staff described how antenatal clinics were attended by specialist midwives such as the outreach midwife and diabetes midwife. This was confirmed by documentation we reviewed and by one of the patients we spoke with.
- There was access to medical care for patients who had other conditions for example; clinics were held for patients with diabetes. This gave assurance that teams within the trust worked across disciplines to ensure the best outcome for patients.

Seven-day services

- Junior medical staff and midwifery staff confirmed the availability of consultant advice out of hours. They told us consultants had always responded quickly by offering support and attending when required.
- We were told that diagnostic imaging was a seven day service. Staff told us they felt this was good as it meant that patients didn't have to wait until a weekday before diagnostic imaging was available to support clinicians identifying and starting a course of treatment.
- There was availability of an anaesthetist and epidural anaesthetic 24 hours a day, seven days a week.
- Staff confirmed the availability of pharmacy cover 24 hours a day, seven days a week. This was supported by a patient who told us about staff being able to sort out her medication at 2am as part of her emergency admission to the hospital.

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Access to information

- We asked antenatal and delivery staff how they dealt with pregnant women from out of the area who presented without their hand held notes. We were told that they would contact the patient's booked hospital of choice for information including about any potential social or medical issues requiring escalation to colleagues or other agencies.
- We noted that staff notice boards relating to specific patient care were located away from public view for reasons of confidentiality. However all the staff we spoke with were aware of where the information was held.
- Discharge information was communicated to GPs and community nurses when women were discharged from the gynaecology directorate. Discharge summaries were written and sent to GPs to ensure they were aware of the care and treatment given, in order to ensure continuation of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at four sets of patient notes for termination of pregnancy (ToP) and they complied with the requirements of the Abortion Act 1967.
- In discussion staff spoke with confidence about Gillick competency assessments relating to children and young people. These were used to check whether these patients had the maturity to make decisions about their treatment.
- The six sets of patient's notes that we reviewed on the ante-natal ward included discussion and confirmation of consent to treatment.
- Nursing staff on the gynaecology ward said they requested assistance from the medical wards for patients who may lack capacity and have behaviours which put themselves or others at risk on a busy surgical ward. They recognised the need to provide additional support to patients who lacked mental capacity.
- Staff across the division had an understanding of the deprivation of liberty safeguards and their role and responsibility with regards to the care of a patient who may lack mental capacity.
- Mental Capacity Act training was included in safeguarding training. Information provided by the trust showed that compliance rates for this training were 89% for nurses and midwives.

Are maternity and gynaecology services caring?

Good



We rated services as good for caring because :

- Patient feedback about midwifery services was unanimously positive, staff appeared well motivated and dedicated to both their roles and patients.
- Patients we spoke with told us they felt safe and well cared for. Patients told us staff were caring, accessible and helpful.
- Patients families and significant others told us they had been involved in their care and treatment and that staff respected their privacy and dignity.
- The trust had specialist midwives in bereavement and on-site registrar services who provided support, compassion and care for women and their families in time of bereavement.

Compassionate care

- We observed staff caring for patients on wards and in out-patient departments. We saw staff interact with patients in a caring, kind and respectful manner.
- All of the women we talked with spoke positively about the treatment and standard of care they had received. They all told us they had a named midwife, received 1:1 care during labour and were treated with dignity and respect.
- The trust showed good results in the 2015 Maternity Survey. The trust scored better than other trusts in nine of the 19 questions. The trust also achieved high scores in many of the other questions. For example women scored the trust higher than the national average, for feeling they were given the information and explanations they needed after the birth.

Understanding and involvement of patients and those close to them

- Women we spoke with stated they had been involved in decisions regarding their choice of birth and were informed of the risks and benefits of each. All of the women we spoke with told us they felt in control of their labour and birthing, involved in their care and supported by staff.

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- We spoke to two patients on the antenatal ward and three patients in antenatal clinic and in each case; they were able to identify their named midwife. Each of the women we spoke with confirmed their midwife had been accessible throughout their pregnancy.
- We observed staff discussing how to meet the needs of a high risk patient taking account of her preferences and balancing this with the risks involved providing her care. We then reviewed these patients' records, which confirmed the discussions and highlighted how these were communicated to the patient.
- We spoke with three patients' relatives on the post-natal clinic all of whom told us that they had been fully involved and included in caring for their pregnant family member.
- Data from the NHS friends and family test, showed 93% of people who had used maternity services would recommend the service. Data also confirmed that 100% of people would recommend antenatal services at the trust. However we did note that overall the response rate for the survey was low at 10%.

Emotional support

- Gynaecology clinic treated a variety of conditions including those seeking a termination of pregnancy (ToP). Staff described how they ensured that ToP patients are not mixed with other patients and leaflets for ToP were only made available on the days the clinic provided this treatment. We observed staff treat patients sensitively and non-judgementally in the gynaecology clinic.
- There were fourteen clinical specialist midwives and these included: a midwife specialising in stopping smoking, infant feeding; supporting parents/pregnant women with learning disabilities; teenage pregnancy, substance misuse and medical disorders. These midwives were also available to give advice and support to staff as well as women and their partners who used the service.
- The trust currently had registrar services on site; this allowed women who had given birth at the hospital to register their babies. One parent we spoke with told us that they had found this service extremely helpful on a previous occasion when they had needed to register both the birth and death of a baby. The person we

spoke to commented; "I don't know how I would have faced having to go into town and wait around to register everything, the fact that it was all here and the staff were so lovely and helpful meant everything."

Are maternity and gynaecology services responsive?

Good



We rated services as good for responsive because :

- Patients were consistently cared for by named and accessible midwives and antenatal clinics were provided at a variety of times to ensure working mothers could attend.
- The service worked closely with GPs and patients to coordinate and integrate pathways of care that met individual needs.
- Gynaecological services were also provided by the trust and included a Termination (ToP) and Early Pregnancy Gynaecological Assessment Unit. (EPAU).
- Staff provided a variety of information to patients about pre and post-natal care including what to expect from antenatal care, pain relief during birth and breast feeding.
- A team of community midwives delivered antenatal and postnatal care in women's homes, clinics and GP locations.
- The trust was aware of its risks, in relation to gynaecology and maternity services and the need to ensure services were planned and delivered to meet the increasing demands of the local and wider community.

Service planning and delivery to meet the needs of local people

- We visited the Early Pregnancy Assessment Unit (EPAU). The examination bays were small, with only curtains to divide each bay. Staff told us that if a patient felt uncomfortable, they had access to a small side room. This did not provide assurance that patient's privacy could be maintained at all times.
- Services were planned and delivered to enable women to have the flexibility, choice and continuity of care wherever possible. A lead midwife was available for

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women using the service. Managers told us that a debriefing session was offered to women following any care which had deviated from the patient's choice and plan of care.

- In delivery suite, in helping to make the patient's experience as comfortable and relaxed as possible, each of the 15 birthing rooms had décor in calming colours, adjustable lighting and an en-suite toilet and bath/shower room.

Access and flow

- Inpatient maternity care was provided on the antenatal and post natal wards, delivery suite and birthing centre 24 hours a day, seven days a week.
- We asked about patients who present from out of the area and were told the delivery suite would contact the patients 'booked' hospital. This ensured staff liaised with other agencies who may be involved in a patient's care.
- Patients told us they were transferred from the operating recovery rooms to the wards without delay.
- Data received from the trust showed that there had been no closures of the maternity unit between April and December 2015. Information from the trust confirmed that the maternity department had not been forced to close or go on divert in the 12 months prior to our inspection.
- Data received from the trust showed that 99.1% of women had received one to one midwifery care during labour.
- Data confirmed that the trust's inpatient referral to treatment times [RTT] across gynaecology had remained between 94.9% and 100% from April to December 2015. This was higher than the trust target of 90%.
- Similarly RTT for gynae oncology outpatients had been between 95% to 100% between April and December 2015. This again was higher than the trust target of 95% overall.

Meeting people's individual needs

- There were processes in place to support women with mental health concerns. Staff were able to describe to us the process they would use to access consultant psychiatric support.

- In discussion with us, staff were clear regarding the process in place to make information available in alternative languages and formats. This provided assurance that people had access to the information they needed.
- The care pathway was decided at the first booking appointment, but could be changed to reflect decreased or increased risks throughout a pregnancy. Patients were given a booklet at the first booking appointment and that provided useful and helpful information about pregnancy including risks and delivery options.
- If needed, staff could access an interpreter for patients whose first language was not English.
- We looked at four sets of gynaecology and eight sets of maternity notes and noted that in each case people's individual circumstances had been taken into account and documented. Staff told us how they accessed additional support for patients or themselves in treating patients with complex health or social needs.
- We noted that information on how to complain was displayed throughout the hospital. We spoke with patients and relatives who knew how to raise concerns, make complaints and provide comments, should they wish to do so.

Learning from complaints and concerns

- The service had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and they had designated staff who handled complaints in the service.
- Complaints about maternity, gynaecology and the early pregnancy assessment unit were investigated and whether these had been partially upheld, upheld or unsubstantiated was recorded. We reviewed documentation regarding complaints and noted that the majority of the complaints were individualised and many related to poor communications between staff and patients. Trust management were aware of the complaints that had been received and were able to show us how these had been managed and resolved.
- Data received from the trust prior to inspection confirmed that gynaecological services had received 13 complaints between April and December 2015 and maternity services had received 27 complaints during

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the same period. Records we reviewed confirmed that where mistakes had been made, the service had responded appropriately and taken action to try to ensure they were not repeated.

Are maternity and gynaecology services well-led?

Good



We rated the service as good for well-led because :

- The service was managed by a cohesive team who understood the challenges of providing good, quality care. They were aware of their shortfalls and had taken steps to address them.
- Staff were encouraged to drive service improvement and used creative and innovative ways to try to ensure they met the needs of women who used the service and the organisation.
- Staff were proud of the services they offered and the work they did.
- The trust's vision and values were well known throughout the hospital. The values were represented in all key documents and embedded in the staff appraisal process.
- All staff we spoke with were aware of the trust's priorities and challenges. The senior team was visible and accessible to staff, and managers were seen by staff as supportive and approachable.

Vision and strategy for this service

- There was a clear vision and strategy for the organisation that was apparent throughout the hospital and had been communicated to staff.
- Staff we spoke with were clear about their roles and responsibilities in relation to the vision of the service. They were committed to the delivery of a high standard of service and individualised care to women.

Governance, risk management and quality measurement

- There was a risk management strategy dated 2015 – 2016, this incorporated the maternity services; community, gynaecology ward and specialist gynaecology services. The strategy was to be used in

conjunction with the trust Risk and Governance Strategy, Incident Reporting Policy, Procedures for the Management of Serious Incidents and Infection Control Policies.

- There was a separate obstetrics and gynaecology plan that included planned audits for both areas of the service. For example compliance with NICE guidelines in relation to infertility and ectopic pregnancy.
- Managers demonstrated awareness of governance arrangements. Senior staff we spoke with were able to detail the actions taken to monitor patient safety and risk. This included incident reporting.
- Maternity and gynaecology dashboards had been developed, which gave a snapshot of important indicators that were being used to monitor performance, quality and safety against set targets. For example, the percentage of caesarean sections and instrumental vaginal deliveries in the case of maternity and surgical site infections (SSI) and readmission post-surgery rates.

Leadership of service

- Management structures showed clear lines of accountability. Staff we spoke with at all levels were aware of their roles and responsibilities.
- Managers were described as visible, approachable and supportive. All staff we spoke with were positive about the support they received from senior staff within the gynaecology and maternity division.
- Junior and middle-grade medical staff were highly enthusiastic about the leadership provided by the senior medical team.

Culture within the service

- Staff on the wards told us they attended regular staff meetings and had regular appraisals, which they found valuable, and that their immediate line managers were accessible and approachable.
- Staff reported managers operated an 'open door' policy for them to raise any issues or concerns and felt confident they would be acted upon. Staff told us they would recommend the service as a place to work.
- There was an open and positive culture across all the gynaecology and maternity services within the trust. Staff told us the positive open culture within the directorate, promoted loyalty and teamwork among the medical and nursing teams.

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Public engagement

- The trust sought the views of women who have used the service, via questionnaires, we saw available in each of the outpatient clinics we visited. On the antenatal and postnatal wards we noted that women were given the opportunity to share their experience via comment cards.
- The main focus on public engagement lay with the trust's Foundation Trust Members (FTM). This group supported the trust in engaging with members and the wider public. FTM members engaged with the wider public through attendance at a number of events. For example attendance at local events including the Bolton Health Mela and the University Fresher's week.
- FTM also attend at local area forums to discuss pertinent issues and respond to questions from members of the public.

Staff engagement

- The NHS 2015 Staff Survey was administered between 29 September and 30 November 2015.







Cross-organisational samples of 850 Bolton NHS Foundation Trust staff were invited to complete feedback; of this number, 379 returned a completed questionnaire, representing a 44.7% response rate.

- When the 2015 results are compared to 64 acute trusts who participated, the trust scored significantly better on 34 items and close to average on 49 items. Engagement with staff being one of the trusts' high scoring areas.

Innovation, improvement and sustainability

- Bolton NHS Foundation Trust had been shortlisted for three awards at the 2016 Health Service Journal (HSJ) Value in Healthcare Awards. Improvements made in the care of women who experience intra-uterine death and stillbirth had been shortlisted in the Obstetrics and Gynaecology category 2016.
- The trust had developed working partnerships with external agencies. For example Victim Support held a drop-in session once a month to offer support and advice to both patients and staff on domestic violence.

Services for children and young people

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

Bolton Hospitals NHS Foundation Trust offers services for children and young people at Bolton Hospital, through outpatient services at Bolton one (reported under outpatients) and via community based children's services (reported under community health services). This report will cover the provision within the children's ward and neonatal unit at Bolton Hospital.

The trust has a level three neonatal unit that provides the highest level of specialist intensive care for the sickest infants and preterm babies from within the Bolton area and also accepts referrals for intensive care from out of the Greater Manchester area. The unit also provides high dependency and special care for babies who no longer require intensive care. There are 38 cots in total including 22 level one cots, seven level two cots and nine level three cots. The neonatal unit operates as part of a regional neonatal managed clinical network to ensure best outcomes for babies.

Most other services for children and young people under 16 are provided from the paediatric ward and the observation and assessment unit. The paediatric ward has 31 inpatient beds, which includes three High Dependency Unit (HDU) beds. There are an additional seven day-case beds in a separate bay, which are staffed on a separate rota. On the observation and assessment unit there are a further seven assessment trolleys (one of which is an isolation cubicle) and a waiting room.

The ward is laid out in two bays (one seven bed bay and one four bed bay) and 17 cubicles. The ward has a play area, patient kitchen, parents' lounge, quiet room and a multi-sensory room. The service also offers teacher provision during term-time.

At Bolton Hospital, children's surgery is performed from the paediatric unit. From September 2014 to August 2015, there were 7555 admissions to services for children and young people. Of these admissions, 94.7% were emergency admissions, 4.7% were day case admissions and 0.6% were elective admissions. The ward also undertakes child protection examinations.

As part of our inspection from 21 to 24 March 2016, we visited inpatient areas, paediatric accident and emergency (A&E), the paediatric assessment area and neonatal unit. We spoke with a range of staff providing care and treatment in children and young people's services including: 21 nurses, ten trainee doctors, four consultants, seven health care assistants, two play specialists, a domestic, a physio, a student nurse and senior managers.

We talked with nine parents and three patients on the ward areas. We observed patient care, talked with carers and reviewed 37 patients' records of care and treatment.

We reviewed comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Services for children and young people

Summary of findings

Overall we rated children and young people's services at Bolton NHS Foundation Trust as good. This was because:

- Processes were in place to use available evidence to achieve good outcomes for children and young people.
- Guidelines were based on national standards of best practice and audits were undertaken to identify compliance with action plans for improvements.
- Systems were in place to support children and young people and their families to provide informed consent to procedures.
- Staff were kind and compassionate in their communications with parents and their children. They were given information in a way they could understand.
- Children and young people felt informed and involved in their treatment options. Regard was given to emotional health and support was provided to promote independence when the child was discharged.
- Children and young people were involved in their care and were aware of their treatment options.
- Feedback from children and young people who used the service and their families was positive with quotes that the service was 'excellent' and that parents were 'very pleased with the care and the explanations given.'
- Individual needs were considered and needs met wherever possible in a way that did not single people out as different.
- There were strong links with community resources which helped provide continuity of care for patients when they were discharged from hospital.
- Senior staff were represented at trust board level and felt children's services were listened to and action was taken, where necessary.
- Partnership working and engaging with patients and staff was a priority for the management team.

- Innovation and improvement was encouraged and implemented.

However,

- Paediatric nurse staffing did not meet Royal College of Nursing (RCN) guidance in terms of patient to staff ratios in 41 out of 87 shifts (47.1%) over one month that we reviewed.
- Paediatric nurse staffing did not meet RCN guidance in terms of the Advanced Paediatric Life Support (APLS) or European Paediatric Advanced Life Support (EPALS) requirements as there was no suitably trained nurse on shift in 36% of the shifts we reviewed.
- Neonatal nurse staffing was not compliant with British Association of Perinatal Medicine (BAPM) guidance in terms of the patient to staff ratio. Over a three month period the figures varied from 95.4% to 82.9% compliant.

Services for children and young people

Are services for children and young people safe?

