Bolton NHS Foundation Trust

Inspection report

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Date of inspection visit: 24 May and 07, 08, 09 June 2023
Date of publication: 18/10/2023

Ratings

Overall trust quality rating	Good
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Bolton NHS Foundation Trust provides a range of hospital and community health services in the Northwest Sector of Greater Manchester, delivering services from the Royal Bolton Hospital (RBH) site in Farnworth, in the Southwest of Bolton, close to the boundaries of Salford, Wigan, Blackburn and Bury; as well as providing a wide range of community services from locations within 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.

At Bolton NHS Foundation Trust, the Integrated Community Services Division consists of domiciliary, clinic and bed-based services across the Bolton footprint to GP registered population.

There are 598 general and acute beds; 78 maternity beds and 35 critical care beds with 225,561 bed days reported (up 235 from last year). There are 5,315 WTE staff, the total headcount of staff is 6,088. The trust had a financial turnover of £478,339k in 2022/23, this was up 9% on the previous year .

We carried out an announced (staff knew we were coming) well led inspection of Bolton NHS Foundation Trust following an unannounced (staff did not know we were coming) inspection of the Childrens and Young People's services provided by this trust.

This was because we received information giving us concerns about the leadership and management at the trust. There were specific concerns raised regarding the confidentiality and effectiveness of the Freedom to Speak Up (FTSU) process across the trust and the management of staff issues and processes including the inappropriate use of the Disciplinary Policy and Procedure.

Our findings

We inspected the children's and young people's core service because they had not been inspected since 2016 and there had been opportunities for improvement following an incident which we felt required review to ensure the safety and quality of the services.

Our rating of services stayed the same. We rated them as good because:

- We have rated safe, effective, caring and responsive as good, with an improvement in the safe domain for the Children and Young People's services however the trust well-led rating went down to requires improvement.
- In rating the trust, we considered the current ratings of those services not inspected at this time.
- Leaders mostly had the skills and abilities to run the trust. A new chair commenced in post on 01 June 2023. They understood the priorities and issues the trust faced. They were visible and approachable in the trust for patients, but staff gave a mixed review as to their visibility and approachability at the hospital and also reported visibility as less evident in the community services.
- We were informed of a significant breakdown of trust and relationships between some elements of the board and the Council of Governors with the potential to affect the effectiveness of how the board managed and governed. There were a number of concerns raised about the poor governance regarding the appointment and management of some key board members which the trust was reviewing.
- Throughout interviews and conversations with staff we were told that the lack of face-to-face meetings of senior leaders and governors during the pandemic had had a significant and lasting negative impact on relationships and promoted a culture of mistrust in some quarters.
- The trust had a vision and strategy until 2024 for what it wanted to achieve. However, at the time of the inspection the strategy and enabling strategies were under review and some staff questioned how current the trust strategy was. A clinical strategy was being developed. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff did not always feel respected, supported, or valued but they remained focused on the needs of patients receiving care. Some staff expressed reservations about raising concerns without a fear of retribution, did not always feel listened to and feedback was not consistent, whilst others described a just culture. This included concerns about the effectiveness of the Freedom to Speak Up function within the trust. The processes for the management of disciplinary and grievance issues required improvement. However, the children's service had a culture where patients and their families could raise concerns without fear.
- We received conflicting views of the culture of the organisation with many staff we spoke with through the focus groups describing the organisation as having a "just" culture and not recognising the organisation described recently in the media. Whilst many other people had contacted us with quite the opposite opinion.
- Leaders operated governance processes that had recently been strengthened and were in the main effective. However, policy governance needed to be strengthened. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of their division.
- Leaders and teams used systems to manage performance however these were under review to make improvements. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Some staff reported having limited ability to contribute to decision-making to help avoid financial pressures compromising the quality of care. It was acknowledged by the trust that governance lacked strength in some areas but was improving with the leadership of the new Chief Nurse.

Our findings

- Elective recovery had shown signs of improvement however, in some pathways it continued to be more difficult to address. In particular, the breast cancer, urology and colonoscopy pathways.
- The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, the connectivity across the organisation was a significant challenge. The electronic patient record system was not yet active in all areas. The information systems were not fully integrated but were secure. Data or notifications were consistently submitted to external organisations as required.

However,

- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations. Although, work by the established and developing equality groups would benefit from further corporate support. They collaborated with partner organisations to help improve services for patients.
- Staff were committed to learning and improving services and demonstrated a strong determination to provide quality care to patients. They had an adequate understanding of quality improvement methods and were promoting the skills and developing the capacity to use them. The trust had only recently invested in the Quality Improvement team to improve this. The management of complaints had improved. Learning was evident from serious incidents and mortality reviews.
- There was a palpable sense of strong family values across the trust from every level which supported the quality of care seen.

How we carried out the inspection

Prior to the inspection we spoke with each person who contacted us including former employees of the trust. During the well led inspection we conducted interviews with executive directors, non-executives and leaders for key roles. We also spoke with a variety of staff including consultants, doctors, therapists, nurses, healthcare support workers, pharmacy staff, patient experience staff, domestic staff and administrators.

We held 12 staff focus groups attended by over 320 representatives from all over the trust. This was to enable staff to share their views with the inspection team. The focus groups included junior and senior staff from pharmacy, junior and senior nursing staff, junior doctors and consultants, allied health professionals and staff from across the equality networks. We also had focus groups for the non-executive directors and governors. We received approximately 40 contacts from individuals wishing to share their experiences under protected disclosure.

We reviewed strategies and policies and minutes from meetings including the main committees and the Board. We reviewed the management of serious incidents, mortality reviews and complaints. We reviewed the processes used to identify and manage risk from Ward to Board.

Due to the nature of the concerns raised we also conducted a thorough review of the disciplinary process, the resolution (Grievance) process and recruitment process.

During the core service inspection, we also spoke with staff, patients and relatives. We visited the ward and other areas providing care to children and young people and reviewed patient records.

Our findings

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

- The trust must ensure staff feel supported to speak up without fear of retribution by seeking and acting on feedback from relevant persons or other persons on the service provided in the carrying on of the regulated activity, for the purpose of continually evaluating and improving such services. (Regulation 17(2)(e))
- The trust must ensure that the board and council of governors are working effectively together to create constructive relationships and governance arrangements at this level. (Regulation 17(1))
- The trust must ensure it aligns relevant policies and procedures and that all policies are up to date. (Regulation 17(1))
- The trust must ensure the disciplinary and grievance / resolution procedures fully meet the current required legislative standard and are fair to the person involved, follow correct procedure and are consistently operated effectively. (Regulation 19(5))
- The trust must ensure that records relating to care and treatment of each person using the service are accessible to authorised people as necessary to deliver people's care through improved IT connectivity. (Regulation 17(2)(c))
- Development and investment in workforce and systems must be prioritised to make sure clinical pharmacy services including medicines reconciliation rates are improved across the trust. (Regulation 12 (2)(b)(g))
- The trust must continue with plans to strengthen the trust position on equality, diversity and inclusion are managed and monitored in a timely way and that all reasonable steps are taken to make reasonable adjustments to enable people to carry out their role in line with the requirements for employees under the Equality Act 2010. (Regulation 19 (1) (c))

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure the review of the trust strategy is completed in a timely way, ensuring clear aims and objectives are supported by current and relevant enabling strategies to turn them in to action.
- The trust should promote and communicate relevant strategies via different means to make them meaningful to all staff. Staff should be provided with the opportunity to comment and contribute where appropriate.
- The trust should continue to improve governance processes in particular the senior oversight of risk, policy governance and the management of risk.

Our findings

- The trust should ensure that the networks for staff from ethnic minority groups; Disabled staff and LGBTQ+ staff, have suitable corporate support to improve their effectiveness and that the socio-economic, age and gender networks, currently in developmental stages, are supported to develop in a timely way.

CYP core service

- The service should ensure that appraisals for medical staff are completed in a timely manner.
- The trust should ensure that mental health risk assessments including environmental assessments are thoroughly completed.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders mostly had the skills and abilities to run the trust. A new chair commenced in post on 01 June 2023. They understood the priorities and issues the trust faced. They were visible and approachable in the trust for patients, but staff gave a mixed review as to their visibility and approachability at the hospital and also reported visibility as less evident in the community services.

The roles within the trust senior leadership team were reflective of other trusts and included key roles such as the trust Chief Executive Officer (CEO), Chair, Medical Director, Chief Nurse, Chief Finance Officer, Chief Operating Officer, Director of Strategy, Digital & Transformation and Chief People officer (CPO). There were also key lead roles allocated to the executive team members including Infection Prevention and Control, Senior Information Risk Owner (SIRO), Caldicott Guardian and leads for equality and diversity, learning disability, mortality, and discharge.

Due to a range of circumstances, there had been some changes within the executive team. The CEO had been in post since March 2020, at a challenging time for the NHS having taken up post a week before the COVID-19 pandemic national lockdown. Evidence from interviews indicated that this impacted on the effective support for the CEO and their relationship with the chair.

The CEO was also the place lead; this was seen in both a positive and negative way by staff; some reported that this meant the trust was focussed on the needs of the people of Bolton whilst others felt it took the CEO away from the trust and the needs within the organisation.

The CEO demonstrated a very strong personal commitment to and ownership of the executive team's welfare and wellbeing, they viewed their executive colleagues very positively, could articulate their strengths and were supportive to their development needs. They recognised the need for board development and the need to engage effectively with governors, particularly with a new Chair joining the trust.

We were informed of a significant breakdown of trust and relationships between some elements of the board and the Council of Governors with the potential to affect the effectiveness of how the board was run and governed. There were concerns raised with us about the poor governance of the appointment and management of some key board members which the trust was reviewing.

Our findings

The trust had just appointed a new Chair following the resignation of the previous Chair in March 2023. There was a shared view that the outgoing Chair had been a capable chair, however, they had become less present and visible during and after the pandemic. The first board development meeting was held face to face was in October 2022 and the first formal public face-to-face Board of Directors meeting took place on 30 March 2023. This loss of visibility of a pivotal leader had significantly impacted on the senior leadership team and consequently the effectiveness of the leadership and senior governance at the trust. The role of the council of governors and its relationship with the Board had also been affected.

