Bolton NHS Foundation Trust

Royal Bolton Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal Bolton Hospital

Inspected but not rated

We carried out this unannounced focused inspection of the medical and emergency department services at The Royal Bolton Hospital.

Bolton NHS Foundation Trust provides hospital and community health services in the North West sector of Greater Manchester, delivering services from the Royal Bolton Hospital and providing a wide range of community services from locations across Bolton.

Royal Bolton Hospital provides acute care to the populations of Bolton, Salford, Wigan and Leigh.

It is estimated to have a catchment population of 1,000,000; compared with a resident Bolton population of 285,000.

The emergency department is described as a type 1 (consultant-led 24-hour service with full facilities for resuscitating patients). The total attendances in October 2022 were 11250 compared with 11673 in October 2021. There are separate adult and paediatric emergency areas, a minors' area, a same day emergency care unit (SDEC) which was re-launched (September 2022) and a pilot urgent treatment centre.

The medical service consisted of 16 in-patient wards, 54 respiratory beds with a ward based non-invasive ventilation service. Coronary Care Unit, 35 cardiology beds as well as diabetes, gastroenterology, haematology, acute stroke, acute frailty, medical assessment, three care of elderly and three escalation wards.

Bolton NHS Foundation Trust was last inspected in December 2018 and January 2019, with the report published in April 2019. The overall rating was good, well led at trust level was rated outstanding. The inspection included the emergency department, Medicine and Maternity.

Whilst acknowledging the recognised national challenge faced by urgent and emergency care services, fundamental standards of care remain paramount to patient safety.

We did not rate all the domains inspected however we rated safe in the emergency department because 2 requirement notices have been served which limits the rating to requires improvement in safe. The other previous ratings of good remain and they remain good overall.

We did not rate the medicine service. The ratings of good remains.

Urgent and emergency services

Inspected but not rated

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

The service had enough staff to care for patients and keep them safe. Staff managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.

People could access the service when they needed it.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

However:

Staff did not always have training in key skills such as safeguarding children

Triage times were not always in line with the national expectation.

Patients experiencing mental health illness could wait extended periods of time in the waiting room and not all areas where patients waited were ligature free.

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have the training on how to recognise and report abuse in children.

Nursing staff did not always receive training specific for their role on how to recognise and report abuse in children. The Royal College of Paediatric and Child Health sets out that clinical staff should undertake level 3 children's safeguarding training. Of the 138 staff required to complete the training, 54 members of staff, (39%) had completed it meaning that the service could not be assured staff had the knowledge to recognise children at risk of harm or abuse. Following the inspection, managers informed us that an improvement plan was in place and that progress of this was being monitored by divisional and trust wide governance processes.

Staff received training on how to recognise and report abuse in adults, 86% of the 201 staff required to complete adult safeguarding level two training had completed it and of the 29 staff required to complete adult safeguarding level 1, 93% had completed it.

Urgent and emergency services

Staff knew how to make a safeguarding referral and who to inform if they had concerns and a manual prompt was built into the electronic system meaning that staff could not move past the prompt without answering whether there was a concern or not. Staff that we spoke with during the inspection told us that referrals were easy to make, and support was available from the safeguarding team.

All ED records of patients aged 0 to 19 years went to a specialist subsection of the trust safeguarding team to ensure that any indication of harm or abuse had been identified and appropriately escalated.

An electronic flag on the patient record system indicated to staff if the patient was a looked after child meaning that staff could be extra vigilant.

Cleanliness, infection control and hygiene

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Areas were visibly clean and had suitable furnishings such as disposable curtains and wipe clean mattresses which were clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE). A monthly hand hygiene audit demonstrated an average compliance of 86% in the adult area of the ED and 98% in the paediatric area of the service. During the inspection we saw that staff observed the uniform policy, were bare below the elbows and washed their hands regularly.