Requires improvement



We rated this service as requires improvement for safety because:

- Paediatric nurse staffing did not meet Royal College of Nursing (RCN) guidance in terms of patient to staff ratios in 41 out of 87 shifts (47.1%) we reviewed.
- Paediatric nurse staffing did not meet RCN guidance in terms of the Advanced Paediatric Life Support (APLS) or European Paediatric Advanced Life Support (EPALS) requirements as there was no trained nurse on shift in 36% of the shifts we reviewed.
- Neonatal nurse staffing was not compliant with British Association of Perinatal Medicine (BAPM) guidance in terms of the patient to staff ratio. Over a three month period the figures varied from 95.4% to 82.9% compliant.
- Door entry systems were not secure on both the paediatric and neonatal units. We alerted service leads to this at the time of our inspection and immediate action was taken to mitigate this risk.

However;

- Records were kept securely to maintain confidentiality for the patient but were available for staff to view when required.
- Processes were in place to report incidents with details of full investigations having been completed, where appropriate. Staff were aware of the process although some staff told us they did not always receive feedback on progress of the investigations.
- Systems were in place to monitor medicines management and infection prevention and control with action plans identified.
- Paediatric staffing met the RCN guidance in terms of the requirement for a senior member of staff to be available at all times.

Incidents

- There were no serious incidents reported in paediatrics or neonates from December 2014 to December 2015. However, on the weekend prior to our inspection there had been a serious untoward incident on the neonatal unit. The trust had taken appropriate initial steps to investigate the incident at the time of our inspection and had reminded all staff regarding the importance of checking medication dosages.
- We talked with approximately 50 members of staff and they were familiar with the trust's electronic reporting system. They knew how to report incidents and who to escalate concerns too. Most staff felt the incident reporting culture was an open process and that appropriate learning was shared following incident occurrence.
- Nursing and medical staff attended a monthly complaints, litigation, incident and pals (CLIP) meeting. Incidents were reviewed at this meeting and action plans were drafted following them. If any trends were identified, root cause analysis were completed.
- Weekly grand rounds (discussed any clinical cases of concern).
- There was a twice daily safety huddle where urgent safety messages were shared.
- In the neonatal unit governance issues were discussed at monthly governance meetings (CLIP meeting) and bi-monthly Greater Manchester Network governance meetings.
- In the neonatal unit there were monthly perinatal meetings which discussed cases where patients had died or where lessons could be learnt for the care of other patients.
- In paediatrics morbidity and mortality meetings were quarterly.
- 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. Duty of candour was understood by staff we spoke with and we saw evidence that the duty of candour regulation had been applied correctly.

Cleanliness, infection control and hygiene

Services for children and young people

- Processes were in place to monitor and report on infection prevention and control procedures and all areas we visited were visibly clean.
- Hand sanitiser and hand washing facilities were available in all areas we visited and we saw staff using them appropriately.
- We saw that protective equipment such as gloves and aprons were available and used appropriately in all areas we visited.
- Audits were undertaken for hand hygiene, infections within a central line (and methicillin-resistant Staphylococcus Aureus (MRSA).
- From July 2015 to January 2016 in neonatal hand hygiene audits showed compliance rates on average of 98.2%. In paediatrics hand hygiene audits showed compliance rates on average of 97.2%.
- From June 2015 to December 2015 the neonatal unit were within the trust's target for infections within a central line with the exception of August 2015 when results were marginally above the trust's target.
- From January 2015 to December 2015 the neonatal unit and paediatric unit did not have any MRSA infections.

Environment and equipment

- Door entry systems were not secure on both the paediatric and neonatal units. The security system that was in place on the neonatal unit and paediatric unit used an intercom system for visitors entering the ward and a swipe card system for staff. However, for exiting the ward, there was a push button allowing visitors to leave without being supervised. This meant there was a risk that children could leave the paediatric ward unsupervised and also raised a concern in relation to child abduction.
- During our inspection we saw visitors letting people into the paediatric unit. Staff members did not challenge this. Prior to our inspection this issue had not been identified as a risk by the trust. We escalated our concerns to the trust who took immediate action, by putting signs on the doors to remind people of the importance of not letting people in. Additionally the estates department surveyed the doors within 24 hours and had a quote for the work within 36 hours which the trust gave us assurance was authorised to proceed with.
- We observed staff using clinical equipment competently on the neonatal unit and paediatric unit.
- Most equipment in storage was up to date and portable appliance tested (PAT). However an incubator and two audioscope sets were due for testing in January 2016 and had not been recalled at the time of our inspection. We escalated this issue and the technician for appliances removed them for testing.
- Resuscitation trolleys were well stocked and all equipment was in date. Appropriate checks had been undertaken.
- The trust had an effective stock ordering system. Each item had a card and this was moved to a central ordering rack when an item needed ordering. Staff then ordered the required items and returned the card once the item had been received.
- Fridges and freezers used for storage of expressed breast milk were checked daily and the temperature recorded. There was a system in place to report any temperatures that were outside of the recommended range.
- Clinical waste was stored and disposed of safely. Used sharps such as needles were stored in dedicated sharps bins to prevent injury to staff.
- The children's ward was audited on 3 July 2015 to assess compliance with the trust's infection control policy. It achieved 89% compliance. An action plan was drawn up following the audit and actions were allocated and signed off as completed. The actions from it had been addressed at the time of our inspection. The service was audited on an annual basis.
- The neonatal unit was audited on 5 October 2015 to assess compliance with the trust's infection control policy. It achieved 94% compliance. An action plan was drawn up following the audit and actions were allocated and signed off as completed. The actions from it had been addressed at the time of our inspection. The service was audited on an annual basis.

Medicines

- Systems were in place to ensure medicines were stored and prescribed safely. We checked the drugs audits on the neonatal unit and the paediatric unit and they were fully completed confirming that all drugs were in date.

Services for children and young people

- The service had an electronic system for discharge letters that incorporates discharge medications.
- The trust had gentamycin prompts available on the neonatal unit for nursing and medical staff.
- Controlled drugs were checked on a nightly basis by a band six nurse and another qualified staff member.
- Fridges used for storage of medicines were checked by staff who signed the attached log daily to ensure it was maintained at the correct temperature. The fridge checks included minimum and maximum temperatures.
- The service had a designated pharmacist. They coordinated all aspects of the pharmacy service including providing prescribing advice and supplying medications.
- In the 20 records we reviewed, all prescriptions were dated and signed.

Records

- We reviewed 20 patients' records on the paediatric unit and 17 patients' records on the neonatal unit.
- Systems were in place to ensure records were stored safely and available for professionals to use.
- In paediatrics all the medical records clearly identified the name and grade of the doctor or nurse reviewing the patient. All records were dated and signed. Early warning scores (EWS) were completed and acted upon. Allergies, ages and weights were documented in all records reviewed.
- Of the records we reviewed, in 80% discussions were recorded that had taken place with family members. In 80% of records there was evidence that a patient had been seen by a consultant within 12 hours.
- Each of the patient records we reviewed had documented they had been seen by a consultant within 24 hours of their admission.
- All neonatal records showed a diagnosis and management plan. They evidenced daily ward rounds and reviews by senior clinicians.
- There was evidence of discussions with the patients' families and documented consent.
- Early warning charts were in use with clear evidence recorded when escalation to medical staff was required.

- In 25% of the neonatal records we looked at medical staff did not record their grade.
- In 23.5% of medical records there was evidence that a patient had been seen by a consultant within 12 hours of admission.

Safeguarding

- The intercollegiate guidance document for safeguarding requires all staff working with children to have completed level three safeguarding training. During our inspection we were not assured regarding the levels of safeguarding training provided to staff. We escalated our concerns regarding safeguarding to the trust at the time of our inspection.
- The trust recognised that the Neonatal and Acute Paediatric Team at Bolton NHS Foundation Trust did not offer complete assurance to us at the time of our inspection. This was due to a variety of training delivery and recording systems.
- The trust subsequently assured us that in paediatrics 96% of nursing staff, 93% of medical staff and 96% of other staff had completed level two safeguarding training at the time of our inspection. In paediatrics 95% of staff had completed level three safeguarding children's training at the time of our inspection.
- In neonatal 100% of staff had completed level two safeguarding training. However, 75% of nurses, 72% of medical staff and 76% of other staff had completed level three children's safeguarding training. This is not in accordance with national guidance. The service has put in place an action plan to address this.
- Consultants supervised all junior staff managing safeguarding cases.
- Junior nursing staff were supported by senior nursing staff when there were safeguarding concerns.
- In the neonatal unit, the trust target for safeguarding vulnerable adults was 98%. The unit was 94.9% compliant at the time of our inspection.
- Staff we spoke with were aware of safeguarding procedures and knew who to escalate any concerns to and how to report concerns on the intranet.
- The service had quarterly safeguarding meetings that discussed cases of concern and themes.

Services for children and young people

- There was a female genitalia mutilation policy in place within the trust and staff we spoke with were aware of it. Staff were aware of protocols related to child sexual exploitation.

Mandatory training

- The trust split training into statutory and mandatory training. Statutory training included topics such as control of infection, fire safety awareness, safeguarding, manual handling and equality and diversity. Mandatory training included resuscitation, information governance and medicines management.
- Staff were reminded by email when they were due to complete statutory and mandatory training.
- Statutory and mandatory training was monitored by the education practitioners within the service. The figure for paediatric staff having completed statutory training was 99.2%. For mandatory training it was 97.5%. These figures were above the trust's targets of 95%.
- In the children's unit 97% of staff had completed basic life support training, which was above the trust's target.
- On the neonatal unit mandatory training was bespoke and 94.2% of staff had completed this at the time of our inspection. This was slightly below the trust's target of 95%.
- BAPM guidance states that all practitioners working with neonates should have NLS (newborn life).
- On the neonatal unit, 87% of staff were qualified in service which exceeds the national standard of 70%.

Assessing and responding to patient risk

- Staff recorded information on early warning score (EWS) charts. Early warning scores are generated by combining the scores from a selection of routine observations of patients for example pulse, respiratory rate, respiratory distress, conscious level.
- The paediatric unit used paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS) to highlight when a patient's condition was deteriorating. The documented score indicated what action to take.
- The trust carried out monthly audits of the early warning tools on a spot check basis (random date each month). In February 2016 the paediatric unit scored 95% overall for completion and escalation of early warning scores.

- In the neonatal unit, staff had introduced the 'fresh eyes' initiative which meant that a different nurse reviewed patients at 1am and 1pm to try and ensure nothing had been missed.

Nursing staffing

- We reviewed paediatric nurse staffing to ensure compliance with Royal College of Nursing (RCN) guidance on safer staffing. This guidance recommends a staff ratio of 1:3 for children under two years of age and 1:4 for children above two years of age.
- At the time of our inspection there were 20 children under two, 10 children over two and two HDU patients. To comply with RCN guidance, the service should have had 10 registered nurses on duty. However, there were only seven registered nurses on the ward at the time of the inspection.
- No patient safety issues had been reported as a result of the staffing situation. No incidents were logged regarding the staffing situation. However, the risk was logged on the risk register.
- Staff told us that to mitigate any risks they had ensured that experienced staff were in HDU and managed the most acute patients, a further experienced staff member had been allocated seven patients within a bay and that the remaining nurses had five patients each.
- A band six and assistant practitioner managed 19 patients throughout the night in the observation and assessment area. This is against RCN guidance which recommends that a minimum of two trained nurses should work within a given area at any point in time.
- We reviewed rotas on the paediatric unit considering the RCN guidance for staff to patient ratios. In February 2016, the ward was not compliant with this guidance on 41 out of 87 shifts (47.1%). On average the ward was understaffed by at least one nurse.
- We looked at the skill mix on the paediatric unit and found that throughout February 2016, there were HDU trained staff on each shift as recommended by Paediatric Intensive Care Standards. However, RCN guidance recommends that there should be a trained APLS nurse on each shift in each area (ward and observation and assessment unit). In 36% shifts there was no APLS trained nurse in either area.

Services for children and young people

- In paediatrics there were no paediatric immediate life skills (PILS) trained nursing staff. PILS training helps health professionals treat seriously ill children or children in cardiac arrest until the arrival of a cardiac arrest team.
- Paediatric staff told us that when the unit opened, consideration had not been given for the dependency of the patients on the unit.
- The service had made efforts to improve staffing levels by employing an additional twilight staff member. However, during the winter of 2015-16, there was a significant increase in the demand for paediatric HDU beds. This resulted in the management of excess critically sick children at Bolton. The trust told us this was because there were no beds within the region to transfer the patients to other units. Following escalation of our concerns the trust told us that the lack of paediatric HDU capacity was to be risk assessed and placed on the risk register. Discussions were also taking place regarding HDU bed provision at a network level.
- Senior nurses told us they had supported nursing staff on the ward in provision of clinical care approximately once per month during winter.
- The service did have two Advanced Paediatric Nurse Practitioners who were supernumerary to the nursing workforce. However, their role was to support the medical workforce in the assessment and decision making of patients on the observation and assessment unit. This supported the efficiency and flow on ward F5 as well as Children's A&E.
- Senior staff told us, during extreme pressures in the last financial year, the paediatric unit had closed beds twice, cancelled elective admissions twice and completely closed the unit to admissions because it was deemed to be full on three occasions due to staffing, capacity or a combination of both. No patients were treated and transferred to another trust during 2015/16. However, during our inspection staff told us that patients had stayed within A&E and that recently a baby had stayed there overnight because the ward was full. Staff had deemed this the most appropriate action given the acuity of patients on the ward. The incident was subject to a divisional review.
- The sickness rate on E5 and F5 has been above the trust's target for 2015/16. The average rate for 2015/16 was 5.67%.
- The observation and assessment unit and paediatric ward were not separately staffed by nursing staff. This risk was recorded on the risk register. However, this register was not robust as it did not include controls that had changed since the risk had been added or reflect the additional risk that long-term sickness had on the department staffing levels.
- Medical staff reported that nurses were frequently stretched because of shortfalls in the number of nursing staff on the paediatric unit.
- We observed a nursing handover. At the start of the handover, messages for all staff were shared then individual patients were allocated to staff. The nursing staff then went to individual handovers of each patient's care where multi-disciplinary team involvement was considered along with potential discharges.
- We reviewed nurse staffing in line with BAPM guidance from December 2015 to February 2016. We found that the trust was compliant with BAPM guidance in December 2015 (95.4%) and January 2016 (95.3%). However, in February 2016, the service was 82.9% compliant with BAPM. We discussed this with the neonatal staff who told us that in 2015 they had started to close the unit to new admissions when they fell below BAPM compliance. As part of the Greater Manchester Network (to secure better outcomes for babies), the network felt that by closing to admissions the service was leaving babies more vulnerable as other units had lower BAPM compliance than them. Service managers agreed to create a guideline to provide clarity for the process of managing variation in staffing levels; and how to make decisions to establish when the unit could no longer accept patients due to capacity/ acuity of patients. We discussed the reasons why BAPM compliance had reduced in February. This was mainly due to staff sickness.
- In neonatal nursing sickness had recently improved from 10% to December 2015 - 4.68%, January 2016 - 5.3%, March 2016- 5.62%.

Medical staffing

Services for children and young people

- The paediatric unit was consultant led and had resident or non-resident cover throughout the week. Consultants were resident from 9am to 10pm (Monday –Friday) and from 9am to 4pm at weekends. Non-resident consultant cover was provided outside of these times.
- The proportion of consultant, middle grade and junior doctors was similar to the England average. A consultant was always available for advice either on site or on call from home. Medical staff told us that consultants were accessible and that during on call periods they regularly phoned in to check on events on the unit.
- The paediatric ward had additional junior doctors working at weekends to support service demands.
- All medical staff had current APLS certification.
- Staff told us that all medical teaching and regular meetings were held in the teaching room on the ward. This provided constant medical presence on the ward at all times.
- A paediatric radiographer had recently retired and the Trust had not yet completed the recruitment of a new radiographer. This reduced the provision of the service by paediatric trained radiographers.
- Neonatal staff explained that there was a middle grade vacancy. This meant that daytime shifts had proved challenging to cover. Staff reported that when the shifts were not covered, it felt ‘very pressured on the shop floor.’ Staff reported they had missed 20 regional training courses because of the reduced numbers available. Plans were in place to address this.

Major incident awareness and training

- Major incident plans had been developed and business continuity plans were in place.
- In paediatrics, the staff had laminated cards and instructions. Staff knew their roles and what to do in the event of a major incident.

Are services for children and young people effective?

Good



We rated this service as good for effective because:

- Processes were in place to use available evidence to achieve good outcomes for children and young people.
- Guidelines were based on national standards of best practice and audits were undertaken to identify compliance with action plans for improvements.
- Systems were in place to support children and young people and their families to provide informed consent to procedures.

However,

- the requirements of the Mental Health Act were not fully understood by staff and further training was required in this area.

Evidence-based care and treatment

- Services for children and young people used available evidence to provide good quality care.
- Policies, procedures and guidelines were available for staff to access on the trust intranet and documents we saw were based on national guidance for example National Institute of Clinical Effectiveness (NICE) guidance for managing head injury patients.
- There were clear pathways in place to help staff identify sick and deteriorating children.
- Management pathways were available and staff reported they found them helpful.
- The trust’s guidelines were reviewed annually. They were all up to date, evidence based and referenced. Any changes had been actioned promptly.
- Facing the Future standards recommend paediatric patients are seen within 24 hours of admission by a Consultant. The trust was 100% compliant with this recommendation.
- Facing the Future standards recommend paediatric patients who are admitted to a paediatric department with an acute medical problem are seen by a consultant or middle grade within four hours. The trust was 95% compliant with this standard.
- The trust encouraged regular audits (for example sepsis and jaundice). It held audit meetings for the sharing of findings. Staff told us that audit findings were acted upon and changes were implemented as a result (for example insulin audit).