The Deputy Chair had stepped up to Acting Chair whilst recruitment was undertaken. The new chair took up post just a week prior to the Well led inspection. The Acting Chair had been in post for 2 months and was a very engaged NED who understood the trust performance and system role, they were clear on the need to be visible and noted the impact working remotely during COVID had had, including with governor engagement.

The Chair, although very new to post, was committed to being visible and accessible. They were clear on the health needs for the local population and demonstrated commitment to the trust strategy on PLACE. Further work was required to ensure that there was effective governance and improved relationships with the Council of governors.

The medical director was experienced and well respected; they were visible and approachable. They were leading on the development of the Clinical Strategy which was being presented to the Board in July 2023. They were clear on areas of challenge including improving the job planning position; strengthening innovation within the medical workforce; data quality in some areas; improving the care of the deteriorating patient; improving the management of serious incidents and a key area of focus to improve access to rheumatology services.

The Chief Nurse had been in post since May 2022 and held the role of Director for Infection Prevention and control (DIPC) and Patient Experience lead. They were positively starting to make an impact on the ward to board assurance of how safe and caring services were, although this was not a universal view. They promoted patient centred care and increased patient experience feedback. They were driving the use of data to provide a stronger level of assurance. We saw evidence of leadership development through leadership conferences.

The Director of People was also the Deputy Chief Executive Officer (DCEO). They joined the trust in 2018 as the Workforce Director and was appointed DCEO in January 2022.

Interviews with the other executive team members including the Director of Finance, Chief Operating Officer, Director of Strategy, Digital and Transformation demonstrated that the trust had succession planning in place for key posts. All senior leaders had experience in the NHS or within their field of expertise. They could articulate the challenges facing the organisation and actions being taken in their area. All executives valued the partners inclusion in Board meetings and demonstrated clear links between the trust and the locality. These included the Director of Social Services, the Director Public Health, the Deputy Place Based Lead and the Associate Medical Director for the Locality. There was a genuine enthusiasm to improve the services for the people of Bolton. However, this had not yet been fully reflected in strategies and operational plans.

Development needs were being addressed through regular appraisal processes, however compliance needed to improve for some groups of staff.

Our findings

There was a varied mix of skills and experience across the non-executive directors (NEDs). There was support for the executive team by the non- executive directors. Directors appeared to work cohesively together but also provided constructive challenge. They told us there was the right balance of challenge and support at Board meetings including learning from mistakes. They were open to change which was acknowledged by their support of the different thinking and actions instigated to improve assurance introduced by the chief nurse.

Although the trust had an established council of governors, they did not always work effectively together or with the board. There was friction within cohorts of the council with differing views of the effectiveness of some board members. Some governors shared with us that Bolton was a paternalistic place and that this was reflected within the trust. They spoke of the impact of the pandemic being felt deeply in Bolton. This had led to reduced physical presences within the trust and consequently, reduced connections for governors with leaders, staff and service users which had resulted in some feeling a lack of inclusion. A cohort felt that communication directly between governors was not effective and, in some instances restricted, especially in relation to emails. Concerns were also raised with us about the reduced visibility of NED's and feeling that decisions had been made by executives without the correct level of consultation or authorisation by the Council. This was refuted by other governors. However, there was consensus that they had resumed active inclusion in committees, the ward accreditation programme, walk arounds and formal trust meetings.

We found that the executive directors were cohesive and worked well together. It was noted that the board leadership, and the Council of Governors, had been slower than other trusts returning to face to face working and recovery to 'normal working practices. The Council of Governors met in April 2023, for the first time in person, since February 2020, before the pandemic.

Some staff reported that senior leaders were less visible and although courteous were felt to be more outward looking than focussed on internal challenges. Other comments included that since the pandemic, it has become a more difficult world to work in at a managerial or divisional level, with the focus on political and financial issues which outweighed clinical issues, it was felt that this hampered local clinical development.

Divisional leadership

Each of the divisions was led by divisional director of operations, divisional medical director, divisional director of nursing and divisional governance leads, we interviewed them to understand the leadership at all levels. We found that they worked together to lead the divisions providing a rounded leadership model. They demonstrated ownership of challenges and risks within their division which were evidenced through clear lines of reporting into the committee structures and governance processes.

At interview, the divisional leaders shared how they worked together, and the challenges faced within their divisions. They reported that there was, overall, a good level of morale however there were a number of areas of concern raised including IT, the introduction of the electronic patient record and the constraints of the aged estate. There was a very strong patient centred focus from all the leaders we spoke with.

Pharmacy Leadership

Medicines safety and governance committees had a clear line of reporting to the executive board via the Clinical Governance and Quality Committee and Quality Assurance committee.

Our findings

The chief pharmacist and senior pharmacy management team oversaw pharmacy services and had identified risks and escalated when appropriate. A review of current pharmacy opening times was underway following staff feedback and audit of services. Capacity and demand modelling was planned for pharmacy to help push forward business cases for increasing staff establishment.

Fit and proper persons

There is a requirement for providers to ensure that directors are fit and proper to conduct their role. This includes checks on their character, health, qualifications, skills, and experience. During the inspection we conducted checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed the records provided by the trust and found that required checks were evident within the files.

Vision and Strategy

The trust had a vision and strategy for what it wanted to achieve. However, at the time of the inspection, the strategy and enabling strategies were under review and some staff questioned how current the trust strategy was. A clinical strategy was being developed. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a comprehensive five-year strategy (2019 – 2024) which had 6 ambitions:

Ambition 1: To give every person the best treatment, every time.

Ambition 2: To be a great place to work.

Ambition 3: To spend our money wisely.

Ambition 4: To make our hospital and our buildings fit for the future.

Ambition 5: To join-up services to improve the health of the people of Bolton.

Ambition 6: To develop partnerships across Greater Manchester to improve services.

The strategy was under review, as were some of the supporting strategies. The clinical strategy was under review and this was being led by the Medical Director supported by the Chief Nurse. The first draft was scheduled to be presented to the Board in July 2023.

The Trust's Quality Improvement Plan 2023 – 2028 had been presented to the Clinical Governance and Quality Committee in June 2023; This plan described the key ambitions and set the direction of travel for quality improvement at Bolton for the next three years. These goals included:

1. Reducing mortality.
2. Preventing ill health and improving wellbeing for our local population.

Our findings

3. Harm free care – to provide safe, high quality and compassionate care to every person every time.
4. Enhancing patient and carer involvement and experience.
5. Fostering a continuous improvement and safety culture through learning, enablement, and empowerment.

This plan was linked to the trust strategy (2019-2024) and referred to the digital strategy and the clinical strategy (Under review) as well as the EDI Plan (2021-2025) and the People Plan (2023 – 2026).

Other strategies including research and development were under development.

The medical director sat on the Clinical Standards Board although senior medical staff told us that they were not engaged in the wider place and systems initiatives. Some divisional leaders and consultants we spoke with felt disengaged with the development of the clinical strategy and felt they had more to offer.

The trust worked closely with the system partners who were represented on the trust Board and we were informed had been involved in the development of the strategy. The trust worked closely with their partners who also attended the trust Board meetings.

Staff we spoke with felt that the strategy needed to be re-energised within the trust. Some staff felt that work pressures and staffing challenges limited their ability to be actively involved. This was reflected in the data for care hours per patient day (CHPPD). These tell us about staffing levels in relation to inpatient numbers on an inpatient ward. Overall, at a trust level, the trust had the third lowest CHPPD in the ICS for 8 of the 12 months between March 2022 and February 2023. Although sickness rates and turnover of staff were within the expected range based on the sector average.

Culture

Staff did not always feel respected, supported, or valued but they remained focused on the needs of patients receiving care. Some staff expressed reservations about raising concerns without a fear of retribution, did not always feel listened to and feedback was not consistent, whilst others described a just culture. This included concerns about the effectiveness of the Freedom to Speak Up function within the trust. The processes for the management of disciplinary and grievance issues required improvement. However, the children's service had a culture where patients and their families could raise concerns without fear.

Before, during, and after the inspection, we received information of concern from staff regarding the culture in the trust.

We held 12 staff focus groups at all levels during the inspection, attended by over 320 representatives from all over the trust , we also spoke with other staff directly. Themes from these conversations were that the trust was a good place to work with strong camaraderie, many stating that they would be happy to be cared for at the trust. However, a minority expressed that the poor culture presented a significant challenge and did impact on patient care.

Staff reported feeling supported by clinical executives and at divisional level but less so by other executives. They also reported feeling the loss of face-to-face interactions as impacting on their ability to be involved in decision making and driving excellence. Some reported that improvements were short term and there was a lack of medium to long term planning to improve services.

Some expressed that the intense pace of work and increased levels of stress had resulted in staff speaking to each other in a less professional way but also that this was often dealt with locally.

Our findings

Junior medical staff raised concerns regarding access to training due to the minimal staffing levels and again IT was a consistent barrier for staff. The limitations of the estate were also raised as a stressor.

Community staff voiced that they never saw the executives, they knew that there were executive buddies for each site but had not seen them. Staff felt that there were limitations for nurse progression. Staff mostly felt valued in their immediate team but not beyond that. Most said they would be comfortable raising concerns with their manager.

Nursing staff expressed inconsistencies in leaders' approaches. Whilst some reported nurturing and supportive leaders, others felt left to run the wards unsupported. Others reported leaders talking to them in an unprofessional manner. Some felt that they could not progress without compromising their own integrity. Many responses demonstrated a mistrust in managers to deal with difficult issues like behaviours. Some had had positive outcomes, but others felt they had not been believed and things had been allowed to escalate.

Overall, we received conflicting views of the culture of the organisation with many staff we spoke with through the focus groups describing the organisation as having a "just" culture and not recognising the organisation described recently in the media. Whilst others had contacted us with quite the opposite opinion. A "just" culture is defined by the NHS as where managers treat staff involved in a patient safety incident in a consistent, constructive and fair way.

In the 2022 Staff Survey results for the trust, all scores were either in line with benchmark median scores or above, both for overall themes and sub themes. The sub theme for Compassionate Leadership showed no change and was above the benchmark median however the questions for this sub theme relate to 'immediate line managers' rather than senior leaders. The sub theme for Raising concerns showed a little deterioration since the 2021 survey although was still above the benchmark median. The benchmark group highest scores had also deteriorated in 2022.