Personal protective equipment was available including personal issue respirator hoods which were kept charged and accessible in a storeroom within the department.

Any patient admitted with shortness of breath had a rapid PCR test for COVID-19 and patients with suspected infectious illnesses such as flu or norovirus were cared for in cubicles which had doors fitted rather than curtains so that the spread of the infection could be contained.

Staff cleaned equipment such as blood pressure monitors and pulse oxygen monitors after patient contact and observed aseptic non touch technique when treating people with intravenous cannulas.

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.

The design of the environment followed national guidance. There was a dedicated room for patients experiencing mental health illness located within the department. This was a private room where all ligature risks had been removed and contained heavy furniture which could not easily be moved. There were 2 doors and an alarm within this room. When the room was in use the department had designated a cubicle next to the nursing coordinator desk as the preferred place for other patients experiencing mental health illness. This was an ordinary cubicle where the risk of

ligature was reduced as much as possible such as by removing oxygen tubing. In the event of another patient experiencing mental ill health attending the department, the patient would be assessed and placed in the waiting room. The service had identified this to be unsatisfactory and listed this as a risk upon its risk register. At the time of the inspection facilities management were conducting joint inspections of the unit to determine a solution.

All curtains used within the department were anti ligature curtains.

A safety alert had been issued for non-invasive ventilation equipment used within the department. Equipment had been borrowed from the respiratory ward meaning there was continuity in what equipment was used. This sat as a risk upon the service risk register as new ventilation equipment had not yet been procured.

A daily safety check of specialist equipment including emergency equipment was in place throughout the department. Resuscitation equipment was located in the waiting area so that if someone deteriorated, they could be quickly treated, and a dedicated trolley was kept in the event that someone collapsed in the waiting area. At the time of the inspection we found that 1 trolley contained some out of date items. This was immediately rectified and in response the service, along with the medical service, conducted an audit of all emergency equipment to ensure that it had not expired.

A separate children's area was located within the service. This was a secure area and could be accessed via buzzer or swipe card meaning that children within the department could not wander, nor adults gain access unless they were meant to be there. In addition, it meant that children did not witness any distressing scenes from the adult area.

Multiple alarms were located within the department. During the inspection we witnessed on 2 occasions the effectiveness of these bells as staff quickly responded to help. In addition, patients had access to and could reach call bells and when they were pressed, we saw that staff responded quickly.

A 2 bedded paediatric resuscitation bay was located on the unit and had direct access to the adult resuscitation unit meaning that additional help, support and equipment could be quickly and easily obtained. There was a sensory room in the paediatric area which meant that children had a calming space to wait where they were not overstimulated. This is important for children with conditions such as autism or those with sensory impairments who may find the busy unit stressful and upsetting.

The service had suitable facilities to meet the needs of patients' families including a relative's room where relatives could wait for their loved ones. Access to hot and cold drinks and a telephone were available.

Staff disposed of clinical waste safely in a locked utility room which was then transferred daily to the trust wide site for safe disposal.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

A band 7 streaming nurse was located at the front door of the service. This meant that patients could be quickly and effectively signposted to the most appropriate services such as the urgent treatment centre without waiting. The service streamed about 24% of patients to alternative services through October 2022, above the England average of about 16%.

Urgent and emergency services

Patients walking into the service booked in at reception before being triaged by 2 band 6 triage nurses. They were trained in Manchester Triage (MTS) which is a nationally recognised method of initial assessment. If a patient presented to the department and told reception staff, they had chest pain, stroke symptoms or had cancer then the patient was given a higher priority and therefore triaged more quickly. Patients undergoing treatment for cancer often had a reduced immune system so this meant they could be treated quickly and also moved to an area away from other patients who could be infectious.

Patients presenting with chest pain received an electro cardio graph (ECG) before they were triaged, and band 6 staff had patient group directives to administer a strong antibiotic for patients presenting at triage with symptoms of sepsis meaning the patients received the required treatment as quickly as possible.