Services for children and young people

- The results from the National Paediatric Diabetes audit 2014/15 showed a lower number of patients (18.6%) than the national average (21.9%) had well controlled diabetes.
- The service took part in national audits, for example the neonatal national audit programme (NNAP) and we saw evidence that they acted upon recommendations.
- The neonatal unit were working towards Bliss accreditation.
- The neonatal unit held level two certification from the baby friendly initiative and were working towards level three.
- The trust had policies and procedures in place to manage critically ill children, which included guidance for delayed transfers.
- The paediatric assessment unit provided a telephone advice line for GPs and was overseen by a consultant paediatrician.

Pain relief

- Children and young people had their pain assessed and appropriate methods of reducing pain were offered.
- The service demonstrated adequate pain management for neonates. They used sucrose and had clear guidance for the usage of morphine.
- In paediatrics, nurses used a range of tools to monitor patients' pain levels. If a child was under eight, or unable to verbally report their pain, the trust used the FLACC score system. FLACC is a behavioural tool used to assess patients' pain. In patients over eight, children were asked to report their own pain levels. The service also used physical (behaviour) assessments to determine a patient's pain levels. Records showed evidence of completion of age appropriate pain related charts.
- Children and young people we spoke with told us they had been offered pain relief. Parents and children fed back on the service's electronic survey tool that pain had been effectively monitored.

Nutrition and hydration

- Suitable and sufficient food and drinks were available to maintain patients' nutrition and hydration. Staff had access to dietician advice if they needed it and were

able to offer a variety of drinks and food from the children's menu. This offered a variety of foods to appeal to children of all ages. Food was checked before servicing to ensure it was at the appropriate temperature for safe consumption.

- Breast pumps, fridge and freezers were available on the neonatal unit and the paediatric ward for mothers to express and store breast milk safely for future use.
- On admission to the children's ward, patients were assessed for fluid and nutritional needs. Patient records we reviewed showed that any fluid or dietary intake was monitored and recorded, where necessary.
- The trust had a clear total parenteral nutrition (TPN -) guideline that was available and up to date.
- Staff told us that dietetic input was excellent. For example, if a patient was identified with a cow's milk allergy the dieticians would fully manage the pathway for the patient.

Patient outcomes

- Outcomes for children and young people were monitored by the service and they engaged with national audit programmes.
- The results of the National Paediatric Diabetes Audit 2014/15 showed the trust to be performing slightly better than other areas in England. The mean HbA1c result was 69 compared with 70.6 in England.
- Between June 2014 and May 2015 non-elective readmission rates for children and young people following discharge were slightly higher (worse) than the England average. The rate was between 0.8% and 0.9% higher.
- Multiple admission rates for children and young people with asthma were marginally worse (17.1%) than the England average (16.8%) for the period from July 2014 to June 2015. The trust had created an action plan to address this with re-audit dates identified. For the same time period patients living with epilepsy had a greater number (34.5%) of multiple admissions than the England average (27.8%).
- The NNAP results for 2014 (published December 2015) suggested that the neonatal unit was not meeting the standards in five areas when babies were admitted to

Services for children and young people

the unit. Senior staff told us they were unsure where the data was from and that there had been a data capture and quality issue. The service told us they had met three of the five standards.

- Service leads showed us data, which demonstrated that 99% of babies less than 29 weeks gestation had had their temperature taken within an hour of birth. This meant that, had this data been used, the service would then meet the NNAP standard. For the provision of antenatal steroids, the trust had undertaken a small audit which showed that 95% of patients had had steroids which was above the NNAP standard.
- Service leads told us that 98% of eligible babies had had retinopathy of prematurity screening but that the remaining 2% had not had this completed because they were too poorly. The service had benchmarked itself against some other similar units and had found they had better results. As such, no formal action plan had been put in place to address this.
- For the breastfeeding standard, the trust had put in place an action plan to improve the breast-feeding rates.
- An audit had been undertaken to review documented consultations, which showed 90% of consultations were documented within 24 hours. The service has put in place an action plan to address this.
- The nursing education leads from the Greater Manchester Neonatal Network meet monthly and have been developing Best Practice Standards and Network guidelines. Recent areas covered included respiratory care and bereavement.

Competent staff

- Medical and nursing staff reported they received good support and their induction was comprehensive.
- Staff were trained in their speciality on the neonatal unit and staff had opportunity to undertake a post registration qualification in neonatology.
- All staff that we spoke with, including student nurses, told us they had completed an induction programme before working in the service.

- Practice educators worked on the ward areas and the neonatal unit. Part of their role was to monitor mandatory training and offer support where further training needs were identified.
- In paediatrics, 99.1% of staff had received their appraisal. This was above the trust target of 85%.
- In neonatal 76% of medical staff and 89% of nursing staff had received their appraisals. For medical staff this figure was below the trust target. We escalated this issue to the clinical lead at the time of our inspection, who identified that he would review this more closely in the future.
- The paediatric unit had access to the opinion of a consultant paediatrician at all times. Specialist paediatricians were available for immediate telephone advice for all specialities.
- All medical staff had a training session with play leads. This session gave medical staff understanding of play leads roles but also provided them with additional hints and tips that play leads used.
- Staff were unaware of the requirements of the Mental Health Act relating to detained patients. This had resulted in a patient being granted leave when the requirements of their section did not permit this. The patient had not been consistently given their medication in a timely manner prior to their condition deteriorating. We discussed this issue with senior staff, who told us that in paediatrics there was no mental health act training in place. A system was not in place to manage patients with mental health needs that deteriorated whilst awaiting a level four bed. The unit did not have a training plan to address this issue. The risk was on the risk register. However, the risk register was not updated to make it dynamic and reflective of changing factors. Mitigation actions such as providing further training were not listed.
- We escalated this training issue to senior staff at the time of our inspection and were assured the risk register would be reviewed and the training needs would be addressed.

Multidisciplinary working

- Ward and department staff worked with a range of other professionals to ensure a multi-disciplinary approach to care and treatment.

Services for children and young people

- We saw other professionals supporting the care of children while they were patients on the ward. The neonatal unit had dietician, pharmacy and retinopathy support. Paediatrics had dietician and pharmacy support along with speech and language therapy, OT, physiotherapists and play therapists.
- Education staff provided support for children and young people who were able to engage in schoolwork.
- There was collaborative working in place between the service and the local authority.
- The acute and community paediatric teams worked closely together. Community paediatrics were part of the family division and attended meetings, shared safeguarding responsibilities and were available for consultation.
- The neonatal unit had a community outreach team to support care of their discharged patients at home.
- We observed a handover on the paediatric ward. There was a range of different levels of medical staff. Discussions were held regarding patients' care and multi-disciplinary team (MDT) needs. All patients on the ward were discussed. Staff told us that the senior nurse usually attended the post ward round handover. However, there were only doctors present at the handover we observed.
- Physiotherapy provision was reported to be good. The service had expanded to the community to support the needs of patients. The team were available from 9am to 5pm Monday to Friday. On Saturdays the service was available from 9am to 5pm. On Sundays there was on call provision between 12 to 4pm.
- Play leads worked with children at their level to ensure they understood what equipment was. They also carried out assessments of the children/ adolescents to identify their play/recreational needs during their hospital admission and used distraction during procedures.
- Staff reported there were challenges transitioning children with complex needs. This meant that children with complex needs who were becoming adults did not have one designated professional they could be referred across to.
- GP's were notified of patients' hospital admissions on discharge. A copy of the letter was given to parents along with advice leaflets (where required).
- Child and Adolescent Mental Health Service (CAMHS) provision was not comprehensive and delays in provision were reported. Staff reported that the delay of provision in tier four beds resulted in lengthy stays for patients.
- The neonatal service had an outreach team which saw patients who were oxygen dependent, less than 2kgs in weight, short term tube fed or at the request of a consultant.
- The paediatric unit also had a housekeeper who worked Monday to Friday. The housekeeper supported mealtimes, ordering, stock control and cleaning rotas in order to release clinical staff and increase their time to deliver care for patients.
- The Neonatal Unit had a house keeper team that works Mon – Sun. The housekeepers maintain stock rotation, order stock, clean and maintain equipment thus releasing clinical staff and increasing their time to deliver care to the patients.

Seven-day services

- Staff told us there was seven-day access to pharmacy services and the wards had their own pharmacists.
- The neonatal team had an outreach service that was available from 8am to 6pm Monday to Friday and from 8am to 4pm on weekends and bank holidays.
- Breast feeding advice was available seven days per week.
- The paediatric play leads worked on the ward seven days per week.
- The service reported having good access to diagnostic imaging from Monday to Friday between 9am and 5pm. Out of these hours access to imaging was available in an emergency. However, at weekends staff reported that obtaining ultrasound scans was problematic. No incidents were logged regarding this issue.
- Consultants regularly reviewed their patients. Consultants were available on the unit seven days a week.

Access to information

Services for children and young people

- Staff across the service were able to access information they required. However, the IT system was reported to be very slow and created delays in the provision of early discharge summary information.
- GPs were informed of a patient's discharge electronically.

Consent

- Systems were in place to support children and young people and their families to provide informed consent to procedures.
- A consent policy was available for staff to view. This included details on when and how to seek patient consent and included information regarding a child being competent to consent for themselves, parental responsibility, mental capacity of the parent and making decisions in the 'best interests' of a patient.
- Staff demonstrated the use of Gillick competency principles (used to help assess whether a child or young person has the maturity to make their own decisions and to understand the implications) when assessing people's ability to consent to procedures. We witnessed nurses involving children and young people in making decisions about their care and treatment and using terminology the child could understand.
- We found that a child's or their parent's consent was appropriately sought prior to any procedures or tests being undertaken. Children were involved in giving their consent, as appropriate and parents confirmed this.
- The play specialist informed us there was widespread use of play materials to help with consent procedures.

Are services for children and young people caring?

Good



We rated this service as good for caring because:

- Staff were kind and compassionate in their communications with parents and their children. They were given information in a way they could understand.

- Children and young people felt informed and involved in their care and treatment options. Regard was given to emotional health and support was provided to promote independence when the child was discharged.
- Feedback from children and young people who used the service and their families was positive with quotes that the service was 'excellent' and that parents were 'very pleased with the care and the explanations given.'

Compassionate care

- We saw staff treating patients with dignity, respect and compassion. Parents described the care on the neonatal unit as 'excellent'. They said doctors and nurses communicated well and 'never tired of answering questions'. Parents were 'very pleased with the care and explanations given.'
- Parents on the paediatric unit explained that the staff communicated well, facilities were good and they were kept informed.
- The service sought feedback using the friends and family test. It scored better than the national average for 1 out of 25 questions in the friends and family test. In the remaining 24 questions the service scored in line with the national average.
- Parents were encouraged to stay overnight with patients and to be with their child during procedures and on recovery following anaesthesia.
- Staff told us that, when the unit was busy, it could affect them not being able to provide the level of care they wanted to.
- Senior leaders told us their teams went the extra mile. In the neonatal unit examples were provided of where staff facilitated care in families' and patients' best interests. This included supporting a family after a best interests decision was made regarding their child's health through the courts. Staff took their own time to transfer the patient to the hospice of the family's choice. The staff had also provided clothing for the baby during her stay within the unit.
- Staff told us about the challenge they faced in managing children with mental health disorders.

Understanding and involvement of patients and those close to them

Services for children and young people

- Staff communicated with patients and their families so that they understood their care, treatment and condition.
- We saw staff communicating with parents and their children with respect and in a way they could understand. Parents told us they understood the plan of care and potential outcomes.
- Staff recognised when people who used the services and those close to them needed additional support.

Emotional support

- Parents and their children told us they felt safe on the ward areas and in the neonatal unit.
- A bereavement service was available. On the neonatal unit a side room was used to provide privacy for families of a baby at the end of life. The chaplain attended a poorly patient at the family's request.
- The play specialists were available to support children of all abilities to relieve any anxieties.
- Play specialists were available to provide support for children of all ages and abilities with emotional needs.

Are services for children and young people responsive?

Good



We rated this service as good for responsive because:

- Individual needs were considered and needs met, wherever possible, in a way that did not single people out as different.
- There were strong links with community resources to provide seamless care for patients when they were discharged from hospital.
- Engagement with patients and their families was undertaken with the use of electronic and paper based surveys.
- Children and young people of all ages had timely access to care and treatment.

However.

- The parent facilities in the neonatal unit would benefit from being updated.

Service planning and delivery to meet the needs of local people

- Bed spaces on the paediatric unit were used flexibly for different ages of children. Children of different ages and sexes were nursed in the same bays.
- We saw electronic games and books used to distract children from the procedure and reduce anxiety.
- In both paediatrics and the neonatal unit, there were facilities for parents to prepare drinks and sleep if they needed to stay with their child. Parents we spoke with were grateful for somewhere to stay but said the rooms needed some refurbishment.
- School staff supported the educational needs of children.
- There were strong links with community services for children and young people.
- At the time of our visit there were no adolescents with mental health issues. Staff told us they would be cared for in bays and any risk to their safety would be removed.
- Play specialists prepared children for theatre and used child friendly information.
- There were a wide range of services in place to support young people transitioning into adult services.

Access and flow

- Children and young people of all ages had timely access to care and treatment.
- Admissions to the neonatal unit were from the delivery suite, post-natal wards, and other units or transferred from other specialist neonatal units to be closer to their families. There were separate areas for babies who needed different levels of care. The service had an escalation plan that reflected the needs of the network to offer support to all the areas it covered.
- Admission to the paediatric wards was via the GP, the assessment unit, a planned admission, from the emergency department and via referral from the community team.

Services for children and young people

- Children over 16 who were under a paediatrician were offered care within the paediatric unit.
- GPs could call the advice line for discussion about a child's condition and refer patients to the assessment unit if they needed a paediatrician's review.
- On nursing handover sheets, which identified a predicted discharge date. Priority discharges were highlighted as 'golden discharges'. These patients included those who could continue to be cared for in the community and were seen by medical staff first on early ward rounds.
- Staff told us that they had a good relationship with the community team and regularly referred patients with wound or sutures to them for ongoing care.
- Patient records we reviewed showed a consultant had seen each child within 24 hours of their admission.
- The care provided by the Neonatal outreach team facilitated earlier discharge thus enhancing patient flow whilst simultaneously enhancing and supporting a smooth transition towards parental autonomy.
- The service offered patients access to a sensory room. Additionally, there was a play room with a range of toys and activities for differing age ranges.
- None of the substantive ward staff were registered mental health nurses. However, CAMHS staff were supporting ward staff with monthly meetings to discuss issues around mental health needs of children and young people.
- Play specialists were available to provide support for children undergoing procedures and were present at the preadmission clinic to help reduce any anxieties.
- An outreach service was provided by the neonatal unit staff to support parents with breast-feeding and other general concerns.
- A chaplain service was available for children and families of all religions. Staff were aware how to contact the service. The service offered patients and their family access to a multi-faith room.
- Some transition clinics were in place for children who would need ongoing support into adulthood for their condition for example clinics for epileptic, asthmatic and diabetic patients. This was planned to meet each young person's individual needs.

Meeting people's individual needs

- The service had translation link workers for the four main languages spoken in the local area. Other languages were catered for either using trust staff or through language line.
- The service worked closely with the community team to try to promote management of patients at home. Staff reported that the community team had good provision in place to support complex needs patients.
- The paediatric ward had a teacher working on the unit during term-time. The teacher provided learning materials for all children of school age who were medically capable to undertake the activities.
- In the neonatal unit the 'listening ear' was used which provided a visual clue to patients and staff when noise levels rise above acceptable levels for the neonates.
- On the neonatal unit, vouchers discounting 25% off food were provided for parents who stayed with their children. A fixed amount parking ticket was also provided.

Learning from complaints and concerns

- Staff reported the complaints process was transparent and supportive.
- On the neonatal unit, staff kept a log of informal concerns that were expressed to them and how they were resolved. This then helped all staff to be aware of any concerns raised. Nursing staff were also able to see if there were any trends and address them.
- Information was displayed and leaflets were available in child friendly versions for patients and their families to feed back their comments to the trust.
- Staff we spoke with were aware of the complaints process and told us they would try to resolve any issues immediately. If this was not possible they would direct the family to the complaints process.

Are services for children and young people well-led?

Services for children and young people

Good



We rated this service as good for well led because:

- Senior staff were represented at trust board level and felt children's services were listened to and action was taken where necessary.
- Partnership working and engaging with patients and staff was a priority for the management team.
- Innovation and improvement was encouraged.

However,

- The risk registers were not continually updated to ensure they were dynamic. This meant the trust board did not have a complete oversight into current issues within the division and mitigation that was in place.

Vision and strategy for this service

- The trust vision was to be "an excellent integrated care provider within Bolton and beyond delivering a patient centred, efficient and safe service". Staff were aware of the vision and values held by the trust.
- In the neonatal unit the strategy for the unit was provided by the local network. The unit aimed to provide the best job they could within the network requirements.
- Staff we spoke with were clear they wanted to provide the best possible service they could for their patients.