However, it was noted that the staff survey had a continually lower than average response rate of 35.7% of staff (against an average of 44.5%) which was a decrease from 40.7% in 2020 and 38.9% in 2021.

Freedom to Speak Up (FTSU)

Due to the nature of information shared with us prior to the inspection, we undertook a full review of the trust's policy and processes to ensure that staff were enabled to voice concerns in an open and honest environment without fear of retribution. We found that the FTSU process was supported by 2 FTSU Guardians and a network of 44 FTSU champions from a variety of staff groups across the divisions. All had received training to support them in the roles.

There was a Freedom to Speak Up Policy, the Workforce Partnership Forum had agreed the updated policy in June 2023 after it had been through the review process. The previous policy remained in place until the updated one had been approved.

The Board lead for FTSU was a NED. There were monthly FTSU meetings attended by senior executives where cases would be discussed. The FTSU quarterly report went to the People Committee and an annual report went to the Board. There was also an annual report to the Council of Governors. The trust participated in the National Speak Up Month each year. Review of the last 2 annual reports showed that behaviours were the predominant concern raised through the FTSU process and this included behaviours of staff to other staff: staff to managers and managers to staff.

Our findings

Most staff reported that they felt able to raise concerns through the FTSU process or their union representatives. However, there was a mixed response as to the outcome of using the FTSU process with some feeling that they shouldn't have bothered, whilst others reported positive experiences. Some reported a lack of confidentiality through the process and the negative experiences of others had prevented them from feeling able to speak up. Concerns were also raised about lack of impartiality and consistency.

Disciplinary and Grievance

Due to the nature of information shared with us prior to the inspection, we undertook a full review of the disciplinary and grievance processes. The HR policies and a random sample of 7 cases provided by the trust were reviewed by senior human resource professionals.

We found that the disciplinary and grievance processes did not always follow best practice and were not consistently applied in the 7 cases we reviewed, which identified that sections of the trusts process had not been adhered to.

We found that the policy was lengthy at 58 pages although 31 pages were appendices, it was not felt to flow in a good order and was confusing with regards to the steps. There were 2 elements that did not fully adhere to the ACAS Code of Practice including, the right to be accompanied / support for staff and a lack of criteria for lodging an appeal against a Warning or Dismissal. We also had first-hand information shared with us to corroborate the concern re staff support at meetings.

We found that allegations of misconduct were not always clearly identified and some of the cases that seemed serious in nature were dealt with from a more supportive perspective which did not always hold the employee to account for their actions. After the inspection the trust informed us of a panel, this information was not supplied as part of the case files provided for review. The trust policy/ procedure does not mention a panel within the fast track section, therefore it indicates that panels are not held in fast track cases and the individual would not be expecting such if the policy/process is followed.

The "fast track" system within the policy was not consistently applied in these cases and there was no evidence of robust oversight or audit of these procedures to ensure fair application and use of the fast track process.

We found that a fact-find exercise was carried out before an investigation was commissioned, as per guidance, however it was reported to us that some staff had found this process to be formal and accusatory in nature rather than a fact find and had been conducted as if it were the investigation. The fact find documentation was not completed in 3 of the 7 cases.

Informal actions that could be considered, if formal action was not appropriate, were retained on the employee's file and may have been referred to later should a similar incident occur. However, best practice would indicate that if there was no case to answer and no sanction was made then this should not be able to be used against the individual if further conduct issues were to arise. It may be managed under a different process if required, for example, capability. The policy also did not state a length of time that any information would be held.

The process to follow if an investigation was not going to achieve the 8-week timeline was not evidenced as being followed in all the 7 cases we reviewed.

Our findings

Finally, we found that throughout the policy and procedure, the language was not inclusive and was felt to be harsh in tone, some examples of this were referring to the employee as “The Accused”, “Their Défense”, “The Appellant” and he/she. There was potential for the policy to be discriminatory, for example for people with protected characteristics, due to the option to alter the length of a sanction based on absence.

Post the inspection the trust told us that there was monthly reporting on cases that exceeded the 8-week timescale via the Divisional Performance meetings between the divisional leaders and Executive Directors and were also presented on the Board dashboard. The People Committee also provided oversight including the review and scrutiny of cases.

The Resolution Policy was reviewed, and we found that the terms fact finding, and investigation were interlinked within the policy which made it confusing for the reader. There was use of dated language throughout the policy which could be more inclusive in tone. The Formal Resolution Meeting appeared to be conducted as a hearing and prior to any formal investigation of the facts taking place. The person who the complaint was against was also in attendance at the meeting. This does not resonate with usual practice.

It lacked clarity regarding the hearing or appeal process. Knowing that grievances were often related to perceived bullying and harassment, we found nothing within the policy defining bullying and harassment.

Recruitment Procedure

Due to concerns raised with us prior to the inspection about HR processes we reviewed the policies during the inspection. We found dated policies with language not consistent with current best practice, especially regarding EDI. The policies were also long and lacked clarity on process.

The Recruitment Policy was appropriate; however, it had not been updated since 2018 and as with the Disciplinary Policy the language was not inclusive and did not always follow best practice. For example, the use of the word “colour” in the Equal Opportunities statement and the phrase “disabled people” and it was lengthy at 35 pages. Following the inspection the trust informed us that the policy had been updated and was agreed at the July 2023 Workforce Partnership Forum.

Equality and diversity

The trust board had representation from the staff from ethnic minority groups. Around a fifth of the Bolton community are from ethnic minority groups.

There was an Equality, diversity, and inclusion (EDI) steering group that reported to the People Committee and then to the Board. There was a NED with a lead role for EDI.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports were presented to the Board annually.

The Workforce Race Equality Standard aims to ensure employees from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It requires a Trust to demonstrate progress against nine standard indicators specifically focused on race equality through the collection, analysis, and use of workforce data to address any underrepresentation, poor treatment, or unequal opportunities.

Our findings

The 2022 WRES data for the trust showed staff from ethnic minority groups were underrepresented in all clinical roles above band 6 with no BME staff at Bands 8d or VSM. The 2022 WRES data showed disparity in the experience of staff from ethnic minority groups in the following indicators:

- Indicator 2: likelihood of appointment from shortlisting. The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants had increased since 2021 by a relative likelihood of 0.22. For the last two years the trust had appointed proportionately more BME applicants from shortlisting than white applicants. However, in terms of headcount there were 506 out of 3220 white staff appointed from shortlisting and 134 BME staff out of 702 appointed from shortlisting.
- Indicator 6: harassment, bullying or abuse from staff in last 12 months. There had an been a slight decrease of 0.3 % of the number of BME staff reporting harassment, bullying or abuse from staff.
- Indicator 7: belief that the trust provides equal opportunities for career progression or promotion There has been a significant decrease by 27.4% of the number BME staff that believe the Trust provides equal opportunities for career progression or promotion.
- Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months. There had been an increase of 1% of BME staff that had personally experienced discrimination at work from manager/team leader or other colleague.

It also showed:

- The relative likelihood of BME staff entering the formal disciplinary process had seen an increase of 0.07 in Apr 21 to Mar 22 but remained an improved position in relation to 2020 data.
- While the number of BME voting board members had increased there were still only 3 BME members on the Board.
- More BAME staff have raised concerns via the Trust's Freedom to Speak Up process compared to the previous year (15% totalling 24 concerns).

The NHS Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that enables trusts to compare the experiences of disabled and non-disabled staff. It supports positive change for existing employees and enables a more inclusive environment for employees.

The 2022 WDES data for the trust showed that;

- The proportion of staff with a disability increased to 3.3% in 2021/2022 compared with 2.9% in 2020/2021. An increase of 0.4%. The highest proportion of staff with a disability were represented at Band 8d and Band 9 (8%).
- There had been a significant reduction of 25.9% in the number of Disabled staff believing that the trust provided equal opportunities for career progression or promotion.
- The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts had reduced by a relative likelihood of 0.53.
- There had been a reduction of 3.2% in the number of disabled staff saying their employer had made adequate adjustment(s) to enable them to carry out their work.
- There has been an increase in bullying and harassment towards disabled staff from patients/service users, their relative or other members of the public but a reduction in the number of disabled staff reporting incidents.

Our findings

- There had been an increase in the engagement of disabled staff but a decrease in non-disabled staff. There was no disabled representation on the Board.
- There had been a reduction in the percentage of Disabled staff saying they felt pressure to come to work and an increase in feeling their work was valued.

The trust had WRES and WDES action plans available to the public on their website which covered all the above indicators plus others. They had actions and leads identified however, not all the actions were timebound and there were no indicators for measurement of progress. Although the Equality, Diversity and Inclusion team and the staff networks were identified within the plan it was unclear if all the relevant networks had been involved in their development.

There were 3 staff networks within the trust: for staff from ethnic minority groups, disabled staff, and LGBTQ+ staff, with 3 more networks in developmental stages. The socio-economic and age networks were about to be launched, and the Gender network had met once at the time of inspection. The three developed staff networks had highly motivated chairs. However, there was a lack of formal corporate support to enable them to deliver their work plans more effectively.

EDI fell within the Peoples Strategy which has a 4-year plan around learning and development, celebration, policies and procedures, workforce, community partnerships and governance. To support the strategy there are an equality target action group and a people and culture group. Equality Impact Assessments were embedded within the document control policy and all business cases required them. However, the trust acknowledged that the quality of these assessments needed to improve.

A new faith facility had been established. The mosque, temple, and community room were opened in March 2023. This was following engagement with staff, the local community and faith leaders. The local community donated money towards the funds demonstrating the strong partnerships between the trust and community.

Pharmacy Culture

Pharmacy staff had annual appraisals and had regular personal development reviews. Pharmacy staff said they felt supported by pharmacy leaders but did not always feel appreciated and included in the wider trust.

Pharmacy staff told us due to workload pressures clinical pharmacy services across the trust had significantly reduced which had an impact on medicines reconciliation rates and medicines safety.

Governance

Leaders operated governance processes that had recently been strengthened, and were in the main effective, throughout the trust and with partner organisations. However, policy governance needed to be strengthened. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of their division.