Between 1 and 22 November 2022, 86% of patients were triaged within the national 15 minute standard. If the time to triage went above 15 minutes or more than 8 patients were waiting to be triaged, then additional staff were sent to support the area. The median time to initial assessment for October 2022 was 2 minutes which was better than the England average of 10 minutes.

Diagnostic tests including blood testing and CT scanning could be accessed from the department 24 hours a day, 7 days a week meaning that patients could receive the most appropriate treatment as quickly as possible. Point of care testing was in place within the unit which allowed staff to check for in the blood gases of patients within the service.

A total of 18,135 paediatric patients aged 16 and below attended the service between 1 June and 12 December 2022. Of those, 14,779 (81%) were triaged within 15 minutes. Of the remaining 11%, 20 incident reports had been made in relation to extended triage times with none reported as resulting in harm.

A rapid assessment triage area assessed patients arriving by ambulance. This area had 3 bays and if the triage area became full and it was required nurse and care for patients on the corridor,a ratio of 1 registered general nurse to 5 patients was in place. There were 2 registered general nurses allocated to this area meaning that a total of 10 patients could be cared for on the corridor. A standard operating procedure and escalation process was in place to support the care of patients on the corridor.

A presentation priority matrix was used within the service to support staff with decision making. This matrix signposted staff in a stepwise approach. For example, a patient with abdominal pain graded orange outcome (high priority on MTS triage) would be suitable for the majors assessment area and would require specific blood tests within the first 30 minutes. This meant that patients received timely diagnostic assessments. A patient presenting with coffee ground vomit would be transferred to the major's assessment area, escalated to the nursing co-ordinator and undergo appropriate tests.

Clinical observations were undertaken in line with national guidance and the service's deteriorating patient policy. Staff used a nationally recognised tool to identify and escalate deteriorating patients and treatments such as antibiotics for patients with suspected sepsis were administered within the expected timeframes. Staff undertook training on how to recognise and manage sepsis and prompts on the electronic patient recording system signposted staff to think about sepsis at all times, for example if the patient had an early warning score greater than 5, had a mottled or ashen appearance or blueish colouring to lips. In addition, if recorded clinical observations were outside of the expected range the system flagged up a sepsis alert to the staff. This meant that not only did staff know how to identify and treat sepsis, they were supported by the electronic reporting system in use. This is important because when staff are undertaking multiple tasks in a busy and pressurised environment it can be easy to miss or misjudge signs and symptoms. We

reviewed 5 patient records and found that clinical observations were recorded appropriately. Two patients with suspected sepsis had received treatment in line with national standards. Results from a clinical observation (NEWS2) audit carried out in October 2022 demonstrated that 88% of the 60 records had been completed in line with service standard, 8 were not applicable and 6 had not met the standard.

Patients were identified on an electronic patient record system depending on their presentation, for example the notes of patients presenting with mental health illness were highlighted orange to alert staff there may be a risk of suicide or absconding meaning additional surveillance could be considered and implemented where appropriate.

Patients attending with mental illhealth were triaged by staff in the emergency department and then referred for a mental health assessment by staff from another provider. This team was in the hospital and provided 24 hour a day, 7 days a week support. Due to pressures on this service often patients waited lengthy periods of time to be assessed. This delay in assessment particularly of patients in non-monitored areas such as the waiting room opened up risk to the individuals waiting to be assessed. The service had recognised this and in response to a serious incident within the department the service had updated its procedure for caring for patients awaiting mental health assessment or admittance to include hourly contact from staff within the service. This meant that not only could the patient be seen and determined that they had not absconded but also had any other care needs such as nutrition and hydration met.