Governance, risk management and quality measurement

- Staff were aware of the issues on the risk register and measures that were in place to address them. However, when we discussed concerns regarding nurse staffing senior staff confirmed to us that the risk register was not dynamic and that it was not continually updated with changes to risks and controls.
- The observation and assessment unit and paediatric ward were not separately staffed by nursing staff. This risk was recorded on the risk register. However, this register was not robust as it did not include controls that had changed since the risk had been added or reflect the additional risk that long-term sickness had on the department staffing levels.

- The paediatric and neonatal teams strived for quality and were encouraged to audit and undertake quality reviews to improve practice.
- Audit programmes were in place to monitor compliance with procedures and standards.
- The service had monthly ward meetings which were held in the morning and the evening to try and capture as many staff as possible. Minutes were kept in a file and staff who didn't attend the meeting were expected to read them and sign to confirm this. We saw evidence this happened when we reviewed the file.
- Staff in all areas we visited were clear about their roles and understood what they were accountable for. The annual report for safeguarding children was presented to the trust board in the December 2015 meeting.
- Performance and governance dashboards were in use. 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.

Leadership of service

- Senior staff were reported to be approachable, visible and supportive.
- Medical
- Staff reported they received appropriate information about the service from managers and that they felt part of discussions to move the service forward.
- The staff we spoke with were aware of who their immediate managers were and described the managers of both areas as being supportive and approachable.
- There was an identified lead nurse on both the paediatric ward and the neonatal unit for each shift. Each unit had a clinical lead who had responsibility for their specialties. There was always senior medical advice available from clinical leads for the paediatric and neonatal areas. Staff told us they were approachable and available.

Culture within the service

- Staff reported leadership was good and they felt supported. Senior clinicians were reported to be 'reasonable, approachable and helpful.'

Services for children and young people

- Staff were happy to recommend the trust as somewhere for children to receive treatment.
- Junior medical staff in paediatrics reported they felt supported in their roles, particularly by the consultants.
- Staff told us that they worked as part of a co-operative team.
- Staff we spoke with wanted to provide the best care they were able to. The neonatal and paediatric teams were aware of the pressures within the service. In paediatrics, nursing staff told us that if a nurse had particularly challenging patients, either due to behaviour or acuity, other nurses would try and ensure that they took turns to provide their care on subsequent shifts.

Public engagement

- There was a system of gathering views from patients and their parents on the children's wards. The feedback was analysed on a monthly basis.
- Engagement with patients and their families was undertaken with the use of electronic and paper based surveys.
- On the neonatal unit, staff used feedback from the parent questionnaire to improve parent facilities.
- The service sent all parents a questionnaire. They regularly reviewed and revised questions.
- The service took part in the NHS Friends and Family test. In paediatrics, they also undertook surveys using an electronic system.

Staff engagement




- Staff meetings were held monthly and minutes taken for those staff who could not attend.

- Staff told us that, on the paediatric unit, they had developed a 'success tree' which was used to celebrate their achievements.
- The trust had staff awards in recognition of staff activities.

Innovation, improvement and sustainability

- The trust were early adopters of the neonatal behaviour assessment scale (NBAS).
- The neonatal unit were early adopters of volume ventilation.
- The neonatal unit introduced 'Matching Michigan', a two year programme designed to reduce infections in central lines, before it was rolled out as best practice. The service was nominated for an award from the Health Service Journal (HSJ) for this.
- The neonatal unit introduced the 'fresh eyes initiative', which is where nursing staff look at other nurses' patients at 1am and 1pm to promote things not being missed.
- The neonatal unit were awarded a HSJ 'value and improvement in technology' award for their use of cooling (a system that cools the baby, giving them the best chance of survival and avoiding long term harm).
- The neonatal unit were taking part in eight research studies at the time of our inspection.
- The service was looking into developing Advanced Neonatal Nurse Practitioner and Assistant Nurse Practitioner programmes across both units.

End of life care

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

Bolton NHS Foundation Trust (the trust) provides integrated End of Life (EoL) care across the hospital and community setting.

End of life care encompasses all care given to patients who are approaching the end of their life and following death, and may be delivered on any ward or within any service of the trust. It includes aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services.

The Specialist Palliative Care Team (SPCT) was led by a palliative care consultant and the clinical service lead, who had overall management responsibility for the team.

The specialist palliative care nurses provided face to face contact seven days a week; the team consisted of hospital and community nurses, who provided support for patients with complex specialist needs, Monday to Friday, 8.30am till 4.30pm; cover at weekends, 8.30am till 4.30pm, and was supported by one member of either team covering hospital and community. Outside these hours, support was provided by the Bolton Hospice helpline, which was available 24 hours a day.

The team worked very closely with the local hospice and a member of the team attended the morning multidisciplinary meeting (MDT). A weekly specialist MDT was held every week with representation from the specialist care team, hospital nurses, community nurses and the specialist palliative care team. Representatives from the hospice, chaplaincy, bereavement service and the MDT Coordinator also attended this meeting.

From April 2014 to March 2015, the SPCT (Community and Hospital) received 2,419 referrals (2,083 cancer patients and 336 non-cancer patients). There were 1,428 deaths in the trust during this period.

The service also included the Palliative Care Therapy Team, who worked Monday to Friday, 7.30am till 5pm. The team were based at the local Hospice and specialised in providing occupational therapy and physiotherapy to patients with life limiting conditions, including end of life patients. During the period April 2014 to March 2015, they received 649 new referrals (553 cancer patients and 96 non-cancer patients).

A palliative and end of life educator and an end of life facilitator provided education and support across the trust, working closely with Clinical Commissioning Groups (CCGs) and care homes.

The Bereavement and Donation Team provided bereavement support during end of life care and care after death. The team also work with NHS Blood and Transplant (NHS BT) to support eye retrieval and tissue donation.

The SPCT worked closely with the chaplaincy department and the trust's mortuary staff.

During our inspection we observed care on inpatient wards, looked at records for 6 patients, spoke to 3 patients and 1 relative and 37 staff across the disciplines, including doctors, nurses, administrative staff, the management team, resuscitation officer, bereavement officers, porters, chaplains and mortuary staff.

End of life care

Summary of findings

We rated End of Life Care as 'Good' overall. This was because:

- There were no 'Never Events' or serious incidents in the year prior to our inspection, processes were in place to ensure that learning from incidents took place and duty of candour was undertaken when required.
- End of Life staff were 100% compliant with mandatory training.
- A rapid discharge pathway checklist enabled Pharmacists to process prescriptions quickly.
- The Specialist Palliative Care Team (SPCT) responded promptly when required and worked in line with best practice and national guidelines.
- The partook in the National Care of the Dying Audit and the results showed that they scored above the England average for the majority of indicators.
- There was a proactive and comprehensive end of life care training programme in place.
- There was good evidence of multidisciplinary team working across the hospital and in community settings.
- There was a visible person-centred culture with caring, compassionate staff who considered the needs of patients nearing their final days or hours and their families.
- There was a co-ordinated approach to meeting the needs of the local population and involving other organisations.
- There was a clear work plan in place for end of life care that showed measurable progress.
- There was good leadership with a clear view of strategy.
- Staff told us that the management team worked well together and that they were proud of the service that they provided.
- The mortuary staff had won the 'Non-clinical Team of the Year Award' in 2015 and were very proud of this.

However:

- Consultant cover at the hospital was not at establishment and there was long-term Consultant locum cover at the hospice.
- There was no electronic patient record system in general use in the hospital and patient transfer between services relied on paper-based records.
- The 'Care After Death' Audit revealed that ward notes did not reveal the trust's bereavement nursing and chaplaincy services being routinely offered to bereaved families or carers.
- The Bereavement Team was being restructured at the time of our inspection and the support offered by them was expected to be undertaken by staff on the wards, overseen by a Band 7 Bereavement Nurse. Staff did not feel supported throughout the consultation period for this and were unclear on what the service would look like going forward.
- There was a lack of private rooms available to break bad news to families and friends.

End of life care

Are end of life care services safe?

Good



We rated the End of Life (EoL) care services at the Royal Bolton Hospital as 'Good' for being safe. This is because;

- There were no “never events” or serious incidents relating to end of life care during this period. Nine incidents had been reported between January and December 2015, all being classed as low- or no harm.
- Staff were 100% compliant with mandatory training.
- There were processes in place to ensure that learning from incidents took place.
- Processes were in place to carry out the duty of candour process.
- Appropriate personal protective equipment (PPE) was in place and used in ward areas and in the mortuary.
- Anticipatory medicines (four core medicines) were supplied to facilitate timely discharge and a drug prescription was supplied for use in the community. A Rapid Discharge Pathway checklist enabled pharmacists to process prescriptions quickly.
- Ward staff confirmed that the SPCT responded promptly when they were needed.

However;

- The medical cover at the hospice was being provided by a locum on a long term basis due to a vacancy. The trust had two Consultants for end of life care but one was on maternity leave at the time of inspection.

Incidents

- Staff told us they were comfortable using the incident reporting system and knew how to report incidents.
- The end of life committee reviewed all incidents and complaints relating to end of life care.
- Nine incidents had been reported between January and December 2015, all being classed as low- or no harm. Three incidents were linked to medication – prescribing errors. Learning was cascaded in divisions through the divisional governance arrangements and trust wide, learning was shared via SBAR alerts and a monthly learning ‘hourglass’ slide set.
- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There

were no “never events” or serious incidents relating to end of life care during this period. We were told that some mortuary breaches were possibly due to delays in verifying deaths; subsequently training was provided to enable nurses to verify death. However, no data was yet available which would indicate that this change in practice had reduced mortuary breaches.

- Nursing staff told us that the team had learned from previous incidents and as a result implemented the use of the recommended syringe driver, so there was only one method and rate of delivery of medicines; this was supported by practical training focussing on setting up the device and the safe administration of medicines.
- Staff were informed via email of learning following incidents and any incidents and outcomes were discussed at multidisciplinary meetings.
- The resuscitation team provided a good example of Duty of Candour, which 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. They told us that if the root cause analysis (RCA) following a resuscitation found that there had been avoidable factors, then the consultant would ring the family to inform them and discuss.

Medicines

- A rapid discharge pathway checklist enabled pharmacists to process prescriptions quickly; for example, oxygen was dispensed within four hours. The checklist was regarded as very useful for weekend discharges, when other disciplines were not available. The wards felt more empowered to deal with discharges and, as a result, staff felt that communication with patients was better and discharges could take place within four hours.
- Anticipatory medicines (four core medicines) were supplied to facilitate timely discharge and a drug prescription was supplied for use in the community.
- There was a rolling programme of syringe driver training for clinical staff across the trust.
- Syringe drivers were kept in stock to be used as required; staff told us that there were a sufficient amount syringe drivers in the hospital and community setting.

End of life care

- Syringe drivers were maintained by the Biomedical Engineering (BME) Department and we saw that there was an up to date asset and maintenance record for them.

Records

- The Record of Dying Care was a paper-based document which was in use throughout the trust. As this had only recently been introduced, mandatory training was being introduced for the completion of the Record of Dying Care, to ensure that clinical staff correctly completed the new document, patients were kept safe, and relatives informed.
- The service used a unified document for recording the 'do not attempt cardio-pulmonary resuscitation' (DNACPR) status of patients. This document travelled with the patient between locations and organisations, for example, if the patient was discharged home or to a hospice. The document was reviewed if there was a change in the patient's location or circumstances.
- The Hospital Specialist Palliative Care Nurses used a database to record details of the patient's care and treatment and their notes were securely stored on this system. They told us that they found it user-friendly and it recorded all patient episodes whether in the hospital or community. However, the Palliative Therapy Team, based at the hospice, used a different system to record patient records and this did not interface with the system at the hospital. Work was in progress to enable both teams to use the same system.
- There was no electronic patient record system in general use in the hospital and paper DNA CPR records were physically handed over to ambulance crews and community Palliative Care Nurses.
- The mortuary had approximately 70 standard operating procedures / policies regarding safety and infection control, for both routine and high risk post-mortems. They were readily available online to mortuary staff.
- A risk assessment was completed for every post-mortem, taking into account history from a coroner or from the case notes, determining risk factors, such as drugs, tuberculosis, HIV and Hepatitis.

Safeguarding

- Trust-wide safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had

a safeguarding team which provided guidance during the day in the week. Staff had access to advice out of hours and at weekends from the hospital on-call manager.

- Staff gave us examples of things they would report as a concern. They told us they received feedback from safeguarding referrals they had referred and received learning from other safeguarding referrals at team meetings.
- Training statistics provided by the trust showed that in the Specialist Palliative Care Team and Mortuary Team, 100% of staff had completed safeguarding adult training.
- The trust's target for safeguarding children training was 95%. In the Specialist Palliative Care Team and Mortuary Team, 100% of staff were compliant.

Mandatory training

- The trust provided mandatory and statutory training for a range of subjects, such as blood transfusion (where applicable); fire safety; infection control; Safeguarding Children and Adults; Equality and Diversity; Medicines Management; Resuscitation; Conflict Resolution and Information Governance.
- Staff in the Specialist Palliative Care Team (SPCT), Mortuary Team and Bereavement Services were 100% compliant with mandatory training. The trust told us that they were a forerunner in introducing mandatory training elements on end of life care for all new clinical staff covering "The 5 Priorities of Care" and the Record of Dying Care completion.

Assessing and responding to patient risk

- An early warning score system (EWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above). Repeated checks of the early warning scores were documented accurately.

End of life care

- The trust had a programme of work around the deteriorating patient with six different work streams, one of which was end of life care. The work stream groups reported to the Mortality Reduction Group Committee.
- Ward staff had contact details for the Specialist Palliative Care Team and contacted them as soon as a patient was identified as being in the last days, or hours of life. They were also able to contact the Bereavement and Donor Team and the Chaplaincy Team.
- Ward staff confirmed that the SPCT responded promptly when they were needed.
- The Macmillan Nurses from the SPCT carried out pain assessments with the acute pain team to establish whether patients had increased needs, such as mouth care or whether medication should be delivered via a syringe driver.

Nursing staffing

- Staffing for end of life care was the responsibility of all staff across the wards and not restricted to the SPCT.
- The end of life team comprised 11.47 whole time equivalents (WTE) clinical nurse specialists. The whole end of life care team was 23.83 whole
- We were told that the team recently lost a few palliative link nurses to the hospice, as they had a recruitment drive.
- We were told that nurses could be busy at night that could limit access to breakthrough pain medication. One patient felt that staff / nurses were very caring, but that there were not enough of them.

Medical staffing

- At time of the inspection, the end of life care medical team comprised one part-time consultant who provided services in both the hospital setting and community setting. We were told that the service should have one hospital based consultant. However, the consultant was on maternity leave at the time, and a hospice-based consultant. The latter post was vacant and there was long-term locum cover in place.
- We were told that recruitment for consultant staff was underway.
- Weekend and out-of-hours on-call advice was provided by the Bolton Hospice Helpline. Staff could use this facility to access specialist advice and support if a patient deteriorated on any of the wards.

Major incident awareness and training

- In the event of a major incident, the mortuary staff would follow the trust's major incident plan; the most senior member of staff in the mortuary would be bleeped. In the case where additional storage was required, then the coroner would decide how to proceed; there was a major incident mortuary at another trust.
- The Greater Manchester area had a MASFAT (mass fatalities) Group and the trust were part of the group. The Greater Manchester NHS trusts had access to a mobile mortuary unit that could be erected anywhere in the event of a major incident. The unit included a chapel of rest viewing area.

Are end of life care services effective?

Good



We rated the End of Life (EoL) care services at the Royal Bolton Hospital as 'Good' for being effective. This is because;

- The specialist palliative care team (SPCT) worked in line with best practice and national guidelines relating to end of life care for adults.
- There were a range of evidence based policies in place. Staff were aware of them and knew how to access them.
- The 2015/16 National Care of the Dying Audit was published in March 2016. The results showed that the trust scored above the England average for the majority of indicators.
- The service had a proactive and comprehensive training programme on end of life care in place for clinical nurse specialists, medical, nursing, therapy and non-clinical staff.
- There was good evidence of multidisciplinary team working with various services across the hospital and community settings.
- Patients were monitored for pain and provided with appropriate pain relief, where required. Nursing staff carried out joint visits with the acute pain team, to assess if intravenous medicines were required.

End of life care

- We observed nutritional assessments were completed and nursing records, such as nutrition and fluid charts were completed accurately.
- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- The Specialist Palliative Care Team provided a seven day service, Monday to Friday 8.30am to 4.30pm. Weekend cover was supported by one nurse covering both hospital and community settings; however, it was considered that one nurse was not enough. They were addressing this and were investigating more varied shift patterns. Outside these hours, support was provided by the Hospice helpline, which was available 24 hours a day.

However, we also found that: -

- There was no electronic patient record system in general use in the hospital, meaning that patients' transfer between services relied on paper-based records, including for DNA CPR documentation.
- We reviewed five care records on Ward B3 and we found that in four clinical records no assessment of the patient's mental capacity was recorded where this would have been expected.
- We were made aware of two instances/complaints where family were not consulted with regards to DNA CPR status, whilst family raised concerns about the patients' mental capacity to consent to DNA CPR.

Evidence-based care and treatment

- The specialist palliative care team (SPCT) worked in line with best practice and national guidelines such as those from the National Institute for Health and Care Excellence (NICE) relating to end of life care for adults. Clinical audits included monitoring of NICE compliance and other professional guidelines.
- There were a range of evidence based policies in place, including the 'End of Life' policy, 'Verification of Death' policy and 'Care after Death' policy. These policies were available from the trust's intranet and staff knew about them and could access them easily.