The Board was supported by a full committee structure. There was ongoing work to review and improve terms of reference for committees. Reports varied in quality and the level of detail however, more visual data was being promoted within reports to improve the level of assurance. The trust was aware improvements were required and had contracted with an external organisation to review some governance processes.

Our findings

Board Assurance Frameworks (BAFs) and risk registers

A Board Assurance Framework (BAF) should inform the trust board and key stakeholders as to how strategic risks are being managed. The purpose of a BAF is to establish principal objectives (strategic and divisional) and these should directly relate to the Trust Strategy.

We reviewed the Bolton trust BAF and found that the BAF linked to the Trust strategy in terms of the trust ambitions, however it did not identify clear strategic priorities or objectives. The Bolton BAF was detailed; it identified the risks to achieving the principal objectives however, these were found to be more operational than strategic.

Gaps in controls and assurances were identified and actions for improvement were in place. However, there was no formal Trust/ Corporate risk register in place. However, all risks scoring over 15 were captured on divisional and corporate services risk registers. These were then summarised on one document within the risk management committee. Within the BAF all risks scoring over 12 were linked to the relevant BAF section providing oversight and triangulation of risk. We saw that divisional risk registers were comprehensive and reported through the Risk Management Committee, chaired by the Chief Nurse. This group reported to the Quality Assurance Committee, chaired by a NED, and hence reported to the Board. The BAF was working for the Board however the structure of this BAF did not represent usual practice in the management of an organisation's key risks. Development of a formal Trust / Corporate risk register might allow the BAF to focus on strategic risks and the impacting high-level issues rather than being operationally focussed.

Policy governance

We reviewed the Document Control Policy version 11 which had been ratified in July 2021 and was for review in July 2024. This policy applied to the development, management, identification, and authorisation of all procedural documents available within working areas.

We found that it provided clear instructions on the development of new policies including Equality Impact Assessments. Authors were expected to keep their documents up to date to reflect changing practices, legislation, and new evidence. There were clearly defined approval and review mechanisms. Document control was through divisional governance leads and the Procedural Document Oversight Committee (PDOC).

Documents indicated that compliance was monitored within divisions and status reported through the PDOC. A random sample of 20 policies signed off in the previous 12 months was audited by the Risk Assurance Team. However, the digital platform did not appear to be being used effectively to monitor and drive compliance.

We reviewed 20 policies on the trust intranet and found that the policies were clearly laid out for ease of access. Of these we found 6 policies that were out of date, 1 had a review date of May 2023 but the other 5 were at least 3 months out of date.

We also reviewed all the workforce policies which were in date. We were told that work was underway to ensure the deadlines for review and approval of final workforce policies were met and that all dates on footers, front sheets, and the main document align. Draft policies were considered by the virtual policy review group and comments and feedback considered before final draft policies went to the Workforce Partnership Forum for approval.

Medicines governance

Our findings

The trust medicines policy had recently been reviewed and updated and included a vision for medicines optimisation across the trust with an ambition that the trust would have systems, processes, and work practices to prevent or reduce the risk of harm to patients from medicines.

Challenges in increased trust activity and workforce shortages meant plans for medicines safety and clinical pharmacy services had not always been delivered.

A comprehensive pharmacy audit dashboard had oversight of medicines optimisation and pharmacy services including medicines reconciliation, safe and secure medicines audits, controlled drugs and dispensing and discharge medicines turnaround times.

Medicines reconciliation, to show people were prescribed the correct medicines when admitted to the trust, were completed. Medicines reconciliation audits for January 2023 to June 2023 showed trust targets of 95% of patients to have their medicines reconciled within 24 hours were not being met. Latest audit figures showed on average 37.5% of patients had their medicines reconciled within 24 hours (level 2 medicines reconciliation) on weekdays and 30.62% at weekends. Post inspection the trust provided evidence of a new report to help improve the accuracy of medicines reconciliation data and to inform resource and business planning.

Medicines audits at ward level had identified some medicines storage issues and action was being taken to address these.

Controlled drugs were audited, and the highest areas of non-compliance had action plans in place to drive improvements.

Pharmacy staff inputted into medicines management training for internal staff although this was currently limited due to business-as-usual workload pressures.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance however these were under review to make improvements. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Some staff reported having limited ability to contribute to decision-making to help avoid financial pressures compromising the quality of care.

There was a Risk Management Policy in place although it was due for review in March 2023. The review was delayed due to a divisional governance review by an external organisation, which had been commissioned due to some inconsistencies in risk management arrangements.

The policy identified roles and responsibilities for individuals and committees. There was a process for the management of risk within each division. Divisional leaders held accountability for the management of risk within their division which was escalated appropriately through to the Risk Management Committee.

The Risk Management Committee received clinical risk information viewed from a corporate perspective, including any bespoke reports following incidents such as a recent fire to provide assurance. Both of these Committees reported into the Quality Assurance Committee which reported to the Board of Directors.

Financial risk was overseen by the Finance and Investment Committee.

Our findings

Some staff we spoke with reported not having the opportunity to fully contribute to decision-making regarding changes that would impact on the quality of care.

We reviewed the Integrated performance report from March 2023 which was presented at all board meetings and through the committee structures. There was a report for each division which covered quality and safety, operational performance, workforce and finance. Statistical Process Control (SPC) was utilised to assess progress. There was a business support team to manage the use of data which was reported to have improved through the pandemic.

Patient stories were also reported to be strong indicators and drivers for change.

Inpatient activity levels at the trust were in the second quintile of all trusts nationally and had increased by 38% during the latest 12-month period available (March 2021 to February 2022).

Activity levels for outpatients at the trust were in the middle quintile of all trusts nationally and increased by 24% during the latest 12-month period available (March 2021 to February 2022).

Accident & Emergency (A&E) attendances at the trust were in the middle quintile of all trusts nationally but had increased by 33% during the latest 12-month period available (March 2021 to February 2022).

During the six months between November 2019 and May 2020 the trust was able to reduce the waiting lists by 30% but in the three years since the pandemic began in March 2020, waiting lists had increased by 74%.

We saw from the Integrated Performance reports that there had been no patients waiting 104 weeks since October 2022. Patients waiting 78 weeks continued to reduce to March 2023 the trust reported that it was on target to achieve zero 78 week waiting patients after 1st April 2023, except for patients within the exclusion criteria who were not clinically suitable to be treated yet. From the July 2023 report there were 33 patients waiting 78 weeks and the trust was working with partners to increase activity to address some key areas.

The June 2023 figure for patients waiting 65 weeks was 554, this was below the trust target of less than 618 but slightly higher than the previous month. The trust had delivered over 100% of the submitted operational plans for outpatient first attendance and elective treatments in June despite industrial action. Before the pandemic (between April 2018 and February 2020), there was an average of 6.4 patients per month waiting 52 weeks or more for treatment. Since the pandemic (between March 2020 and March 2023), there was an average of 1747.6 patients per month waiting 52 weeks or more for treatment.

Day case rates continued to be over 90% and the trust was looking at ways to stretch this performance.

Patients waiting longer than 6 weeks for diagnostic tests was 22.4% as of April 2023, with the trust reporting challenges in cystoscopy and audiology impacting on recovery targets. In June 2023 this had reduced to 14.2%.

The number of patients starting cancer pathways was recovering following dips in activity post pandemic. Trust performance had been primarily better than the England average.

We saw that the 2 week all cancer wait performance for March 2023 was below the national target of 93% at 79.6% which was attributed to radiology capacity in Breast services. The trust was continuing to work to increase Breast radiology capacity through recruitment although it was expected that the 2 week wait position would continue to be impacted in

the medium-term until this was resolved. The trust failed to meet the 62-day standard for May 2023 with performance at 77%, breaches were largely due to delays to first appointment in breast services as well as several clinically complex patient delays in colorectal, gynaecology and lung services. However, the trust performed better than Greater Manchester (57.63%) and the national average (59.4%) on this metric.

The trust did achieve the Faster Diagnosis standard in March 2023 with performance at 79.3% however this had fallen to 66% in May 2023. After the inspection the trust informed us that this had recovered in June 2023 to 76.39% against a national average of 73.5%.

Pharmacy risk management

The Pharmacy risk register identified several risks due to insufficient pharmacy staffing including staffing of clinical pharmacy activities, business as usual services, homecare services and no education and training pharmacist.

We were told pharmacist support on critical care was not at the level recommended by the Faculty for Intensive Care Medicine.

Audits of medicines optimisation and key risks were managed including audits of medicines reconciliation, controlled drugs, antimicrobial stewardship, missed doses and safe and secure handling of medicines.

Trust objectives for antimicrobial stewardship in the latest quarter had an overall compliance rate of 84%. An upward trend of improvement was seen across the standards with areas for improvement highlighted and promoted.

The medicines safety committee action plan was proactively monitored to help ensure risks and required improvements were acted upon.

The Medicines Safety Officer had a clear role in promoting safe medicines handling and disseminating learning from incidents. However due to pharmacy workload pressures plans for sharing learning and other medicines safety projects were often delayed.

The Medicines Safety Nurse had an important role in supporting nursing staff and managers in all areas relating to medications safety and acted as a resource to nursing and midwifery staff across the Trust.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, the connectivity across the organisation was a significant challenge. The electronic patient record system was not yet active in all areas. The information systems were not fully integrated but were secure. Data or notifications were consistently submitted to external organisations as required.

We spoke with the Senior Information Risk Officer and the Caldicott Guardian. We found there was an Information Governance Committee which reported to the Strategic Operations Committee which covered the Performance, Strategy and Digital agenda for the trust and reported to the Board. It also reported to the Risk Management Committee which reported to the Audit Committee which maintained oversight of risk within the trust.

The Information Strategy was being refreshed at the time of the inspection.

Our findings

Generally, the trust was behind the expected position with regards to digital advancement as the Electronic Patient Record was still not rolled out across community, maternity, and outpatients. Many staff were concerned about the inconsistent provision of Wi-Fi connectivity which had a significant impact on the use of IT. One ward had a large area with no Wi-Fi connectivity. It was reported that virtual ward initiatives were not meeting NHSE set targets due to digital challenges with security system protection.