Patients awaiting mental health assessment often waited to be seen in the waiting area. We reviewed 5 records of patients awaiting a mental health assessment and found that patients had waited between 28 minutes and 4 hours 44 minutes for a mental health review. Of these, 2 patients had waited in the waiting room. This meant that the patient was unable to rest, lie down, or sit quietly in private during this time. Of the 5 patients we reviewed 4 had a clearly documented risk assessments of harm free care such as nutrition and hydration. A service level agreement between the 2 services set out that patients should be assessed within an hour. The issue the service had faced was that often patients were initially assessed within the initial hour of attending however patients then waited for extended periods of time to be either reassessed or for a bed once a decision to admit had been made. Only one of the five patients presenting with mental ill health which were reviewed, had a documented individual risk assessment around the suitability of them being in the waiting area. Between June and November 2022, 1,709 patients presented to the service with mental health symptoms requiring mental health assessment.

A newly formed governance meeting between the service and the mental health provider demonstrated that this had been raised and was being monitored. In addition, a consultant led on mental health within the department.

Staff shared key information to keep patients safe when handing over their care to others. A situation, background, assessment and recommendation (SBAR) handover template was used to standardise the information shared when handing patient care over to a different area and team within the wider hospital.

Staff were allocated to be part of a specific emergency team, at the beginning of each shift, that would act as an initial response in the event of a collapse or sudden deterioration of a patient within the service. At the time of the inspection we saw this in practice when a patient presenting to the department collapsed at the front door. The team were fast in responding with the appropriate equipment to the patient.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients 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 and agency staff a full induction.

Urgent and emergency services

Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift in accordance with national guidance. We reviewed staffing rotas between 26 September and 3 October 2022. Between this time, 23 of the 150 registered nursing shifts, were uncovered. The service had utilised registered nursing bank and agency staff and increased nursing associate and health care assistant provision where it could to support the gaps. Enhanced bank shift rates of pay meant that the service was able to utilise more bank staff than agency. This was more cost effective for the service but also meant that staff who already worked and knew the department took up additional shifts.

Staff told us that they were not moved to other areas within the trust to work which demonstrated that the trust understood the importance of adequate staffing within the service and in addition the service was in the process of increasing its establishment to include an additional 10 registered nursing staff to support the waiting room, rapid assessment triage and corridor escalation areas.

The monthly sickness rate for the service ranged from 4.6% to 6.6% from August 2021 to July 2022.

A supernumerary shift leader and a newly implemented floor manager role were in place and the service was in the process of recruiting a second matron so that senior leadership support was available 7 days a week between the hours of 7am and midnight.

Staffing in both the adult and paediatric department was reviewed by the matron and department manager along with patient attendance and acuity 4 times daily. To mitigate low numbers of registered paediatric nurses within the service, the department had created a rotation of senior band 6 registered general nurses into the paediatric department for a supernumerary period to familiarise themselves with paediatric documentation and procedures. This meant these staff could flex where necessary to support alongside the registered paediatric nursing staff. We reviewed the paediatric registered nursing rota for the weeks commencing 3 October, 19 September and 7 November 2022 and found that a minimum of 2 registered paediatric nurses were on duty at all times which was in line with the Royal College of Paediatric and Child Health Facing the Future: Standards for children in emergency care settings which set out that "a minimum of 2 children's nurses in dedicated children's emergency departments must possess recognisable post-registration trauma and emergency training".

The paediatric service was also staffed with 4 health care assistants. Although the establishment was to provide a play worker 7 days a week, only 1 was employed which meant the service could not deliver this 7 days a week.

The minors' unit was staffed by 5 emergency nurse practitioners (ENP's) daily along with 2 physiotherapists and 1 nursing associate and 2 ENP's overnight 7 days a week.

A team to support people with alcohol problems was based within the service between 8am and 5pm 7 days a week.

Volunteers had been reintroduced within the department. The volunteers supported staff in offering hot drinks and food to patients and relatives waiting. The recruitment of volunteers was done in conjunction with the wider trust's human resource department which managed the on-boarding including mandatory and safeguarding training.