- Staff within the SPCT were highly trained and had a good understanding of existing end of life care guidelines.
- The trust had replaced the Liverpool Care Pathway following its withdrawal from use in 2013. The trust had replaced it with a new document called "Record of Dying Care". This was initially piloted on Ward D1 and D2 and was rolled out to other areas. Feedback was mixed; doctors liked it, it worked cross-boundary and it was not seen as a tick box form, however, the length of the document was considered problematic.
- The document was a comprehensive document, used to record the patient's individualised tailored care in line with best practice guidance
- We were told that the 'Record of Care of the Dying Person' was used in the medical assessment unit, however, doctors were not always writing in the record, but were writing in the hospital notes.
- Guidelines for pain and symptom control in end of life care were in place on the intranet and they were re-written in November 2015. There were also algorithms which outlined various routes to follow, including when syringe drivers should be used for sub-cutaneous medication.
- The Amber Care Bundle is an approach used when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment but while talking openly about people's wishes and putting plans in place should the patient deteriorate and be considered at the end of their life.
- Two wards had piloted the 'Amber Care Bundle' and although it had been well-received, we were told that it had not been effectively embedded and required some modification. The trust had advertised for a Band 6 post (initially on a six month contract) to facilitate any improvements required to piloting the Amber Care Bundle with a view to embedding the process and rolling it out across the hospital.

Pain relief

- Staff were able to access clear guidance on the prescription of medications to be given 'as required' for symptoms that may occur at the end of life, such as

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pain, anxiety, nausea, vomiting and breathlessness. Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to promptly manage any changes in patients' pain or symptoms.

- Pain was reviewed for efficacy and changes were made as appropriate to meet the needs of individual patients. The service used link interpreters for patients whose first language wasn't English to assist in assessing pain symptoms and pain control.
- The Specialist Palliative Care Nurses undertook joint visits with the acute pain team, to assess if intravenous medicines were required through the use of a syringe driver.

Nutrition and hydration

- We observed nutritional assessments were completed and nursing records, such as nutrition and fluid charts were completed accurately the wards we visited.
- Patients were supported with eating and drinking by staff based on their individual needs and mouth care needs were assessed when the patient could no longer eat or drink.
- Staff and patients had access to specialist dietetic advice as required.
- End of life patients were supported to eat or drink if this was their wishes, even if this could result in aspiration.

Patient outcomes

- The 2015/16 National Care of the Dying Audit was published in March 2016. The results showed that the trust scored above the England average for documenting evidence that it was recognised that the patient would die within the coming hours or days; discussions had taken place with nominated persons important to the patient and that the patients concerns had been listened to. They achieved average results on whether there was documented evidence that they had asked about the needs of those close to the patient. However, the trust achieved far lower than the England average on whether there was documented evidence in the last 24 hours of a life, that a holistic assessment of the patient's needs regarding an individual plan of care had taken place.

- The audit also showed that the trust had appropriate training in place for medical and nursing staff and allied health professionals, had seven day access to palliative care and at least one end of life care facilitator. However, there was no lay member on the trust board with responsibility for end of life care. The End of Life Committee did, however, have lay member representation and a Non-executive Director with responsibility for end of life care.
- The audit results were published in the inspection period and as a result, the trust had not been able to assess the findings or produce an action plan.
- The trust participated in the National Cardiac Arrest Audit (NCAA) and undertook a root cause analysis (RCA) investigation into every cardiac arrest that took place in the hospital and undertook a monthly review of cardiac arrest deaths that had occurred in the hospital. This allowed for learning to take place and had resulted in a reduction in avoidable deaths.
- A review of deaths that occurred as a result of a cardiac arrest in the hospital identified 20 cases where a decision not to resuscitate, using the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form, should have been considered before the patient had a cardiac arrest. The trust acknowledged this and the trust's Quality Report for 2015 showed that there had been a noticeable improvement in completion of DNA CPR documentation.
- End of Life care was one of six work stream projects across the trust that reported to the Mortality Reduction Group Committee and work around DNA CPR was part of the trust project work at board level and linked to improving outcomes for deteriorating patients.
- The palliative care therapy team carried out a 'We'd Like to Hear From You' patient satisfaction survey between January and December 2015, and 31 questionnaires were returned. Patients were asked to give an overall rating of the service and 81% of respondents rated the service they received as 'excellent', 16% as 'good' and 3% did not answer the question. There were no complaints identified on any of the 31 questionnaires.

Competent staff

- The service had a full time End of Life Care Practice Educator who delivered a wide range of end of life

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training to trust staff and stakeholders. This included Sage and Thyme (communication skills); enhanced communication skills; 5 priorities for caring for the dying person; spirituality in end of life care; verification of death by registered nurses training; dementia and end of life care; capacity and care planning; pain management at end of life; breathlessness management; palliative care emergencies; nausea and vomiting management; palliative care medications; improving practice in care after death and improving practice in bereavement care. Bespoke training could also be offered.

- The service had a proactive training programme in place for clinical nurse specialists, including 1.5 hour training sessions on the five priorities of care and Sage and Thyme communication training. However, due to day-to-day business, not all staff had been able to undertake the end of life training. We were told that attending training and courses was a challenge due to work pressures. All new clinical staff received mandated end of life training on the five priorities of care and record of dying care completion.
- Hospital based staff attended five link nurse training days per year; every other training day was a joint training day with community based staff.
- We observed a link nurse training day, where the summary of new NICE Guidance on end of life care was shared with staff. There was also discussion around 'breaking rules that don't exist', such as open visiting and musicians and pets attending the ward.
- The trust had set up a Palliative and End of Life Care Link Nurse Group whose aim was to have an awareness of the end of life plan; understand the education available to support the plan; provide a forum to share best practice; guidance and promote the use of the Record of Care for the dying person and DNA CPR documentation. The group met on a monthly basis.
- Link nurses had end of life care resource files on their ward where all literature, guidance and training notes were kept.
- We were told that the palliative care staff were doing, or had done the non-medical prescribing training.

- All nurses were provided with syringe driver training. There were dummy syringe drivers available for training purposes.
- Staff told us that the end of life module for Advanced Nurse Practitioners at a local University was optional; however, the uptake was encouraged and supported, so quite a few nurses undertook the module. One nurse was studying for a Master's Degree in End of Life care.
- Every Monday there was 'Verification of Death' training for senior nurses at a local University. As out of hospital (OOH) advanced practitioners were required to verify deaths, this training was required to keep their practice up to date.
- Student nurses visited the mortuary, so they could develop an understanding of how deceased patients were cared for, and get questions they had answered.
- Staff had received appraisals or they had been booked in if they were due on the Specialist Palliative Care Team, Mortuary Team and Bereavement Services. The trust target was 95%.

Multidisciplinary working

- All members of the end of life care team (trust and community) attended a weekly multidisciplinary meeting, including chaplaincy, therapies, hospice and bereavement staff.
- The SPCT had well established links internally across the hospital and with community palliative care services and other community services, such as district nurses. Staff told us there was a good working relationship between primary and secondary care professionals.
- The service used a database to record the multidisciplinary team (MDT) hospital and community episodes of care for cancer and non-cancer patients.
- Nursing staff told us they work closely with the 'Rapid Assessment, Intervention and Diagnosis' (RAID) team, which assessed patients for underlying mental health issues.
- Nursing staff also told us that they work closely with staff from the long stay mental health ward, the Bluebell ward (for patients living with dementia), the alcohol team and with the learning disability nurse.

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- The SPCT worked closely with the bereavement team, to get them involved at the most appropriate time.
- The Bereavement Team had well-established links with NHS Blood and Transplant (NHSBT), the Coroner and Greater Manchester Police with good evidence of giving bereaved families the option of tissue donation after the death of a relative.
- Porters had a good relationship with the mortuary and ward staff and felt part of team supporting patients and families.
- There were processes in place to evaluate the effectiveness of multidisciplinary working across the trust related to resuscitation. 222 calls were monitored and data recorded – resuscitation attempts were audited and root cause analyses allowed for good learning to take place. There was evidence of good working relationship between the resuscitation service and the palliative / end of life care services.
- Clinical Commissioning Groups (CCGs) were working on ‘Electronic Palliative Care Co-ordination Systems’ (EPACS), which is a shared database; the CCG have appointed an EPACS Lead. This system would allow electronic exchange of information and documentation between the hospital palliative nurses, community teams, GPs and the hospice
- The therapy team and hospital and community palliative care teams used different electronic record systems to record details of care and treatment delivered. There were processes in place to share information between teams.
- However, staff told us that there was no electronic patient record system in general use in the hospital, meaning that patients’ transfer between services relied on paper-based records, including for DNA CPR documentation.
- The unified DNA CPR form was used cross-organisations between primary and secondary care.

Seven-day services

- End of life care was provided as a seven-day service, Monday to Friday 8.30am to 4.30pm. Weekend cover was supported by one nurse covering both the hospital and community settings; however, it was considered that one nurse was not enough. They were addressing this and were investigating more varied shift patterns. Outside these hours, support was provided by the Hospice helpline, which was available 24 hours a day.
- Patient referrals were mostly received by telephone and most patients were seen the same day. An audit undertaken in January 2016 showed that all referrals to the SPCT in the hospital were seen within 24 hours. There was an operational policy in place for identifying the dying person.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There were computers available on the wards we visited, which gave staff access to patient and trust information. Policies, protocols and procedures were kept on the trust’s intranet which meant staff had access to them when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- MCA training was included in safeguarding training. Information provided by the trust showed that compliance rates for this training was 100% for SPCT nurses.
- The majority of staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care. Staff understood the principles of capacity assessments. However, we were made aware of two instances/complaints where family were not consulted with regards to DNA CPR status, whilst the family raised concerns about the patients’ mental capacity to consent to DNA CPR.
- We also found that with regards to DNA CPR in the clinical records, there was no evidence in three clinical records that a summary of communication with the patient or welfare attorney had been completed. In four records, the summary of communication with the next of kin (NOK), or reason why not, had not been completed.

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- Patients were provided with (national) leaflets explaining what resuscitation was, so patients could make a better informed decision about whether they wished to be resuscitated in the event of a cardiopulmonary arrest.
- Staff were aware of and understood procedures relating to the Deprivation of Liberty Safeguards (DoLs). DoLs are part of the Mental Capacity Act 2005 and they aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack the capacity to make their own decisions.
- We reviewed five care records on Ward B3 and we found that in four clinical records no assessment of the patient's mental capacity was recorded where this would have been expected.

Are end of life care services caring?

Good



We rated the End of Life (EoL) care services at the Royal Bolton Hospital as 'Good' for being caring.

This was because: -

- There was a visible person-centred culture with caring, compassionate staff who considered the needs of patients nearing their final days or hours and their families.
 - The levels of support offered to families were assessed in a sympathetic way and tailored according to their individual needs.
 - Staff were respectful and caring when they spoke of patients who were nearing the end of their life and families who were suffering a bereavement.
 - Staff were committed to supporting patients' to fulfil their wishes.
 - We saw examples of staff supporting bereaved families sensitively.
 - We observed a specialist palliative care handover meeting, which demonstrated an effective and thoughtful review of patients and appropriate sharing of information.
- The ward had open visiting arrangements in place patients approaching the end of life.
 - The mortuary had a private visiting room for relatives. The room had a memory book, tissues, pens, leaflets and questionnaires and staff made every effort to provide a comforting and pleasant environment for the bereaved family.
 - The trust had adopted a symbol system, which made staff aware of a family in need (identified by the symbol). This ensured that during difficult times families were supported by staff and volunteers.

However;

- The inaugural 'Care After Death' audit carried out in 2015, revealed that overall, across the acute and elective wards, the ward notes did not record the trust's bereavement nursing and chaplaincy services being routinely offered to bereaved families or carers. However, the trust have told us that the Bereavement Team reviewed 100% of all deceased patient notes and offered bereavement support, mementoes and spoke about donation to bereaved relatives or carers.

Compassionate care

- We spoke to three patients, one relative and 37 staff across all disciplines, Patients told us staff were caring, kind and respectful. Staff interacted with patients in a caring way that was tailored to support each patient's individual needs.
- Staff were committed to supporting patients to fulfil their wishes For example, the chaplaincy service carried out a death bed wedding before a patient's passing.
- We observed a specialist palliative care handover meeting, which demonstrated an effective and thoughtful review of patients and appropriate sharing of information. It was evident that care was holistic and that staff had a good grasp of all the issues, including social ones. It was evident that staff were keen and passionate to continue to provide appropriate support to patients.
- Staff in the medical assessment unit which was short stay area only, adjusted their admission and transfer arrangements so that a patient who was approaching the end of life could stay with their partner, who was also a patient.
- Mortuary staff were compassionate, involved families and were empathetic.

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- Porters were proud of the service they provided, and were caring and responsive in providing a service that was respectful and dignified for patients and people close to them.
- The inaugural 'Care After Death' audit was carried out in 2015 and revealed that overall, across the acute and elective wards, the trust's Bereavement and Chaplaincy services were not being offered to bereaved families / carers, or if they were, it was not documented and reflected in the patients' notes. It was also noted that main areas of non-compliance were that patients' eyes and mouths were not closed and that patients were delayed to the mortuary. Following the 'Care After Death' audit, the Clinical Service Lead Palliative & End of Life put forward a number of recommendations for wards to further improve and become 100% compliant with the trust's 'Care after Death' policy.
- The service had access to a child and bereavement specialist nurse, who was able to provide longer-term follow up and independent support.
- The trust was in consultation with other providers on funding an alliance-based bereavement and donation team which would help support patients and people close to them. The funding would be predominantly linked to the donation service element. It was anticipated that there would be one band 7 bereavement person in each of the alliance trusts.
- The Bereavement Team offered three levels of support to patients and families. Level 1 included introduction of the team and the services they could offer; guidance and advice and exploration and facilitation of patients end of life wishes, for example, spiritual support, keepsakes and organ and tissue donation. Level two support identified any further needs and signposting to relevant agencies; multiple visits and discussions with families on reactions to the death of a loved one. Level 3 support included direct referral to other agencies, for example GPs and the RAID Team.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved in decisions and their plan of care and treatment.
- Staff were kind and compassionate with relatives, recognising that they were suffering through a very stressful period.
- Patients and their relatives told us how staff had established a good rapport with them, their relatives and close friends. All of the people we spoke with were complementary about the way staff had cared for and supported them.
- The trust had beds available for patients' relatives and aimed to get the patient and their relatives in a side room/ward when nearing the end of life. The needs of relatives were considered and people close to the patient were provided with food and shower facilities.
- The mortuary had a private visiting room for relatives, which smelled of fresh flowers. The room had a memory book, tissues, pens, leaflets and questionnaires and staff made every effort to provide a comforting and pleasant environment for bereaved families.
- Staff on the Bereavement Team were visibly passionate and committed and gave us examples where they had gone above and beyond to support patients and families. They were happy to visit patients or families in their own homes. For example, the bereavement nurse told us that she supported a patient to witness the funeral of her son by using a video capable application.
- The Bereavement Team was highly thought of by staff that we spoke to throughout the hospital and had offered emotional support to staff members who had been bereaved or were suffering distress as well as supporting families in the immediate aftermath of a death. However, the funding for the Bereavement Team had ceased (having been funded by another organisation) and the team structure was changing the week after we inspected the service, to become part of the Bereavement Alliance. The support offered by them was expected to be offered by ward staff following this though the trust had funded a Band 7 Bereavement Nurse to work as part of the end of life team.
- The Bereavement Alliance had access to a nurse in another trust in the triumvirate, who dealt with childhood bereavement and there was a bereavement midwife in Bolton.

Emotional support

- All members of the Specialist Palliative Care Team made follow-up calls to relatives following a patient's death to provide support at such a difficult time.
- All wards sent out a butterfly condolence card to every family that had been bereaved.

End of life care

- The service had leaflets available for children / teenagers: “saying goodbye to mum” / “saying goodbye to dad” and talked with children / young people about death. The service also used “dying matters” leaflets.
- A support nurse was in post that helped staff on the ward support families and with bereavement.
- The chapel had a memorial tree where families could tie remembrance ribbons and reflect or could write a prayer or message in a book of remembrance. Services of remembrance took place to support families, and these were attended by staff including the Director of Nursing who was responsible for End of Life care at the trust.
- The mortuary manager told us that the nicest part of her job was to look after bereaved relatives.
- The mortuary staff provided key rings/finger prints, casts for babies’ hands and feet, teddies and blankets for children and memory books. All wards also offered mementoes, such as ring boxes, bags for locks of hair and flower seeds (held in a substance shaped into a butterfly). There was a store of mementoes held on the wards.
- There was a lack of private rooms available to break bad news. However, we were told that there is a rolling ward refurbishment programme in place and resource rooms have been identified for private conversations.
- Patients’ records showed discussions of sensitive conversations that had been held with patients and relatives.
- We found people’s diverse needs were met and that there was appropriate provision of care for patients and their families in line with their personal or religious wishes.
- There was a clear work plan in place for end of life which showed measurable process. The Director of Nursing was the executive lead. The work plan focused on service planning to meet the needs of the local population and supporting individual’s needs and wishes. Progress made on the work plan reflected what we saw.
- The mortuary provided a 24 hour a day on-call service which supported people’s individual needs and wishes, and provided support for people close to the.
- The trust was able to facilitate rapid discharges, within four hours, so that patients could die in their preferred place of death, if this was at home.
- Complaints relating to end of life care were reviewed by the Chief Executive Officer and Director of Nursing. Contact with complainants was made straight away over the phone and a face-to-face meeting was offered, either at the hospital or at the complainant’s home.
- Belongings were ready for collection from the bereavement office in butterfly logo bags and this meant that the families did not have to return to the ward where the death had occurred

However,

- The Bereavement Team was being restructured imminently at the time of our inspection. The support offered by them to patients and families was expected to be undertaken by staff on the wards going forwards overseen by a Band 7 Bereavement Nurse. Corneal donations would be collected by an Eye Retrieval Practitioner across the three trusts in the triumvirate and there would be a Band 7 Child Bereavement Nurse and Lead bereavement Nurse in the triumvirate..
- There was a lack of private rooms available to break bad news to bereaved family and friends of a deceased patient. However, we were told that there is a rolling ward refurbishment programme in place and resource rooms have been identified for private conversations.