Although there were integrated care records across Greater Manchester work continued with GPs and social care to integrate.

The trust was facing challenges recruiting IT staff. In response the trust was working with the local college to improve its recruitment opportunities.

The Caldicott Guardian role was held by the deputy medical director but worked closely with the Medical Director and the Chief Nurse. Reporting was structured and regular. Social media was recognised as the biggest challenge.

Each division had an information governance officer, training was delivered at induction and there was a policy and procedure. Information governance training figures were good at 94% and only 2 information governance breaches had been reported in the last 12 months.

The trust reported appropriately to regulators and other external bodies.

Pharmacy information management

Electronic prescribing and medicines administration had been in place since October 2019. Some progress had been made in developing medicines audits, but it was recognised that due to limited business intelligence workforce, full utilisation of medicines information to predict and mitigate risks was not being achieved.

All relevant staff had access to Summary Care Records and the Greater Manchester Care Record to help deliver effective medicines reconciliation processes.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. Work by the established and developing equality groups would benefit from further corporate support. The trust collaborated with partner organisations to help improve services for patients.

The 2022 staff survey results showed little change from the 2021 survey and in some areas were above the national average. However, these figures must be considered against a falling number of staff responding to the survey.

The trust scored significantly above average for Compassionate and inclusive; Recognised and rewarded; Voice that counts; Safe and healthy; Always learning; Flexible working; Teamwork; Morale; Staff Engagement and significantly below average for no themes.

The trust had a Council of Governors which included staff governors and public governors. They were representatives of the local population.

Our findings

We saw positive work being undertaken in the Equality, Diversity, and Inclusion area, especially regarding recruitment of staff to better reflect the makeup of the local population, the introduction of gender pronoun badges was about to start; improved disability leave and the use of a Tailored Adjustment Passport that was about to be launched. The 3 developed staff networks had highly motivated chairs and would benefit from further corporate support to deliver their work plans more effectively.

The trust was heavily reliant on the external NHS patient experience information. The Chief Nurse was taking steps to address this to proactively collate positive and negative feedback directly from patients to inform the board.

The patient experience team had been impacted by sickness but the nursing teams were supporting the programme. Patient stories were utilised at Board meetings and were felt to be very impactful especially by the NED's we spoke with.

The Accessible Information Standard is a legal requirement for health and social care services to make information and communication accessible to support needs of patients, service users, carers and parents with a disability, impairment, or sensory loss. The trust website accessibility statement (April 2022) indicated that it was partially compliant with the Web Content Accessibility Guidelines version 2.1 AA standard, due to some of the PDFs and Word documents essential to providing services. The accessibility regulations do not require the trust to fix PDFs or other documents published before 23 September 2018 if they're not essential to providing its services. However, the trust was committed to any new PDFs or Word documents published meeting the accessibility standards.

The trust told us that there was a review underway of interpreter and translation service provision including British Sign Language.

The trust had strong integration with partners such as the local authority, it was clear that the trust was developing its role within the Greater Manchester Integrated Care System (ICS).

Pharmacy engagement

The medicines safety officer attended regional and national meetings, when workload pressures allowed, to share learning.

The Trust chief pharmacist was working collaboratively with the chief Pharmacists across Greater Manchester to help transform hospital pharmacy services.

Patient satisfaction surveys had been carried out and reviewed by the pharmacy team to drive quality improvements notably in out-patient pharmacy services.

The Controlled Drugs Accountable Officer for the Trust submitted the required controlled drugs quarterly reports to the Local Intelligence Network.

Learning, continuous improvement and innovation

Staff were committed to learning and improving services and demonstrated a strong determination to provide quality care to patients. They had an adequate understanding of quality improvement methods and were promoting the skills and developing the capacity to use them. The trust had recently invested in a Quality Improvement team to improve this. The management of complaints had improved. Learning was evident from serious incidents and mortality reviews.

Our findings

The trust had a quality improvement model which included plans to utilise a Quality Improvement framework and collaborative approach to improvement. They had a small quality improvement team which had been recently extended from 1 to 4 staff. They had identified the need to build capability within the plan. They were working on a central repository for improvement learning and sharing. Annual improvement plans would be linked to the Quality Improvement Strategy priorities. Initial scoping discussions had taken place with representatives from across the Bolton health and social care partnership, with specialist support to outline a plan for a system-wide approach to Quality Improvement.

However, it was too early to quantify the impact of this team or the plan. There was a ward accreditation scheme at the trust (BoSCA) which supported wards to improve the quality of care. This had recently been revitalised with increased frequency and clear actions set and monitored where improvement was not seen to help drive consistent quality across the wards. Governors were included as part of the assessment process.

Complaints

The trust had a clear complaints process in place. Timely responses to complaints were also improving with 64% now meeting set targets against a target of 95%.

However, some staff reported that they felt unsupported when a complaint was raised against them. They had peer support but nothing more senior.

Trends and themes were reported through the Clinical Quality and Governance Committee.

Serious incidents

From 1 April 2022 and 31 March 2023, there were 56 serious incidents reported trust wide.

There were 10,948 NRLS incidents from 1 April 2022 and 31 March 2023, 99.2% of these were reported as low or no harm.

The trust recognised that they had been on an improvement journey regarding the management of serious incidents. The Chief Nurse had led on the improvements with the process being revised in June 2022. Serious Incident documentation which we reviewed was of good quality.

Reports by division went through the Clinical Governance and Quality Committee. In July 2022 there had been over 200 serious incidents with actions outstanding. This had been improved to only 18 remaining at the time of the inspection. All serious incidents were now reviewed by the Medical Director and the Chief Nurse, and they have improved the language used in the serious incident reports to ensure that they are suitable for families to read.

Staff reported that when an incident happened, they received support, but feedback was inconsistent and often impersonal.

Mortality and Reviews

For the 12-month period from January 2022 to December 2022, the trust's SHMI (Summary Hospital level Mortality Indicator) had been within the expected range with a value of 1.07 (compared to 1.0 for England) and 1,445 deaths compared to an expected 1,350.

Our findings

For HSMR (Hospital Standardised Mortality Ratio) between October 2021 and September 2022, the trust was within the expected range with a value of 109.7.

Mortality reviews were conducted using the Royal College of Physicians Structured Judgement Review (SJR) process. If they were escalated for second review due to concerns about care, they were presented to the learning from deaths committee (LFD). Actions and learning were collated from these cases and reported to the Board. The trust was working to improve the sharing of learning including working with partners. We reviewed a sample of SJR's and found them to be of an acceptable standard.

Medical examiners scrutinised those deaths within the trust that were not referred as coronial cases. The Medical Examiner also attended the LFD Committee to improve triangulation of data and identification of areas of concern.

The Mortality Group reported to the Board via the Quality Assurance Committee. The mortality policy was found to be overdue for review.

Pharmacy learning, continuous development, and innovation

The trust was meeting the CQUIN indicator for referral into the community pharmacy NHS discharge medicines service (DMS). Systems for referral into the service had been shared with other local trusts for learning due to its success in implementation.

Pharmacist staff were supported to complete a post graduate diploma in clinical pharmacy and attend internal pharmacy education sessions when workload pressures allowed.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires Improvement ↓↓ Oct 2023	Good ➔➔ Oct 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Good	Good	Good	Good	Good
Overall trust	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires Improvement ↓↓ Oct 2023	Good →← Oct 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Bolton Hospital	Requires Improvement →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023
Bolton One	Good Aug 2016	Not rated	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall trust	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires Improvement ↓↓ Oct 2023	Good →← Oct 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Royal Bolton Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Apr 2019	Good Apr 2019	Outstanding Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Services for children and young people	Good ↑ Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatients and diagnostic imaging	Good Aug 2016	Not rated	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Urgent and emergency services	Requires improvement Feb 2023	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Maternity	Requires improvement Mar 2023	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Mar 2023	Requires improvement Mar 2023
Overall	Requires Improvement →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023	Good →← Oct 2023

Rating for Bolton One

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Aug 2016	Not rated	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Good Aug 2016	Not rated	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Requires improvement Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Requires improvement Aug 2016	Requires improvement Aug 2016

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community health services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community health inpatient services	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Royal Bolton Hospital

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www.boltonhospitals.nhs.uk

Description of this hospital

The Royal Bolton hospital is part of the Bolton NHS Foundation Trust. 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.

We carried out an unannounced inspection of the services for children and young people on 24 May 2023, as part of our continual checks on the safety and quality of healthcare services.

Our rating of this location stayed the same. We rated it as good because:

Services for children and young people

- The service had enough staff to care for children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.
- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

Our findings

However:

- Medicines reconciliation was not always undertaken in a timely way.
- Mental health risk assessments including environmental assessments were not always thoroughly completed.

How we carried out the inspection

We inspected this service with two inspectors, a medicines inspector, a children's inspector and an operations manager on site. During our inspections we spoke with a variety of staff, including allied health professionals, nurses, doctors, clinical support workers, consultants, domestic staff and volunteers. We also spoke with patients and relatives. We visited clinical areas and non-clinical areas across the hospital site. We reviewed patient records, regional and national data and other information.

We held several staff focus groups to enable staff to speak with inspectors. The focus groups included nursing staff, allied health professionals, junior doctors, and consultants.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Services for children and young people

Good ➔➔

Is the service safe?

Good ➔

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The trust had set a target of 85% of staff to have completed mandatory training. Data provided by the trust showed the following compliance rates, in May 2023, for all staff were:

Paediatric Basic Life Support Level 2: 88%

Adult Basic Life Support Level 2: 88%

Basic Life Support: 91%

Conflict resolution: 90%

Equality, diversity and human rights 98%

Fire safety: 94%

Health, safety and welfare: 98%

Infection prevention and control level 1: 95%

Infection prevention and control level 2: 94%

Information governance and data security: 94%

Moving and handling: 97%

Preventing Radicalisation: 95%

Staff told us they were able to access training through a training portal on the intranet which identified any new training for them to complete. Staff told us it was important to complete training and that they were sent reminders when training was due to be completed and were supported by managers to complete training. Training was a mixture of online learning, classroom based and delivered at ward level by practice-based educators.

Services for children and young people

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism, as part of the trusts safeguarding training. The service promoted autism awareness. Staff knew how to respond to patients with a learning disability.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was also a key part of governance meetings; staff were reminded consistently to complete training by managers.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse. The trust had set a target of 95% for staff attendance at safeguarding adults and children training.

Data provided by the trust showed the following compliance rates, in May 2023, for all staff were:

Safeguarding children's level 1: 100%

Safeguarding children's level 2: 98%

Safeguarding children's level 3: 96%

Safeguarding adults' level 1: 95%

Safeguarding adults' level 2: 95%

Safeguarding adults' level 3: 92%

Staff completed the Oliver McGowan mandatory training on learning disability and autism as part of their safeguarding training.

Staff gave examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff could describe caring for children, young people and their families with protected characteristics and how to keep them safe. We were told when a child was admitted, if a social worker was involved in their care, the ward staff would obtain the social workers contact details. Patients with complex health needs often had formal arrangements in place to ensure regular contact with social workers and families.

Staff could give examples of safeguarding concerns and knew how to make a safeguarding referral and who to inform if they had concerns. Each area had visual prompts for the process and the safeguarding adult and children policies were available for reference on the trust intranet. We reviewed 3 safeguarding referrals on different wards and found them to be completed correctly.

Managers recruited staff safely within departments, this included an enhanced Disclosure and Barring Service (DBS) certificate, history of employment and references.

Services for children and young people

Policies and procedures were in place to maintain safety during vising times. All wards had secure access.

Staff had knowledge of the Gillick competences and Frasier guidelines and knew how to apply them. Gillick competence was used to assess a child's capability to make and understand their decisions in a wider context, particularly around consent to treatment. Fraser guidelines are applied specifically to advice and treatment that focuses on a young person's sexual health and contraception.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained.

All areas displayed cleaning schedules, cleaning records were up-to-date and showed all areas were cleaned regularly. Cleaning staff were trained how to clean to minimise the spread of infection. All staff took pride in the cleanliness of the ward areas.

Ward cleaning audits were up-to-date and demonstrated compliance with cleaning procedures. Divisional matron cleaning audits provided by the trust for the period January 2023 to April 2023 showed an average overall compliance rate above the division target of 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff wearing PPE within the hospital. There were enough masks, gloves, aprons and antibacterial hand gel dispensers within clinical areas of the wards. There were processes in place to ensure clinical curtains were changed regularly. Hand hygiene and PPE compliance audits for the division for the period January 2023 to April 2023 showed an average overall compliance rate above the division target of 95%.

Notices as the ward entrances reminded patients to wear a mask and to sanitize their hands before entering. We observed staff were bare below the elbow to prevent the spread of infections. Laminated signs identified patients who were in side rooms on several wards as being barrier nursed to prevent the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Green tags were attached to equipment with the date recorded of when it had been cleaned. We observed equipment being cleaned during inspection. We also observed cleaning of all the toys, so they were ready for use by other children. Staff could explain the different types of cleaning required after a patient discharge.

The division had reported no cases of clostridium difficile in the last 6 months.

Clinical waste bins and sharps bins were correctly labelled and properly disposed of.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Services for children and young people

We saw that children, young people and their families were able to access the call bells in areas and staff were visible if support was required. Children and young people who needed enhanced observation were allocated beds in bays next to the nurse's station. Staff assisted children and young people when they asked or called for help.

Despite an aging estate, the design of the environment followed national guidance. All areas met the standard set out in Health Building Note 04 – In-patient care.

Staff carried out daily safety checks of specialist equipment. Safety checks were carried out on all specialist equipment including the resuscitation equipment and records of this were fully completed.

Electrical equipment in each area had been safety checked and maintained so was safe to use. Each piece of equipment had an asset number which allowed the trust to monitor when it was due for routine maintenance.

Each ward had fire extinguishers which had been serviced in the last 12 months. Fire exits were signposted clearly, and the wards had chairs and slides to move patients in an emergency.

The service had suitable facilities to meet the needs of children and young people's families. We visited multiple wards which were spacious and had ample lighting. Each ward had a playroom for children to play in and an adolescent's room for older children. The room was well ventilated and signposted to ensure children using the playroom must be supervised at all times. The play specialists would clean and wipe down the toys after patient contact.

The service had enough suitable equipment to help them to safely care for children and young people. Staff could access all the equipment they needed to provide care.

Waste was separated and stored securely before being disposed of safely.

The service ensured cleaning products were stored safely in line with Control of Substances Hazardous to Health (COSHH) Regulations 2002. Cleaning cupboards were locked so cleaning products could not be accessed by an unauthorised person.

Assessing and responding to patient risk

Staff identified and quickly acted upon children and young people at risk of deterioration. Staff completed and updated risk assessments for each child and young person and removed or minimised risks, however mental health risk assessments were not always thorough.

The service used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The paediatric early warning system (PEWS) observation charts gave staff directions on whether escalation would be required. The PEWS charts were completed by staff on admission and then at planned frequencies during the patient's stay according to the care plan in place for each patient.

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed these regularly, including after any incident.

Services for children and young people

Of the 10 patient records we reviewed, most risk assessments were completed and had been reviewed in a timely manner in line with the trusts own policy. Mental health risk assessments we reviewed in some patient's notes were not always thorough and environmental risk assessments we reviewed in some patients notes who had mental health issues were either not thorough or had not been completed. However, we saw these were discussed in detail during staff handovers.

The electronic patient record included a range of risk assessments for falls, skin integrity, sepsis, nutrition and bedside rails. Staff demonstrated they had an awareness of any high risk patients and mitigations in place to manage the risk.

The service had 24-hour access to mental health liaison and specialist mental health support and staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide.

Shift changes and handovers included all necessary key information to keep children and young people safe. Staff used a handover sheet to record key information when handing over care to other staff. All staff on duty attended a department safety huddle that was held at least twice daily.

Theatre staff completed the World Health Organisation (WHO) checklist.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough medical, nursing and support staff to keep children and young people safe. Managers accurately calculated and reviewed the number and grade of doctors, nurses and healthcare assistants needed for each shift in accordance with national guidance. The trust used the Safer Staffing model to adjust the planned staffing numbers according to the needs of children and young people.

The required staffing ratio for the children's unit was 1 nurse to 4 patients. From July to December 2022, the actual staffing ratio remained at or above this level. In addition, all shifts had at least 1 paediatric nurse trained in Advanced Paediatric Life Support (APLS) and from September 2022, play specialists were available 7 days per week.

From July to September 2022, fill rates for registered and non-registered staff were below the required standard. However, this had been much improved since October 2022 with all fill rates being above the trust target of 90% and some being above 100%. This came at a time when the trust experienced a 60% increase in children and young people admitted with mental health issues.

At the time of our inspection, the service had a 13.8% vacancy rate for nursing staff and a 1.7% vacancy rate for medical staff. Leaders told us there was ongoing nurse recruitment drives including an international nurse recruitment programme.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Staff were classed as supernumerary during their induction period. During the inspection staff could describe how they orientated a temporary member of staff to ensure children and young people were kept safe.

The service had low sickness rates compared to the sector average. In May 2023, the sickness rate for all staff was 5.4%.

In May 2023, the absence rate for nursing staff was 5.5% and 3.3% for medical staff.

In May 2023, the turnover rate for all staff was 0.65%.

Staffing issues were discussed monthly at divisional and trust board meetings and actions were agreed to make any necessary changes. Staff told us that they were supported to learn and develop, and they had opportunities to progress within the organisation.

Junior medical staff we spoke with said they had access to support and teaching and felt the hospitals academic and research links were an advantage to their ongoing development.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Risk assessments had been carried out when patients had been admitted to the wards and do not attempt cardiopulmonary resuscitation forms (DNACPR) had been completed correctly if needed. The records reviewed were contemporaneous, legible and there was clear evidence of multidisciplinary team (MDT) working.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Staff including locum and bank staff told us that they could access all patient records easily. Electronic record systems were accessed through computers throughout the service. These computers were username and password protected. Staff ensured that computers were locked when they were not attended. Staff told us that they had enough computers to allow patient records to be completed contemporaneously.

We saw that at the children and young people’s outpatient department at Bolton One, some medical records were still in paper format, but these were in the process of being transferred to electronic records. Paper records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, medicines reconciliation was not always undertaken in a timely way.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed on the electronic prescription administration record on the children’s ward and staff recorded medicines administration.

Medicines were available on the ward and were given at appropriate time intervals. Through audits the service had identified further training on the electronic system would be beneficial and was being arranged. The trust completed audits to ensure antimicrobial medicines were prescribed in line with guidance, the results showed the majority of prescriptions followed guidance.

Pharmacy staff reviewed each patient's medicines regularly and provided prescribing advice to the medical team. They also supported the clinical team to ensure monitoring of medicines was completed at the appropriate and recommended time intervals. The pharmacy team also provided advice to patients, their family's and carers about their medicines.

Medicines were mostly stored safely. The temperature of the room and refrigerator where medicines were stored were monitored. However, records showed the temperatures had been above the recommended maximum. The ward staff did not always take the necessary action to ensure the medicines were safe to use. The trust completed audits around the safe storage of medicines, the audits had also identified the temperatures were above the recommended maximum.

Emergency medicines were available and stored safely and securely. There was a process in place to ensure the medicines were within their expiry dates, however we found the records to show the appropriate checks had been made, were not always completed.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation, to show people were prescribed the correct medicines when admitted to the trust, were completed. Audits for January 2023 to June 2023 showed trust targets of 95% of patients to have their medicines reconciled within 24 hours were not being met. Latest audit figures showed on average 55.44% of patients had their medicines reconciled within 24 hours (level 2 medicines reconciliation) on weekdays and 30.26% at weekends. Post inspection the trust provided evidence of a new report to help improve the accuracy of medicines reconciliation data and to inform resource and business planning. The National Institute for Health and Care Excellence sets the standards as 95% within 24 hours of admission to hospital.

Staff learned from safety alerts and incidents to improve practice. Staff told us they knew the process to follow if they identified a medicines incident and lessons learnt were shared to prevent recurrence. Staff also took part in wider learning with other organisations and networks.