Are end of life care services responsive?

Good



We rated the End of Life (EoL) care services at the Royal Bolton Hospital as ‘Good’ for being responsive.

This was because: -

- There was a co-ordinated approach to meeting the needs of the local population, involving other organisations or teams across the area, such as the hospice, GPs, RAID Team and Bereavement Team. Patient needs were assessed which took into account their physical, social, psychological and spiritual needs so that support could be drawn from the appropriate source or service.

Service planning and delivery to meet the needs of local people

- SPCT staff had a good understanding of the needs of the local population. Staff worked as part of

End of life care

multidisciplinary teams and routinely engaged with local hospices, the trust discharge team, adult social care providers and other professionals involved in the care of patients.

- The team had established links with trust community services, such as district nursing teams and allied health professionals. Staff said this promoted shared learning and expertise and enabled patients transferred between services to have consistent care.
- There was a clear work plan in place for end of life which showed measurable process. The Director of Nursing was the executive lead. The work plan focused on service planning to meet the needs of the local population and supporting individual's needs and wishes. Progress made on the work plan reflected what we saw
- The mortuary provided a 24 hour a day on-call service to ensure that the correct documents could be issued in a timely way for the coroner, which ensured that people could then be released immediately without post-mortem which supported people's needs related to their faith and beliefs.
- There was open access for relatives to visit patients who were at the end of life.
- Staff were encouraged to meet the individual needs and preferences of their patients and their families such as open visiting, allowing relatives to stay on the ward, bereavement car parking and comfort packs (made up by a local Buzzy Bees Community Group).

Meeting people's individual needs

- The service was supportive in meeting requirements of different faith groups. There was a policy in place for the rapid release of a deceased patient from the mortuary. Medical and mortuary staff demonstrated an understanding of the processes to follow. This enabled the cultural wishes of families to be respected.
- The trust had adopted a butterfly symbol approach, which made staff aware of a family in need (identified by the symbol). This ensured that during difficult times families were supported (for example by staff offering drinks etc.). The scheme also ensured that the deceased's property was put into a special bag (with the symbol on). Relatives were offered a fingerprint, lock of hair and photo (from medical illustration) of the deceased patient.

- Where a patient was identified as having issues relating to learning disabilities, dementia or cognitive impairment staff could contact specialist nurses within the trust for advice and support.
- We observed nurses interacting with patients living with dementia on the bluebell ward, using a variety of dementia friendly strategies. Staff used aids, for example dolls, computers, karaoke and a piano. Interaction was approached in a caring way, and tailored to support each patient's individual needs.
- There was printed information available for patients and their relatives, including leaflets on what they needed to do after their relative died, as well as the emotional support available.
- The service used interpreters / language line where appropriate to do so.
- The medical assessment unit had a rest room with a television for relatives.
- The trust had a chaplaincy available for staff, patients and the public. The service had three prayer rooms (Christian, Islamic and Hindu) and three full-time volunteers from different faith groups, offering a 24-hour on-call service. The chaplaincy had good links with other chaplaincy services in the area, providing access to Jewish chaplaincy support and Buddhist support, and the chaplain linked in with the hospice chaplain.
- The chaplain told us that not all patients were offered spiritual support, however, because of work undertaken with the wider multidisciplinary team, the number of patients and people close to them seen had increased.
- Staff completed 'preferred priorities of care' (PPC) documents with patients, so that their individual wishes could be met.
- There were close working relationships with local registrars, who supported timely issuing of death certificates onsite for people collecting personal possessions.
- Belongings were ready for collection from the bereavement office in butterfly logo bags and this meant that the families did not have to return to the ward where the death had occurred
- Funding had been identified for two beds for overnight stays for relatives. However, at the time of this inspection no area had been identified for a relatives room.

End of life care

- We saw a number of interventions to support people's individual needs who were end of life, for examples symbols to help patients explain pain symptoms.

Access and flow

- There was a clear protocol for referring patients to the specialist palliative care team (SPCT). End of life care was delivered when required by ward staff throughout the hospital. The SPCT was accessible during normal working hours each day. Outside of those hours, arrangements were in place so that staff and patients were supported.
- An audit carried out in January 2016 showed that the hospital SPC Team received 20 referrals in one week and all patients were seen within 24 hours. We were told by the team that patients were almost always seen within this timescale. However, the same audit showed that of the 19 referrals received by the Community Specialist Palliative Care Team in the same week, only 1 patient was seen within 24 hours. The trust have told us that Community referrals are triaged within 24 hours and can be seen within 24 hours if required.
- The trust had a rapid discharge service for discharge to a preferred place of care (PPC). Following on from NICE guidance, the National End of Life Strategy (2008) was clear that people at the end of life should be able to make choices about their place of death. The rapid discharge pathway was to support patients to be discharged from hospital in the last hours and days of life. Wherever possible, staff aimed to support this within four hours.
- The trust had a target to increase the percentage of death in the usual place of residence to 45% by March 2016. Trust analysis showed that in the last quarter of 2013/14, the percentage of persons dying in their preferred place was at 44%.
- We saw examples where patients were supported to be transferred to their preferred place of care. For example, a patient had expressed a wish to go home so they could be looked after in their sun room overlooking the garden and the trust were able to facilitate this.
- Doctors completed a 'Statement of Intent' to indicate that following discharge of an EoL patient, the patient was expected to die at home, possibly before their own GP could review them (this happened usually over the

weekends). The 'Statement of Intent' prevented the involvement of a coroner or the police when the patient died at home, thus preventing further distress to the deceased patient's family and friends.

- The mortuary's viewing time was 3pm to 5pm; however, there were on-call arrangements in place, which meant that loved ones were able to visit the mortuary.
- There were policies and procedures in place to support extra capacity requirements in the mortuary, which were part of peak time escalation procedures.
- Post-mortems usually took place in the morning so that people could then be released to undertaking teams, which supported individual's needs and wishes.
- There was a lack of private rooms available to break bad news to bereaved family and friends of a deceased patient. However, we were told that there is a rolling ward refurbishment programme in place and resource rooms have been identified for private conversations.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Records we reviewed confirmed that all complaints should be recorded on a centralised trust-wide system.
- All End of Life care complaints were reviewed by the Chief Executive Officer and Director of Nursing. Whilst these were responded to trust within 35 working days, which was trust policy, contact with complainants was made straight away over the phone and a face-to-face meeting was offered. This was undertaken at the hospital or at the complainant's home. The Director of Nursing visited complainants in their home and listened to concerns that had been raised.
- There had been three complaints raised relating to end of life and we saw evidence that learning had been taken and shared across staff groups to support end of life care.
- New initiatives had been implemented from learning from concerns and complaints, for example including starting bereavement cafes to maintain on going support to bereaved families
- The trust had started to send out bereavement surveys to families around two weeks after a patient death. They had not collated any results at the time of our inspection but planned to use the results to capture feedback and improve care and support before and after death.

End of life care

Are end of life care services well-led?

Good



We rated the End of Life (EoL) care services at the Royal Bolton Hospital as 'Good' for being well-led.

This was because: -

- We observed evidence of good leadership, with a clear view of strategy with regards to rollout of the Record of Dying Care, the treatment escalation plan and advanced care planning.
- Staff told us that the management team worked well together, that leadership was good and that the service was now more organised and responsive.
- Staff told us they were proud of the service they provided, in particularly about the discharge pathway, being able to see patients quickly and the good relationships with other services.
- Staff told us that they were proud of having brought hospital and community teams together.
- The mortuary staff had won the 'non-clinical team of the year' award at the Trust Staff Awards 2015; they were very proud of this.
- Mortuary staff told us that the executive team and chief executive are supportive.

However,

- Although Porters overall felt valued, they told us that some wards were friendlier than others were and in some wards, some nurses were not helpful in helping to move equipment.
- Some staff did not feel supported through the consultation period and were unclear on what the future of bereavement services looked like going forward.

Vision and strategy for this service

- We saw evidence of an effective, overarching strategy for end of life care.
- We observed evidence of good leadership, with a clear view of strategy with regards to rollout of the Record of Dying Care, the treatment escalation plan and advanced care planning.

- There was a Palliative and End of Life Care work plan that supported the strategy. Progress of actions was shown on the plan and they were given a red, amber or green rating to indicate whether they were on target.

Governance, risk management and quality measurement

- Monitoring arrangements were in place through the end of life committee to ensure that risks and quality of care related to end of life care were delivered in accordance with the strategy of the service.
- The Clinical Lead Palliative Care Consultant presented a report on end of life care to the Board on an annual basis, in order to provide assurance on governance, risk and quality of care.
- An annual report on end of life patients was presented to the Patient Experience The End of Life Committee, escalated and operational or strategic risks or incidents to the Quality Assurance Group and then to the trust Board.
- The Chaplaincy was well linked into the governance system. For example, they attended corporate governance meetings every two weeks, had links with the wider multidisciplinary team and attended patient experience, equality and diversity and prevent (radicalisation) groups
- The palliative and EOL risk register counted six risks, with a risk score of eight or above. However, the risk register supplied by the trust had no action plans attached to the risks.
- Staff told us that the 'do not attempt cardiopulmonary resuscitation' (DNACPR) document did not match with the policy. The DNACPR form in use was part of the unifies DNACPR policy for the North West adopted for use in Bolton. the form in use was universal to all areas of the health care economy in Bolton and the North West. DNACPR was included on the Corporate Risk Register because of the need to be assured that practice was in keeping with policy and was embedded within the trust.

Leadership of service

- The Director of Nursing had overall responsibility for end of life care in the trust and presented on this to the Executive Board.
- We were told that specialist palliative care team had been subjected to a number of reorganisations up until

End of life care

12 months prior to the inspection. However, staff told us that the management team worked well together, that leadership was good and that the service was now more organised and responsive.

- The Assistant Director of Nursing for Bereavement across the triumvirate trusts was extremely passionate about end of life care across the trust and empowered staff to “break rules that don’t exist” when it came to delivering good end of life care.

Culture within the service

- We found all staff to have a positive approach to end of life care and the culture was to continually improve services collectively across services.
- Staff in the mortuary took dignity of the deceased very seriously and carried out dignity checks on receipt of the body and raised any breaches of dignity through incident reporting in order to improve practice.
- There was an open and honest culture in all services related to bereavement and end of life. This was supportive to staff, patients and the public.
- Some staff did not feel supported through the consultation period and were unclear on what the future of bereavement services looked like going forward.

Public engagement

- There were a number of initiatives in place to promote public engagement in end of life care.
- The service participated in a ‘dying matters’ awareness week and a sponsored ‘bereavement café’ event, both public events. Forty two people who had recently lost a loved one were invited to the first “Bereavement café”

that had been sponsored by a major supermarket. The supermarket had worked with the trust to introduce a buddy shopping service for newly bereaved persons and had produced a leaflet on how to shop.

- Surveys were given to families around 2 weeks after bereavement to give people the opportunity to provide feedback to the trust and this was used to improve services.
- The EoL care steering group had a layperson as a member on the team. Each group meeting started with a patient’s story.
- The service linked in with the local Health watch and the patient experience committee for feedback.
- We were told that the service was exploring the option of capturing video stories.







Staff engagement

- Staff in the service were able to take part in trust initiatives such as listening event and local staff surveys.
- There were a number of mechanisms in place to support staff engagement through the intranet, team brief and meetings, which they said they found useful.
- Porters overall felt valued, however, they told us that some wards were friendlier than others and in some wards some nurses were not helpful in helping to move equipment.

Innovation, improvement and sustainability

- The bereavement team had won a number of awards between 2009 and 2014.
- The mortuary staff had won the ‘non-clinical team of the year’ award at the Trust Staff Awards 2015; they were very proud of this.

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

Outpatient and diagnostic imaging services are provided from a number of departments on the Royal Bolton hospital site. Some specialities such as ophthalmology and ear, nose and throat have specific departments in the hospital because specialist equipment is needed. Other specialities use general outpatient consulting areas such as J block or general outpatients. There were a total of 362,678 outpatient attendances at Royal Bolton between September 2014 and August 2015.

Diagnostic imaging provides a range of imaging services including plain film x-ray, ultrasound, CT scanning (two scanners), magnetic resonance (MR) scanning (one scanner), mammography, nuclear medicine and interventional radiology within four separate areas in the hospital. Services are provided for inpatients, outpatients and patients in accident and emergency. In excess of 220,000 radiology examinations are carried out each year.

During our announced inspection we visited the following areas: J block outpatients, general outpatients, ear nose and throat, the eye clinic, radiology, nuclear medicine, breast clinic and the Churchill unit. We carried out an unannounced inspection at the orthopaedic fracture clinic and returned to the eye clinic for further information on 6 April 2016.

We spoke with 45 staff, including nursing staff, doctors, support and administrative staff, porters, allied health professionals and volunteers. We also spoke with 28

patients or their relatives using the services at the time of our inspection and reviewed 16 sets of patient records. We observed care and treatment and looked at information provided by the trust and other information we requested.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging as good because,

- Staff were encouraged to report incidents and lessons were learnt and shared. There were established systems and practices in place to protect patients and staff from radiation and radioactive substances.
- 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.
- Services followed national and local guidelines based on evidence based practice and 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.
- Patients were treated with dignity and respect by caring, compassionate and kind staff. Patient feedback about staff was positive. High numbers of patients would recommend outpatient and diagnostic imaging services to their friends and family.
- Clinical nurse specialists for a range of health conditions were available to provide additional emotional support. Psychologists provided additional emotional support to patients on the breast unit and Churchill Unit.
- There were a number of rapid access and one stop shop clinics. Emergency referrals could be seen on the same day in the eye clinic. Services had been planned to meet the needs of local people.

- 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.
- 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.
- Leaders at all levels were described as supportive. Staff were supported to develop leadership skills.

However,

- In the eye unit, audit systems did not provide assurance that safety checks were being carried out following a serious patient safety incident.
- Records were not always stored securely and IT systems were sometimes left logged on and unattended. They were not always well organised or contained minimum patient identifiers and 38% of incidents reported for outpatients and diagnostic imaging related to issues with records.
- In interventional radiology, the most recent audit of the use of the safer surgery checklist showed this had only been completed in 47% of cases.
- Ninety-nine per cent of patient records were supplied by health records for outpatient clinics, however, we noted that this figure was based on notes available at the end of clinic rather than at the time of the appointment.
- Clinics in outpatients often ran late and patients were not always informed of delays. 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.

Outpatients and diagnostic imaging

- Some services had outgrown the clinical space available, meaning that areas were frequently overcrowded or additional clinic capacity could not be accommodated.
- There were not adequate plans in place to support the delivery of services on the Churchill unit during times of staffing shortages.

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 imaging services had established systems and practices in place to protect patients and staff from radiation and radioactive substances.
- 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,

- In the eye unit, audit systems did not provide assurance that safety checks were being carried out following a patient safety incident.
- Records were not always stored securely and IT systems were sometimes left logged on and unattended. They were not always well organised or contained minimum patient identifiers and 38% of incidents reported for outpatients and diagnostic imaging related to issues with records.
- Clinic notes were not always available at the time of the appointment.
- In interventional radiology, the most recent audit of the use of the safer surgery checklist showed this had only been completed in 47% of cases.

Incidents

- 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.

Outpatients and diagnostic imaging

- Between February 2015 and January 2016, 825 incidents were reported via the National Reporting and Learning System (NRLS). 76% of these incidents were graded as no harm indicating there was a good reporting culture within outpatients and diagnostic imaging. Staff were able to explain how learning from incidents was shared and gave examples of how practice had been changed.
- 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 PACS system and three were repeat mammographies being undertaken. New systems had been put in place to reduce the likelihood of these types of incidents happening in the future.
- Duty of candour was understood by staff we spoke with and 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. Senior staff told us about a recent example where the duty of candour had been applied following an incident with a faulty needle. They explained how the duty of candour was applied and the actions they took including informing the MHRA and removing all needles from the same batch from within the hospital.
- On the eye unit, we were told about an incident in 2013 where a patient had experienced a corneal burn during a laser procedure. A root cause analysis had been undertaken and learning identified, including the need to check the alignment of the laser equipment. Results of routine audits completed to ensure that laser equipment was checked at the start of each session did not provide assurance that the lessons had been fully learned. The most recent audit in March 2016 showed that the one type of laser had been checked 72% of the time and the other type 70%. We spoke with senior staff who told us that documentation of these checks may lead to low results and that plans were in place to change the method of documentation.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy. Domestic staff cleaned the outpatient and radiology departments out of hours to minimise disruption to appointments. An "I am clean" labelling system was in use which supported staff in identifying equipment that was ready to use.
- We saw staff using personal protective equipment (PPE) 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 over 97% compliance in outpatients, radiology, ophthalmology, breast unit and therapies. In fracture clinic, hand hygiene audit scores were lower at 87%.
- Weekly cleaning rotas for dressing trollies in fracture clinic were not always completed. The rota had only been signed on four dates between January and March 2016, however on inspection the trollies were clean. Staff told us cleaning was carried out, but was not always documented. In other areas, cleaning rotas were completed and signed appropriately.
- There were procedures in place in radiology to support 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. Annual

Outpatients and diagnostic imaging

infection control audits were completed. The breast unit had scored 87% in the environmental audit, but we did not see evidence that other departments received a percentage score. This meant that departments may not be able to easily monitor improvements or deterioration over time.

- In diagnostic imaging, the aseptic non-touch techniques (ANTT) was used when patients were undergoing invasive procedures such as cannulation. ANTT reduces the risk of infection during invasive procedures.
- In podiatry, equipment was decontaminated using an autoclave. Although this still met the Society of Chiropodists and podiatrists standards, the department was working towards using single patient use equipment.
- We saw that one sharps bin had been assembled but did not have the date or department documented as per protocol.
- In haematology, clinical waste and general waste bins had incorrect bags within them. This meant that clinical waste may be being disposed of incorrectly and may pose a risk to the control of the spread of infection.

Environment and equipment

- Emergency equipment was checked daily and weekly although in fracture clinic we saw that logs did not record the tag number securing the trolley. This meant that the contents of the trolley could be tampered with and staff would not be aware of this. The daily oxygen, Entonox (gas and air) and suction checklists were not consistently completed in the fracture clinic.
- All the equipment we checked including vital observations machines, hoists and plaster saws had been maintained correctly and was clearly labelled with the date that the next test or service was due.
- There were warning signs and restricted access to non-ionising radiation premises. The nuclear medicine department was alarmed when closed to ensure radioactive substances were kept safely.
- 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. We noted that one of the

jackets on the mobile x-ray machine had a small hole on the back where the fastening had detached. This was immediately removed from use by the radiology manager. 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 there were radiation protection supervisors in each area.
- Disposal of radioactive waste by the nuclear medicine department was monitored and was in line with permitted levels.
- J block outpatients had moved to its new location in December 2015. There were temporary signs in use and no permanent reception desk; however staff had done their best to manage patients in this environment. There were two entrances to J block outpatients. Patients arriving internally via the hospital had to walk through the department before arriving at reception.

Medicines

- Medicines were stored appropriately in all areas we visited. Medicine cupboards and fridges were locked, with designated key holders having access to these storage areas.
- Controlled drugs (CDs) were stored safely and entries in the CD book were mostly double signed. Staff in fracture clinic explained that at weekends there was only one trained staff member on duty and there was a trust policy to allow them to give up to 30mg of the oral morphine without a second signature at these times. We observed that the log entries were regularly checked by a pharmacist. Pharmacy technicians checked stock medicines and expiry dates weekly in outpatient areas.
- We noted that the pharmacy department had recently updated guidance for checking temperatures and this now included checking room temperatures. This was not widely known by staff we spoke with and some areas did not have access to room thermometers.
- Chemotherapy was delivered daily by an external agency to the Churchill Unit and stored in line with recommended procedures. It was disposed of by the external agency.

Outpatients and diagnostic imaging

- No FP10s (outpatient prescription forms) were stored in outpatients. Doctors issued hospital prescription forms which patients used at the hospital pharmacy. Prescription forms were mostly stored securely, although in general outpatients, the prescription pad was stored in a locked cupboard, along with personal belongings that only one member of staff had access to.
- Medical gases were not always stored safely and securely. In fracture clinic, oxygen and Entonox were stored unsecured in an unlocked clinic room and we also saw that oxygen was stored in a physiotherapy area in J block outpatients. Signs were in place to identify where medical gases were being stored.
- In nuclear medicine, isotopes (radioactive substances) were delivered daily. These were logged and stored in lead boxes to protect staff and patients from radiation. Staff used a hand held scanner to check radiation within the clinic area and patient bathrooms that may be contaminated by radiation. Procedures were in place to ensure that radiation levels were safe prior to cleaning or disposal of contaminated equipment.
- Patient group directives (PGDs) were in place in nuclear medicine and radiology to allow isotopes or contrast media to be administered by injection. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription.
- On the Churchill unit, we found a labelled bag of a patient's take home medication that had been in the medication cupboard since September 2015. We highlighted this to the nurse and this was removed to be returned to the pharmacy department.
- 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.
- On the day of our inspection at J block outpatients, four out of 56 patients were seen without their medical record.
- The health records library was available 24 hours a day, seven days a week meaning that patient records could be accessed out of hours.
- 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.
- 38% of incidents reported via NRLS were categorised as documentation incidents. Incident categories included case notes missing, documentation wrong and misfiled.

Records

- Records were paper based, with electronic reporting of results and letters. In J block outpatients, general outpatients, the breast unit and the eye unit we saw that notes were left unlocked and unsecured. We also saw that computer systems containing personal information and results such as x-rays were left logged on in unattended clinic rooms. This meant that members of the public could access these notes and confidential patient information.
- Data provided by the trust showed that over 99% of all case notes requested throughout the trust were
- Records we reviewed were not always well organised or contained minimum patient identifiers on each page. In J block outpatients we reviewed six sets of records and found that three of these were poorly organised. In fracture clinic, each of the five sets of records we reviewed had pages where the minimum information was not documented. This meant there was a risk that patient information could be misplaced or lost.
- Information governance training, which includes training on records and record keeping was 97%.

Outpatients and diagnostic imaging

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. 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. The trust were unable to provide us with details of how many staff had completed safeguarding children level three for outpatient and diagnostic imaging areas that regularly provided care and treatment for children, such as ENT, fracture clinic and radiology.
 - In interventional radiology, an adapted version of the World Health Organisation Surgical Safety Checklist was in use. The most recent audit showed that in 2015 the WHO checklist had been used in 42% of interventional procedure case notes. The reasons for the low results had been considered and changes implemented, including clearer guidelines as to which procedures the checklist should be used for and looking at whether the checklist is being scanned to the record system before patients are transferred back to the ward. There were plans in place to use a different checklist, more suited to interventional radiology and this was awaiting approval from the governance board at the time of our inspection.
- An early warning score (EWS) system was in use for patients undergoing interventional radiology procedures. There were systems in place to transfer patients to accident and emergency or the high dependency unit if they deteriorated during a procedure.
 - EWS were recorded for patients arriving in fracture clinic from accident and emergency. This allowed nurses to monitor any deterioration and take appropriate action if a patient became unwell. Patients awaiting admission also had an assessment of their risk of developing pressure areas and pressure relieving equipment was provided if necessary.
 - 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.
 - 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.
 - There were protocols in place provided by another provider for nursing staff to assess patients prior to the delivery of chemotherapy, to ensure it was safe to deliver the treatment.
 - Patient safety checklists were completed and double checked for patients attending for a magnetic resonance (MR) scan.
 - In the haematology department, staff were able to tell us how they called for help in an emergency but did not know where the nearest crash trolley was located.

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.
- All outpatient and diagnostic imaging areas met the trust target of 85% for mandatory training. Outpatients, therapies and radiology were all above 90% training. In breast services, the rate was slightly lower at 89%.

Assessing and responding to patient risk

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.
- 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.

Outpatients and diagnostic imaging

- In general outpatients (J block, GOPD) there were nursing staff vacancies (1.95 WTE), however these were not being recruited to. We were told this was because the department was managing with regular bank staff. Nursing staff from general outpatients also staffed clinics at Bolton One. In interventional radiology, there were no nursing staff vacancies.
- There was a good level of skill mix in outpatient departments. Registered nursing staff were used alongside band 2 and 4 unregistered staff workers. On the eye unit, nursing staff were rotated across the different specialist areas to ensure the right skill mix was available and that staff could be moved to other areas if required. The eye unit had applied to receive funding to create advanced nurse practitioner role within the clinics.

Medical staffing

- Consultant radiology was available overnight and at weekends on call.
- 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.
- There was one speciality doctor vacancy in ophthalmology.
- 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%.

AHP Staffing

- 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.
- There were four full time equivalent vacancies for phlebotomists.
- 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. 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 provided when this was needed, for example interventional radiology and in fracture clinic.
- 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 within 5 days of the appointment and for some specialities this was as low as 36%.

Evidence-based care and treatment

- Diagnostic imaging followed national guidelines to prioritise patients based on clinical need

Outpatients and diagnostic imaging

- 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.
- There had been a recent review of the diabetic eye screening programme. This programme aims to reduce the risk of sight loss for people with diabetes. There had been 19 recommendations following this review to ensure the service delivered in line with the national common pathway, including the need to review how the service is commissioned to ensure compliance with national best practice.
- Local audits were completed in radiology to review practice and drive service improvement. Recently, an audit of virtual colonoscopies and MR whole spine had been completed.
- Outpatient therapies 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. Staff members also attended the Greater Manchester regional clinical effectiveness groups to share learning and best practice.
- 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.
- The breast unit was involved in the enhanced recovery programme for patients who were planned for surgery. Enhanced recovery is a programme to improve patient outcomes and recovery following surgery and ensures patients receive evidence based care.
- 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.
- There were a number of nurse practitioners and extended scope physiotherapy practitioners within outpatient departments. Physiotherapists had been supported to develop skills in steroid injections and acupuncture and occupational therapists had gained competencies for wound care in fracture clinic.

Pain relief

- Pain and pain relief was discussed when required during outpatient consultations.
- There were supplies of pain relieving medication such as paracetamol in all outpatient areas staffed by nurses. Stronger pain relief was available in fracture clinic, such as Entonox and opiates.
- Pain was assessed and documented on observation charts in fracture clinic and interventional radiology. There were child friendly pain assessments available.
- Pain was managed in interventional radiology with Entonox, intravenous fentanyl and patient controlled analgesia.

Patient outcomes

Outpatients and diagnostic imaging

- Nursing staff on the Churchill unit had received training to assess patients prior to chemotherapy and to deliver chemotherapy. They were involved with the North West oncology collaborative to share knowledge and skills.
- In diagnostic imaging, there were a number of radiography staff with extended skills. These included plain film x-ray and CT head reporters.
- Appraisal rates were 95% for outpatient and diagnostic imaging staff. This was above the trust target of 85%.
- 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 or perform echocardiograms (ECGs). Assistant practitioners were used in general outpatients to perform Doppler scans and change wound dressings.
- In fracture clinic, staff were trained to develop specific competencies in plaster techniques, wound care and removal of sutures.
- 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.
- Lunchtime continuing professional development sessions were held weekly in radiology. These sessions were where staff shared learning internally.
- In the fracture clinic, there was daily input from occupational therapy and physiotherapy. The service ran 'Q-clinics' which were joint clinics with consultants and therapists for patients with orthopaedic problems.
- The out-patient podiatry service had a service provided an in-reach service to inpatients and there was a service level agreement with the mental health trust which provided some services on the Royal Bolton Hospital site. The team had also developed shared care pathways with district nurses and the tissue viability team.
- Telephone advice was available from the eye unit to GPs, accident and emergency and optometrists.

Seven-day services

- There were radiographers on site 24 hours a day, seven days a week to provide plain film x-rays, mobile x-rays, CT scans and theatre imaging. Outpatient appointments for CT and ultrasound were available in the evening and on Saturdays. The radiology department had plans in place to increase to seven day working.
- Interventional radiology was available 24 hours a day.
- Fracture clinic was open seven days a week, although on Saturday and Sunday the clinic was only open until lunch time. There were some weekend clinics held in outpatients but these were part of waiting list initiatives to ensure trust targets were met.
- Outpatient therapies were provided Monday to Friday. They had surveyed patients to look at the demand for appointments at weekends. They found that patients wanted appointments on their way to or from work and so extended the hours of service provision Monday to Friday.
- Evening clinics were run in the breast unit on Mondays and Thursdays until 8pm.
- The TIA clinic aimed to see patients within 24 hours of referral, however, the service was only available Monday to Friday, meaning that patients referred on a Friday did not get seen over the weekend.
- Patients from the Churchill unit had access to clinical advice via an advice line, which was provided by another provider.

Access to information

Multidisciplinary working

- There were multi-disciplinary team clinics for some specialities such as inflammatory bowel disease and on the breast unit.

Outpatients and diagnostic imaging

- There was electronic access to diagnostic results and images throughout the Greater Manchester area.
- Only 73% of clinic letters were sent to GPs within five days of the appointment. The trust target was that 99% of letters would be sent within this time frame. This was particularly poor for oncology clinic letters (36%) and maxillo-facial (63%) department told us this was a particular problem. We were told that often clinic letters had not been typed when patients attended for the next appointment. Secretaries told us some of the difficulties were due to staffing problems. Senior staff told us that there had been a recent external review to look at this issue and they were awaiting the report at the time of our inspection. The trust had already implemented a number of actions to improve clinic letter turnaround times, including offering overtime until new secretaries could be recruited and trialling remote access to allow secretaries to work in quieter environments.
- We were told that there were two IT systems in use across the hospital and community services were not. This meant that information could not be shared between services easily.

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.
- Consent was taken by the consultant in charge for interventional radiology. This was completed outside of the procedure room in line with best practice. Medical staff also led consent for cataract procedures using specifically developed consent forms.
- On the day of our inspection in J block outpatients, we saw that the team held a best interests meeting for a patient who did not have capacity to consent to treatment. This meeting had been attended by members of the multi-disciplinary team, the learning disabilities nurse and a patient advocate in line with good practice.

Good



We rated caring as good because:

- 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 were available to provide additional emotional support. Psychologists provided additional emotional support to patients on the breast unit and Churchill Unit.

Compassionate care

- Privacy and dignity was maintained at all times in the areas we visited. Patient feedback in outpatient therapist showed that 100% of patients felt their privacy and dignity was maintained. 100% of patients also reported that their therapist had been kind, courteous and caring.
- Reception staff were friendly and helpful, although there were no facilities to prevent patients from being overheard at reception desks.
- Chaperones were available when required in outpatient areas. They were provided at all times in the breast unit. All mammographers were female to ensure patients felt as comfortable as possible during breast screening. We saw patient feedback describing mammography as an “outstanding service at a time when patients are feeling vulnerable and worried”.
- Feedback from patients we spoke with was very positive. They told us staff were very friendly, approachable and gave them time to discuss any particular needs. Patients told us they felt very welcomed and at home on the Churchill unit and that staff were reassuring.

Are outpatient and diagnostic imaging services caring?

Outpatients and diagnostic imaging

- Friends and family test for the breast unit was 95% between December 2015 and February 2016. Overall for outpatients, 92% of people would recommend the service to their family or friends.
- In radiology, the most recent patient experience audit showed 100% positive feedback.

Understanding and involvement of patients and those close to them

- There were welcome boards in each of the areas we visited, identifying key members of staff within that department (for example the matron and department manager) and also showing what different coloured uniforms were. This meant that patients had a better awareness of who staff caring for them were and their job roles.
- We saw that patient information leaflets were available in outpatient areas we visited. These included leaflets produced by charity groups and by the trust.
- Patients were sent clinic letters following their appointments to ensure they were kept informed about the outcomes and future treatment plans.
- In the inflammatory bowel disease (IBD) clinic, patients were given a 'patient agenda sheet'. This was an opportunity for the patient to consider what they would like to discuss during the consultation and what was most important. This meant that the consultant could review this information, discuss what mattered most to the patient and prioritise other items for discussion.
- On the Churchill unit, which was a specialist oncology and palliative care outpatient unit, patients were encouraged to bring family and friends with them. At the first appointment, patients were shown around the unit, offered time to discuss any particular concerns and provided with information about treatment and keeping well during chemotherapy. Similarly on the breast unit, patients told us their relatives and friends had always been welcomed to attend the appointment and during any investigation.
- Patient satisfaction surveys in outpatient therapies showed that patients were given information and time and opportunity to ask questions about their care and treatment.

Emotional support

- There were a number of clinical nurse specialists available to offer additional emotional support to patients. These included breast care nurses, COPD nurses, IBD nurses, children's diabetes nurses and rheumatology nurses. Additionally there was a nurse consultant for IBD. In the breast clinic, the breast care specialist nurse was available to consult with patients following a cancer diagnosis to begin forming a supportive relationship.
- Patients on the breast unit valued the additional emotional support available to them from the breast care nurse and psychologist.
- Volunteers were available on the Churchill unit to spend time with patients and offer additional emotional support. The volunteer we spoke with had previously been a patient at the unit and could therefore share her insight and experiences. There was also a monthly support group for patients receiving chemotherapy or had had this in the past.
- Patients undergoing treatment on the Churchill unit had access to a clinical psychologist for additional emotional support. One of the nurses had also undertaken additional training to complete anxiety and depression assessments and deliver low level support to patients experiencing this. There was access to two psychologists for patients in the breast unit.

Are outpatient and diagnostic imaging services responsive?

Good



We rated responsive as good because:

- There were a number of rapid access and one stop shop clinics. Emergency referrals could be seen on the same day in the eye clinic. Services had been planned to meet the needs of local people.
- Diagnostic waiting times had been consistently better than the England average between January 2014 and November 2015.
- The trust had performed consistently better than the England standard for incomplete pathways referral to treatment times

Outpatients and diagnostic imaging

- Overall, the 95% 18-week target for non-admitted patients was met each month between April 2015 and December 2015.
- 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 often ran late and patients were not always informed of delays. 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.
- The 18-week target for non-admitted colorectal and trauma and orthopaedic patients was missed in each month between April and December 2015.
- In the main radiology department, there was no separate area for inpatients to wait. This meant that inpatients on trolleys or in beds, usually in nightwear or gowns, waited in the same area as outpatients.
- Some services had outgrown the clinical space available, meaning that areas were frequently overcrowded or additional clinic capacity could not be accommodated.