Records showed staff completed medicines management training to ensure medicines were managed safely.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Between November 2022 and April 2023, there were 314 incidents reported for the families division. All the incidents were reported as either no or minor harm. The most common theme of incidents being reported was medication and equipment. Each incident had action plans and lessons learned where appropriate. There were no never events on any of the divisions units in the 6 months prior to our inspection.

Services for children and young people

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy using an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

Serious incidents were investigated jointly by a multidisciplinary team. Children, young people and their families were involved in these investigations where appropriate. We reviewed 3 incident investigations. They were detailed, provided the root causes of the issues which had contributed to the incident, actions were proposed with an action plan owner and review date to ensure completion. Staff involved in reporting were given feedback at the conclusion of any investigation.

Managers shared learning with their staff about all relevant incidents that happened elsewhere in the hospital and trust. Staff told us that they felt informed about incidents that had happened on their ward and elsewhere and that learning was shared well.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at a clinical leads meeting and learning from incidents was fed back to staff in safety huddles and by email. We reviewed ward team meeting minutes and found that incidents and learning were discussed.

Managers debriefed and supported staff after any serious incident. It was evident the wellbeing of the staff involved in incidents was considered and they were supported throughout the investigation process.

Is the service effective?

Good 

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed trust policies to plan and deliver high quality care according to best practice and national guidance. Staff used a patient clinical pathway record to plan, deliver and evaluate care and treatment. The document referenced the National Institute for Health and Care Excellence (NICE) guidance for each plan of care. NICE and trust guidelines were available on the trust intranet. Staff said guidance was easy to access, comprehensive and clear to follow.

Clinical practice reflected guidance and best practice. Key issues in children and young people care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured children and young people received care and treatment based on national guidance.

Clinical audit was being undertaken and there was good participation in expected and relevant national and local audits.

Services for children and young people

The trust performed generally well in national clinical audits.

At handover meetings, staff routinely discussed the psychological and emotional needs of children, young people and their families. We observed that nurses had comprehensive understanding of the patient's needs. They provided background information about each patient and included their emotional and psychological needs and what measures had been put in place i.e. assessments completed, and action plans put in place.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Children and young people were offered 3 meals a day with snacks also available. Staff supported children and young people to eat and drink if needed and provided fresh water.

Staff fully and accurately completed children and young people's fluid and nutrition charts when needed. Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. They completed hydration assessments at the patient's bedside. Results were recorded in the patient's record to ensure the patient's nutritional and hydration needs were assessed and monitored.

Specialist support from staff such as dietitians and speech and language therapists was available for children and young people who needed it. Medical and nursing staff could make referrals for support from dietitians and Speech and Language Therapists for patients. Patients received individualised nutrition and hydration care plans. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed.

The patients and family or carers we spoke with provided positive feedback about the food and drinks.

The service made adjustments for patients' religious, cultural and other needs.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice and patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately and pain scores were recorded in all patients notes we reviewed.

Staff used pictorial aids to assess the pain of children and young people who could not communicate verbally. Children and young people received pain relief soon after requesting it. The patients and families we spoke with told us staff provided prompt pain relief. Families were complimentary of the level of care provided to their loved ones.

Services for children and young people

Pain specialists routinely reviewed children and young people during the week. They supported staff with complex pain management methods. Staff we spoke with were aware of the pain team and how to make referrals to them for individualised advice and said they would contact them for difficulties with pain management.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

Managers and staff carried out a programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas. The service participated in relevant national clinical audits.

The service performed generally better than the national average in the National Asthma and Chronic Obstructive Pulmonary Disease Audit programme (NACAP) child and young persons asthma 2021 organisational audit published in July 2022.

The service performed in line with expectations in the 2022 National Paediatric Diabetes Audit (NPDA).

Managers shared and made sure staff understood information from the audits. Staff we spoke with told us that they were informed of audit results via the ward newsletters and at handover and team meetings. We saw the minutes of the divisional clinical governance and quality committee meetings for March, April and May 2023 which showed that both national and local audits and quality improvement projects were presented and there was opportunity to escalate any issues.

Competent staff

The service made sure staff were competent for their roles. Managers mostly appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of children and young people. Managers gave all new staff a full induction tailored to their role before they started work. Staff said the trust induction programme was detailed and comprehensive and provided all the information and support they needed to do their jobs.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff development and training was supported by clinical educators and practice development nurses. Clinical educators and practice development nurses also scheduled training following incidents. This training would be specific to the concerns raised by the incident.

Managers made sure most staff received any specialist training for their role. Staff completed competencies for the specialist area they worked in.

Managers generally supported staff to develop through yearly, constructive appraisals of their work. The current nursing appraisal rate supplied was 85.9% against a target of 85%. However, the medical appraisal rates showed an average compliance across children and young people wards of 73.7%. Junior medical staff had an allocated clinical supervisor.

Services for children and young people

Staff we spoke with at the inspection told us that they were able to discuss training needs at appraisals and had the opportunity to pursue additional training. There were examples of staff receiving specialist training for their role.

There were handovers at shift changes, during which patients, operational matters and any incidents and complaints would be discussed.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective MDT meetings to discuss children and young people and improve their care. On the wards we visited there were daily MDT meetings which were attended by different members of the MDT which included doctors, physiotherapists, ward sister or manager and discharge planner. Items such as discharge dates, social needs, occupational and physiotherapy, actions required, discharge paperwork, DNACPRs, investigation results, symptom management, medications and specialty reviews needed were discussed.

Staff we spoke with commented on the positive culture throughout the children and young person's wards, they said they felt there was good team working across all clinical and non-clinical staff.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff could make referrals to other clinical specialties, including mental health, for advice and support. Physiotherapists, dietitians and speech and language therapists, specialist nurses and social workers were involved in patient care as required.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. Staff could make referrals to the psychiatric liaison service as required.

We saw evidence of good communication and collaborative working between the trust safeguarding team, Children and Adolescent Mental Health Services (CAMHS), social services and other multi-agency partners.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including at weekends. Children and young people were reviewed by specialist consultants depending on their care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

There was an on-call medical team available out of hours. The psychiatric liaison team was accessible for mental health support out of hours. Diagnostic tests required for urgent management decisions were available out of hours.

Children and young people were reviewed by consultants depending on the care pathway. We were told if a patient's pathway was complex the consultant from the unit, they were an inpatient on would lead the care.

The service always had senior nurses on site and staff had access to an on-call general manager and senior nurse at weekends. The children and young people's outpatient department at Bolton One was open Monday to Friday.

Services for children and young people

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw posters and information leaflets in the service for patients and relatives to promote a healthy lifestyle.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. The In-Patient Admission Bundle included sections which assessed aspects such as alcohol, smoking, eating well, physical activity and mental wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from children, young people and their families for their care and treatment in line with legislation and guidance. Staff made sure children, young people and their families consented to treatment based on all the information available. Staff clearly recorded consent in the children and young people's records.

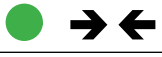
Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. When children, young people or their families could not give consent, staff made decisions in their best interest, considering the patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were mostly completed correctly.

Records showed managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff could access the trust safeguarding team for assistance and guidance with completion of DoLS applications.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We were informed staff regularly assessed the needs of patients with mental health needs. When risk assessments were completed and/or concerns were raised, staff would work alongside mental health nurses to ensure the safety of the patient.

Is the service caring?

Good 

Compassionate care

Services for children and young people

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Call bells were answered promptly by staff. Curtains were pulled around the bed areas to provide privacy when needed.

Children, young people and their families said staff treated them well and with kindness. Children, young people and their families we spoke with at the inspection agreed that staff treated them with dignity and compassion. Parents or carers we spoke with were very satisfied with the care their child had received.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Children, young people and their families we spoke with at inspection agreed that these various needs were met. We saw that handover sheets included information on these aspects.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families and those close to them help, emotional support and advice when they needed it. Children, young people and their families we spoke with at inspection agreed that staff provided emotional support to them and their relatives when needed.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their wellbeing and on those close to them. Children, young people and their families we spoke with at inspection agreed that staff understood this.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

The trust's palliative care team provided support to children, young people and their families who were at the end of life. The trust provided a bereavement service for families who had a relative die when in the hospital. This service provided emotional and practical support for families who had been bereaved. The division held a monthly bereavement group meeting. The trust held an annual baby remembrance and memorial service to support families and teams who are dealing with bereavement and loss.

The hospital had a multi faith spiritual care service with 24hour access to a multi faith prayer room to support to patients and their relatives.

Understanding and involvement of patients and those close to them

Services for children and young people

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff talked with children, young people and their families in a way they could understand. Children, young people and their families we spoke with at inspection reported that staff spoke to them in a way they could understand and would rephrase information differently or simplify it if required.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. All areas invited children, young people, and their families to provide feedback. Data provided by the trust from December 2022 to June 2023 showed 99.8% positive feedback from 1,022 responses.

Staff supported children, young people, and their families to make informed decisions about their care. All areas had leaflets explaining procedures and medical conditions which informed children, young people, and their families about their care. Staff had access to specialist teams who supported children, young people, and their families.

We saw completed examples of patient passports which provided details such as 'things you must know about me', 'things that are important to me' and 'my likes and dislikes' and included details such as 'how to communicate with me', 'how I take my medication' and 'how to tell if I am in pain'.

Is the service responsive?

Good 

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The population around the trust site was diverse and patients could present with complex health needs. Managers planned and organised services, so they met the changing needs of the local population. Staff made sure patients living with mental health problems and learning disabilities, received the necessary care to meet all their needs.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards inspected were adhering to the guidance regarding mixed sex accommodation. There had been no reported mixed sex breaches in the past 6 months. Facilities and premises were appropriate for the services being delivered.

Managers monitored and took action to minimise missed appointments and managers ensured that patients who did not attend appointments were contacted.

The service had systems to help care for patients in need of additional support or specialist intervention. There was access to dietitians, speech and language therapists (SALT), physiotherapists, and other clinical specialties for opinions. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations. The premises were mostly airy and welcoming.

Services for children and young people

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. The psychiatric liaison service was available 24 hours a day and 7 days a week.

The service worked hard to be inclusive and worked hard to meet the diverse needs of those of different cultures in terms of care, treatment and cultural activity.