Service planning and delivery to meet the needs of local people

- A one-stop breast clinic service was provided. This meant that patients referred with symptoms of breast cancer could have consultations with the medical team and any necessary investigations carried out in one visit to the hospital. Patients then returned a week later for test results. Pre-operative assessments were also carried at this time for patients who needed surgery.
- The IBD clinic was also a one-stop clinic, with consultants, a consultant nurse and specialist nurse present. ENT provided a one stop head and neck clinic where patients can be seen by a consultant, have their investigations and receive the results on the same day.

- There was a rapid access transient ischaemic attack (TIA) clinic. Patients were seen within 24 hours of referral during the working week. Referrals were triaged by a consultant and investigations were requested prior to the appointment time.
- Emergency referrals were accepted at the eye unit. Referrals came from accident and emergency, GPs and optometrists. Referrals were triaged and urgent referrals were seen on the same day and with less urgent referrals seen within 48 hours. The eye unit also provided a satellite clinic at a neighbouring hospital site three days per week.
- A drop in clinic was held once a week on the Churchill unit for patients with particular concerns or issues. In the fracture clinic, a similar system was available to patients who could drop in to the clinic at any time if there was a problem.
- One patient told us that she had requested to have chemotherapy at Bolton as this was closer to home and more convenient than travelling to the regional centre. Patients said that the unit was easy to access and were appreciative of free parking due to the frequency of visits to the unit.
- There was an x-ray room located with the fracture clinic. This had reduced the numbers of patients attending the main radiology department and improved patient flow within fracture clinic.
- The breast screening service operated sites in Rochdale, Bury and at Bolton One.

Access and flow

- The did not attend (DNA) rate for outpatients was around 8% which was above (worse than) the England average of around 7%. In radiology, the DNA rate was lower 4.5%. DNA rates were high for musculoskeletal outpatient therapy appointments at 11.3%.
- The trust was using a call reminder service to try and reduce the DNA rate. This was either a voice recorded message to a landline or text to a mobile phone. Patients over 65 received a phone call from an operator. Patients who did not attend were offered one further appointment. Following this if they failed to attend, the referrer would be informed and no further appointment booked.

Outpatients and diagnostic imaging

- Data showed that follow up to new appointment rates were similar to other trusts.
- Clinics often ran late because clinic notes were not available. White boards displayed the clinic type, staff in clinic and had space to display any delays but we saw that delay times were not always written, even when there were delays. We saw this in J block outpatients, haematology and general outpatients. Patients we spoke with had not been verbally informed of the clinic delay. Senior staff told us that if delays were particularly long, patients were offered the choice to rebook their appointment.
- 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.
- The trust had performed consistently better than the England standard for incomplete pathways 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.
- In the eye clinic in from November 2014 to November 2015, a total of 6558 patients had been overdue a follow up appointment by at least four weeks. Of these, 315 patients were still awaiting a follow up appointment in November 2015. However, this number had substantially decreased over the previous six months from 1060 in April 2015. The trust was outsourcing some of the ophthalmology outpatient appointments at weekends to reduce the numbers of patients waiting.
- Clinic finish times were monitored and reasons for delays documented. We saw that on most days there was a least one clinic running late. Out of ten days we checked in J block outpatients, clinics ran 30 to 60 minutes late on six days. The records we saw did not always document the reason for the delay. The musculoskeletal therapy team audited whether patients were seen on time. In March 2016, only two patients waited longer than 10 minutes for their appointment, out of a total of 271 patients seen. The trust told us that 10% of patients waited over 30 minutes to see a clinician but individual departments within the trust told us they did not log or audit whether patients were seen on time or not.
- Data provided by the trust showed to 10.65% of clinics started late.
- 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 had been increased by 2 months from 36 to 38 months and the trust had met the target that 90% of women would be screen within this time frame in February 2016. However, compared to the national target 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 meet 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 March 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.
- 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.
- In the breast unit, capacity was managed to ensure the unit met the two week suspected cancer wait target. When appointments were cancelled by patients, staff filled the appointments with other ladies awaiting appointment times. On the day of our inspection on the unit, two patients had cancelled and the unit had ensured both of these appointments were used by other patients. This included a lady who had been a previous

Outpatients and diagnostic imaging

patient who had found a lump and called the department that morning and at the time of our inspection, was in the unit undergoing diagnostic testing.

- The environment in some of the areas we visited limited the capacity to see patients. In the eye unit, we were told that often there were insufficient numbers of clinic rooms available to hold consultations or waiting areas for patients and the demand for appointments in the breast unit had outgrown the space available. These areas were frequently overcrowded. This had been recognised by the leaders of the services. We saw that as part of the divisional objectives, work was ongoing with estates to develop a plan to reduce the level of overcrowding in both of these areas.

Meeting people's individual needs

- There was a dementia lead in place for the trust. The dementia steering group for the trust had produced an 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. On the day of our inspection there had been a best interests meeting in outpatients for a patient with a learning disability. This had been supported by the learning disability nurse.
- Equality and diversity training had been completed by 97% of staff. Translation was provided face to face. There was access to a telephone translation service if this was not available. In interventional radiology, face to face translation was always used to ensure that patients fully understood the procedure.
- On the eye unit, we saw that patients could access information leaflets in other languages, in large print or audiotape.
- Car parking was provided free of charge to patients receiving regular chemotherapy at the Churchill Unit. The environment was welcoming, light and airy and there were good facilities for patients and their carers.
- There were children's waiting areas in radiology, fracture clinic, ENT and ophthalmology. Although these areas were small, we did not see that they were overcrowded.
- The ENT department had recently invested in an examination couch to use with bariatric patients. Bariatric scales were available in J block outpatients.
- A phlebotomy service was only available in the morning in J block outpatients. Outside of this time, patients had to walk to the pathology department in the main hospital building. Nursing staff reported that they would take bloods if the patient had particular needs for example, we frail or elderly and would be unable to walk to the pathology department. At the time of our inspection a review of phlebotomy services was in progress. The phlebotomy team were auditing the number of patients attending as 'walk-ins' from outpatient areas to monitor the need to provide this service in the afternoon. It was not clear why the decision had been made to provide this service at some times and not others.
- Changing areas were available in diagnostic imaging services. In the breast unit, patients were able to change in the mammography room. We also saw that there were television screens providing music and images to help patients feel relaxed during the mammography examination.
- In ENT, nursing staff and consultants visited patients who were unable to attend a hospital appointment to carry out interventions that district nurses were unable to complete such as changing tracheostomy tubes. This was not a commissioned service.
- In fracture clinic, there was a stretcher available for patients attending from A and E. patients were able to wait in this treatment room, away from other outpatients. Staff were able to provide a bed if patients needed this following a long wait in A and E.
- In radiology, there was no separate area for inpatients to wait. This meant that patients in beds or on trollies who were wearing nightwear or theatre gowns waited in corridors for their scans or to be taken back to the ward by porters. During our inspection we saw that staff did their best to move patients through into scanning rooms quickly. In the MR department, there was an area for these patients screened by a curtain.

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- The optical coherence tomography (OCT) scanner (a scanner to assess eye health) was located within the ward space on the eye unit. This meant that outpatients were waiting in inpatient areas where patients who had undergone surgery were recovering.

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 staff meetings and learning from complaints was also circulated electronically within the trust. There had been one complaint in outpatients about a 20 minute delay in seeing the doctor. The department had apologised for this, however we saw that patients were not always informed about waiting times.
- 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 support the delivery of services on the Churchill unit during times of staffing shortages.
- In the eye unit, staff felt they were not supported to be innovative. A new business manager was in place following a recent practice review and this change needed further time to embed and provide leadership.

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.

Governance, risk management and quality measurement

- Outpatients and diagnostic imaging was managed as part of the elective care division within the trust. There was a standard governance agenda for the division, including health and safety, incidents and policies. Divisional governance meetings were monthly alongside quarterly performance and quality meetings for each speciality chaired by the divisional governance lead.
- 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.

Outpatients and diagnostic imaging

- 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. The radiologist vacancies were on the divisional register. We saw that risk registers were reviewed regularly and actions taken to reduce and mitigate risks had been completed.
- 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.
- There were not adequate plans in place to continue to provide the same level of care for patients on the Churchill unit during periods of staff sickness. Patients who would usually be treated on the unit had been diverted to the regional centre.
- 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.
- Senior staff were being supported to develop their leadership skills. On the eye unit, several senior doctors felt that management were not supportive of the service. They felt the service was being poorly managed from an operational point of view and that they were not supported to be innovative. There had recently been a practice and environment and capacity review completed to look at service specific issues in ophthalmology. We saw evidence from the action plans that a new operational business manager had been appointed and that there were plans in place to improve governance, staffing levels and manage capacity and demand more effectively.

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.
- 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 fracture clinic, registered nurses took it in turns to complete the staff roster to promote a shared experience of how difficult it can be to meet everyone's requests.
- Sickness rates for outpatient nursing was higher than the trust target of 3.75% at 4.7% between January and November 2015. In radiology, outpatient therapies, the rate was lower than target at 2.5%.The nursing turnover rate was 10.8% in 2015.
- 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.

Public engagement

- Radiology carried out a quarterly patient experience audit. In outpatient therapies and ENT outpatients,

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. One senior member of staff told us that frequent changes in managers had made it difficult to initiate change or improvements.
- 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. We saw that this had not been completed on the Churchill unit.

Outpatients and diagnostic imaging

regular patient satisfaction surveys were completed. The external provider of ophthalmology clinics at the weekend completed patient satisfaction surveys and shared this information with the trust. Patient satisfaction was above 90% in the most recent audits we saw.

- 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.

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 breast unit had recently introduced a “spot audit” of staff feelings asking the question “have you had a good day today”. This gave staff an opportunity to say how their day at work had been and why.
- 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 at Bolton One.

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.
- The ENT team had driven improvements in referral to treatment time by setting targets of seven days from referral to initial consultation. They had also adjusted performance on CQUINN targets to speciality specific cancers to identify and drive improvement areas.
- The therapy team had worked closely with the clinical commissioning group to review the services they provided and referral criteria to ensure a sustainable service for the future.
- Advanced orthopaedic practitioners had been developed in the fracture clinic following a workforce development review in response to a shortage of medical staff on rotation and locum staff availability. These practitioners had been trained to senior house officer level and worked alongside consultant orthopaedic surgeons.

Outstanding practice and areas for improvement

Outstanding practice

Accident and Emergency,

- The ED had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- ED Bereavement meetings were offered to those who had lost a loved one, to help them understand what had happened.
- ED consultants were regularly working in place of middle grade staff to ensure the department continued to function with safe medical staffing levels.

Critical Care:

- The ICU team received the 'team of the year' award in 2015 from the trust. The team was nominated for their work on patient diaries, ICU follow up and for their work to facilitate three discharges from ICU for end of life care.

Children's and young peoples services :

- The trust were early adopters of the newborn behaviour assessment tool (NBAS).
- The neonatal unit were early adopters of volume ventilation.
- The neonatal unit introduced 'Matching Michigan', a two-year programme designed to reduce infections in central lines, before it was rolled out as best practice. The service was nominated for an award from the Health Service Journal (HSJ) for this.
- The neonatal unit introduced the 'fresh eyes initiative', which is where nursing staff look at other nurses' patients at 1am and 1pm to promote things not being missed.

In End of Life care :

- There was a visible person-centred culture with caring, compassionate staff who considered the needs of patients nearing their final days or hours and their families. There were systems in place to support this, including the butterfly logo. This was embedded throughout the organisation so that any staff coming into contact with bereaved families could offer care and support where this may be needed.
- The trust had adopted the 'butterfly symbol', which made staff aware of a family in need (identified by the symbol). This ensured that during difficult times families were supported (for example by staff offering drinks etc.). The scheme also ensured that the deceased's property was put into a special bag (with the butterfly symbol on). Relatives were offered a finger print, lock of hair and photo (from medical illustration) of the deceased patient.
- We observed nurse interaction with patients living with dementia on the bluebell ward, using a variety of dementia friendly strategies. Staff used aids, for example dolls, computers, karaoke and a piano. Interaction was approached in a caring way, and tailored to support each patients individual needs.
- The trust had worked with a local major supermarket chain to offer a "Bereavement Café" for newly bereaved families. They had worked with the supermarket to offer "shopping buddies" for newly bereaved persons and had produced a leaflet on how to shop.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Complete mental health assessment forms in the emergency department as soon as practicable and ensure these are distributed and used where appropriate.
- Improve appraisal rates in the emergency department.
- In the emergency department, Improve the focus on audits, ensuring clear action plans are formulated and progress regularly tracked to improve outcomes
- Ensure that robust information is collected, analysed, and recorded to support clinical and operational practice in medical services.
- Must deploy sufficient staff with the appropriate skills on wards, especially on ward D1 and D3 at night and the use of locum cover on the endoscopy unit.
- Must ensure that records are kept secure at all times so that they are only accessed and amended by staff.
- The trust must ensure that staff are up to date with appraisals and mandatory training in medical wards.
- The trust must ensure that paper and electronic records are stored securely and are complete in outpatients areas.
- The trust must ensure that essential safety checks are completed and records of checks are maintained to provide assurance that all steps are being taken to maintain patient safety in outpatients.

Action the hospital SHOULD take to improve

In addition the trust should:

In urgent and emergency care services :

- Ensure building work continues at a suitable pace.
- Improve staffing levels in the emergency department with an aim to reducing agency and locum rates.
- Review the security arrangements for both paediatric entrances to ensure the trust is satisfied the risk is mitigated as far as possible.
- Consider the addition of facilities appropriate for adolescents in the paediatric area.
- Review the number of computer terminals in the clinical areas to ensure this meets the needs of staff during peak periods.

- Continue to work to improve figures in relation to Department of Health targets.

In medical care services :

- The trust should ensure that hazardous chemicals are stored appropriately in a locked cupboard when not in use.
- The trust should ensure that patient is discharged as soon as they are fit to do so.
- The trust should ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- The trust should ensure that patients' privacy and dignity is maintained at all times.
- The trust should ensure that equipment and facilities in the endoscopy services are fit for purpose.
- The trust should ensure that procedures and assessments in place to provide safe care are completed correctly. Especially comfort round and fluid and nutrition charts and assessments.

In surgical services :

- Take appropriate actions to minimise the occurrence of never events.
- Take appropriate actions to improve staff appraisal rates.

In Maternity and Gynaecology :

- Consider improving the electronic patient management systems.

Children and young people's services :

- Review the door exit systems on the paediatric and neonatal unit to improve security.
- Ensure all staff working with children and young people have level three safeguarding training.
- Ensure that there is a trained Advanced Paediatric Life Support or European Paediatric Life Support nurse on each shift.

Outstanding practice and areas for improvement

- Ensure there is sufficient staff to match patient acuity on the paediatric unit,
- Ensure that all paediatric staff have a good working understanding of the Mental Capacity Act and how it works in practice.
- Ensure the risk register highlight all risks and controls that are in place and is periodically reviewed.

In end of life services:

In relation to DNA CPR:

- In all cases assess and record patients' mental capacity as part of the DNA CPR assessment.
- Document a summary of communication with the patient, welfare attorney and/or next of kin (NOK).
- Document consent.
- Ensure private rooms are available to break bad news to bereaved family and friends of a deceased patient.

In outpatients and diagnostic imaging services :

- The trust should ensure that medical gases are stored safely and securely.
- 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.
- The trust should consider how to meet the need to see patients in the TIA clinic with 24 hours over weekend and bank holiday periods.
- The trust should consider how the privacy and dignity of inpatients can be maintained in the main radiology department.
- The trust should consider how to manage environmental capacity in the eye unit and breast unit.

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

Diagnostic and screening procedures
Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Regulation 12(2)(a): Safe care and treatment
"Assessments, planning and delivery of care should be based on risk assessments".
Formal risk assessments for mental health patients and their environment in the ED were not in use at the time of our inspection
Regulations 2014, Regulation 12 (1, 2e) Safe care and treatment
There was limited evidence to demonstrate that laser machines in ophthalmology were safe for use and used in a safe way

Regulated activity

Diagnostic and screening procedures
Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Regulation 18(1) and 18(2)(a): Staffing
"Providers must deploy sufficient numbers of staff to make sure they can meet people's care and treatment needs".
Middle grade staffing in ED was below the required level
"Persons employed by the service provider must receive appropriate appraisal"
Appraisal rates for ED staff were not meeting the trust target

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures
Nursing care
Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17(2)(a): Governance

"Providers must assess, monitor and improve the quality and safety of the service".

There were no ED action plans in place to improve poor audit results

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The regulation was not being met because

Outpatient services did not maintain secure, accurate and complete records in respect of each service user.

Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Regulation

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

the regulation was not being met because

There was limited evidence to demonstrate that laser machines in ophthalmology were safe for use and used in a safe way

Regulation 12(1)(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

The regulation was not being met because

Records were not securely maintained on a number of wards and consent forms were not dated.

Regulation 17(a) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The regulation was not being met because :

There were times when there was insufficient nursing staff available on the wards, especially at night on D3.

The number of nursing and medical staff who had completed their appraisal and mandatory training was below the trust target

Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.