Staff and leaders worked to relieve system pressures and improve patient experience by delivering same day care and treatment when appropriate to prevent unnecessary admissions.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services.

Within the children and young people's outpatient department at Bolton One, when patients had to be seen by different specialities, staff grouped appointments together, where possible, to limit patient travel and save them time.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems and learning disabilities, received the necessary care to meet all their needs. The Psychiatric Liaison Service provided advice on mental health conditions.

The trust safeguarding team were able to support staff with urgent issues or provide advice. There was a learning disabilities team available during normal working hours.

The service had play specialists 7-days a week and for those patients able to attend an education service was available 5 days a week. Staff shared how they had been able to support a child to take examinations whilst in the hospital so as not to interrupt their education.

Wards were designed to meet the needs of children, young people and their families. Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Play specialist had a sensory room which was also available for families and carers to use. They worked with individual children, supplied toys for distraction (including within theatres) and were age specific.

Staff used transition plans to support young people moving on to adult services.

Staff supported children and young people living with complex health care needs by using 'My hospital passport' documents.

Patients who had a learning disability or other cognitive impairment were identified at ward handovers and safety huddles.

Services for children and young people

Staff were aware of ways to meet the information and communication needs of children and young people with a disability or sensory loss. Staff we spoke with were able to describe communication aids for children and young people not able to communicate in the conventional way to allow them to become partners in their care and treatment.

Staff had access to hearing loops to communicate with children, young people and their families. Patient information was available in alternative languages.

Managers made sure staff, children, young people and their families whose first language was not English could access interpretation services when needed. There was a telephone-based interpretation service which allowed immediate access to an interpreter 24 hours a day. Face-to-face interpreters required booking in advance. British Sign Language support could be arranged through the Patient Advice and Liaison Service (PALS).

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and generally received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure they started discharge planning as early as possible. The trust had a dedicated bed management team to manage and maintain patient flow.

There was a complex discharge team who were responsible for enhancing patient discharges for patients with more complex needs. They worked across 7 days and facilitated discharges for patients nearing the end of life or going to a care home.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The service moved children and young patients only when there was a clear medical reason or it was in their best interest.

Managers monitored patient transfers and followed national standards. Bed management meetings were held a minimum twice per day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas.

Staff supported patients when they were referred or transferred between services. Staff supported children and young people with additional needs to be discharged to hospices or their own homes.

At the time of our inspection, the trust did not have any medical outliers (children and young people placed on a non-children and young people's ward). The trusts 'Management of 16 and 17 year olds admitted to adult wards' policy included escalation procedures. The policy included a clear criteria that staff were required to consider before a patient was deemed suitable to outlie in an adult inpatient area.

Services for children and young people

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. The service displayed information about how to raise a concern in children, young people and their families areas. Details about how to raise a concern or make a complaint were displayed on the trust website and displayed in ward areas. The service displayed quality boards in the ward areas. Staff updated these boards monthly and recorded the number of complaints received for each area for children, young people and their families to see.

Between November 2022 and May 2023, the families division received 3 formal complaints raised through the patient advice and liaison service (PALS). Of the 3 complaints received 1 of the complaints was upheld. We reviewed the 3 complaint responses and saw that they were comprehensive, and concerns raised by complainants were addressed. The trust had acted when learning was identified from complaints and learning was shared with the relevant teams and across the wider trust. At the time of our inspection the division had no open complaints.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with during the inspection were able to explain how they would approach patients and relatives who wished to make a complaint. Managers investigated complaints and identified themes. The ward and unit managers were responsible for investigating complaints in their areas. Managers shared feedback from complaints with staff in daily safety huddles, on ward rounds and in team meetings and learning was used to improve the service.

Complaints were reviewed at divisional clinical governance and quality committee meetings and shared in the divisional quarterly governance newsletter.

Children, young people and their received feedback from managers after the investigation into their complaint.

Is the service well-led?

Good 

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders of the family's division worked in a multi professional team and consisted of a director of operations, a divisional medical director and divisional nurse director and a director of midwifery for antenatal services.

Services for children and young people

Children and young people's wards had a ward manager and/or ward sister who were supported by matrons. The ward managers and ward sisters we spoke with on the wards we visited were visible and engaging and had good knowledge of operational matters and the patients on their wards. Matrons met with ward leaders on a one-to-one basis and discussed issues such as workforce and current trends and themes around risk and issues.

As part of the inspection, we interviewed ward managers and matrons, head of nursing and clinical leads and general managers. All were engaging and demonstrated good understanding and knowledge of clinical and operational matters.

Staff we spoke with found divisional leaders approachable and accessible. Leaders proactively sought to make themselves visible and accessible to both staff and patients. Ward manager details were displayed on wards to enable easy contact by patients and relatives, and some ward managers said they would approach new patients to introduce themselves and explain their role.

We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues.

Staff were encouraged and supported to develop their skills and take on more senior roles. The trust had development programmes for staff aspiring to be leaders.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Staff at all levels could describe a vision and strategy for their individual wards. The trust wide vision was displayed in all ward areas and available on the trust intranet. Divisional leaders said divisional strategies were developed based on the needs of the local population and were aligned to the trust vision and strategy.

The trust listed 6 strategic ambitions within their 5-year strategy due to run until 2024;

To give every person the best treatment, every time

To be a great place to work

To spend our money wisely

To make our hospital and our buildings fit for the future

To join-up services to improve the health of the people of Bolton

To develop partnerships across Greater Manchester to improve services

The division held a family care division service review in June 2023 where they presented their updated vision to divisional staff.

Services for children and young people

Culture

Within the service, staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with during the inspection were positive about the culture within the division, saying that it was friendly, with lots of support, and that people all helped each other. They felt the service was open and honest. Clinical leads said they all supported each other, even when not on call, and that there was good will amongst the consultant body.

Staff told us they could raise concerns and were encouraged to do so by local leaders. They had confidence these would be addressed. The service had access to a Freedom to Speak Up Guardian.

Staff felt valued and supported by their immediate managers. At a ward and unit level, staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients. Staff spoke positively about wellbeing resources provided by the trust.

The 2022 NHS Staff survey showed that for items such as 'colleagues are understanding and kind to one another' and are 'polite and treat each other with respect' the trust performed well compared to the national average.

On the questions of 'I enjoy working with the colleagues in my team', and 'feel valued by my team' the trust performed well compared to the national average.

The workforce across the family's division was multicultural. Staff felt their identity and culture was respected.

The trust had developed several staff networks.

• Staff from ethnic minority groups

• Disability

• Lesbian, Bisexual, Gay, Transgender (LBGT)

Governance

Local leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Divisional leaders we spoke with had confidence that the systems for incident and safety matters were robust. We saw that incidents, complaints and audit results were discussed at clinical service governance meetings and mortality reviews, with some actions identified for improvements.

There were governance structures within the trust with representation from all disciplines. Divisional governance group meetings fed into the quality or governance meetings which reported to the executive management committee and to the sub committees of the board.

There was a clear governance structure within the division. They held their own clinical governance and quality meetings. We reviewed clinical governance meeting minutes and we saw that incidents, audits, complaints, compliments, patient experience, risks, risk register and risk management and action logs were discussed at these meetings.

A programme of audits measured the performance of the service, including staff adherence to trust policies and guidance.

The trust board received routine reports on waiting time performance and national audit programmes.

Management of risk, issues and performance

Local leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service maintained a divisional risk register which gave details of risks, the control measures in place, ownership, review date and risk rating level for the different clinical service lines. Ownership of risks and their control measures was allocated to specific individuals, and there was an area on the register where they could provide date and time-stamped risk reviews to monitor progress. Risks could be escalated by Clinical Service Lines to the Executive Board, which could provide Executive support and oversight of risks as deemed necessary.

Risks were recorded at ward and division level in accordance with the governance framework. It was clear from the divisional risk register that high scoring risks were escalated and considered at a more senior level and for the most significant risks at board level.

Records of governance meetings showed that risks were considered at most meetings. Risk registers set out who was responsible for the risk and the dates the risk had been reviewed which included actions taken to reduce or mitigate the risk.

The clinical and non-clinical leaders we spoke with as part of the inspection demonstrated a good awareness and understanding of the risks existing in their areas and for the service as a whole.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust collected, analysed, managed, and used information to support its activities, using secure electronic systems with security safeguards. The trust's website provided annual quality performance reports and board reports which included data about performance. This gave patients and members of the public a range of information about the safety and governance of the hospital. Senior leaders had confidence that data was accurate and reliable.

Information governance and data security training was part of the mandatory training programme, 94% of staff had completed the training against the trust target of 85%.

Wards had computer terminals to allow staff to access patient results and trust guidelines and policies through the trust intranet. Staff had individual logins and passwords to access this information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Ward leaders and staff explained that they would introduce themselves to new children and young patients and their families on the ward, so they knew who to come to if there were any problems. Details of ward leaders were displayed in the main areas of wards to inform children, young people and their families of who to contact with any queries or concerns. When children and young people were ready to be discharged staff collected feedback from them.

Staff we spoke with told us they felt involved and engaged and listened to by leaders and felt they could approach them with suggestions for improvements or concerns. The trust participated in the 2022 NHS staff survey to gain staff views on multiple aspects of their work. We saw that for the parameter 'Able to make suggestions to improve the work of my team/dept' the trust performed well compared to the national average. Similarly, the parameter 'Able to make improvements happen in my area of work' the trust performed well compared to the national average.

Information about incidents, complaints, compliments, and operational aspects was shared with staff at daily ward handover meetings and via ward newsletters. There were also 'safety huddles' where staff reviewed all patients on the ward and were able to raise any problems.

We reviewed minutes of the monthly quality patient experience forum where patient stories', patient experiences and local Health Watch reports were agenda items.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They were developing an effective understanding of quality improvement methods and the skills to use them.

The division has developed a health improvement and prevention plan designed at improving and raising awareness of the health needs of patients and staff.

The division has developed and rolled out human factor training for staff.

All wards and departments were being supported to identify areas for improvement and use quality improvement methodology to bring about the changes. Learning and innovation was shared via the 'Family Care Division Good News' bulletin.