At the time of the inspection the service was in the process of reviewing various rotational staffing models with a view to trialling rotations within the department, however, this was in the very early stages. Rotating staff through different areas of the department allows for wider skills and experience to support all areas of the department.

Medical staffing

Urgent and emergency services

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly including an onsite senior registrar of ST4 trained in advanced life support and doctors in training.

The consultant body was in the department from 8am until midnight and then available on call afterwards. A dedicated paediatric consultant worked in the department and another led on mental health. In addition, a paediatric consultant from the paediatric ward worked shifts twice a week in the service.

The service worked with the deaneries to support recruitment along with international recruitment of medical staff. Allied health professions such as advanced clinical practitioner and emergency clinical practitioners also supported the medical rota.

Teaching time was protected, and the service worked collectively across the wider network to share how they managed to retain and recruit staff. Juniors attended ward rounds and part time and flexible working was prevalent to support colleagues in managing their work life balance.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported serious incidents clearly and in line with trust policy and received feedback from incident investigations. During the inspection we spoke with several members of staff, all were aware of a serious incident which had occurred within the service and understood what actions the service had taken in response. We saw evidence that changes had been made as a result of feedback, a standard operating procedure had been put in place following a serious incident that had occurred within the service.

Staff that we spoke with could give examples of feedback they had received from incidents included feedback about pressure wounds.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. An electronic incident reporting system had a built in step of formal duty of candour being undertaken meaning that senior managers could not progress an incident investigation until this had been completed and staff knew how to apologise informally in the first instance if something went wrong. In addition, incidents and duty of candour were discussed at weekly governance meetings.

The shift leader completed a daily incident for any nursing being undertaken within escalation areas and the service had recognised an increase in the number of harm free care incident reporting such as pressure wounds and falls. This meant that the service could investigate and put action plans in place to address any patterns in incident occurrence.

Urgent and emergency services

Is the service responsive?

Inspected but not rated

We did not rate the service. The previous rating of good remains.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients did not meeting the national standard however, the service was achieving similar performance to other trusts nationally.

The department had fluctuating daily attendance rates. Figures showed that through October 2022 the department attendances ranged between 293 and 419 and on 14 November 2022 there were 459 attendances.

At the time of the inspection there were 118 patients in the department although 211 patients had been seen that day. Data predictions by the service predicted 214 patients. This meant, using the data predictions the service could plan accordingly for example staffing numbers.

The year to date (April to October 2022) 4-hour performance for the service was 60%. In October 2022 the 4 hour performance was 54% compared to a national average of 69% Although this was below the national average, it was in line with similar trusts nationally.

The number of patients waiting over 12 hours from the time a decision to admit was made had increased since August 2021, with a more rapid increase beginning in February 2022. It had more than quadrupled since February 2022, from 113 to 470 in September 2022. The longest waiting time of a patient during the inspection from when the decision to admit a patient had been made, was 42 hours 40 minutes.

Reattendance within 7 days of previous attendance at the service was below the regional and England averages, it ranged from 6 to 8% between September 2021 and October 2022. In August 2022, the reattendance rate was 7%, compared to 9.2% regional average and 8.8% England average.

The median time to initial assessment for emergency ambulance cases had ranged between 2 and 6 minutes since September 2021, at 2 minutes in August 2022. This was better than the England average of 9 to 11 minutes within the same period.

The service followed the operational pressures escalation levels (OPEL) framework and at the time of the inspection was on level 3 (red) level. This triggered a series of actions including discussions at trust level with the wider system with the aim to create flow and movement through the service and wider hospital. The shift co-ordinator maintained close contact with trust leaders and all patients were reviewed to ensure that those requiring the most intensive support in the service received it and those that could be stepped down were, therefore creating a small temporary amount of movement within the service.

Reverse queuing was used within the service in a bid to keep patients waiting to be assessed cared for. This involved patients that had been treated and were waiting for beds on wards being nursed on the corridor.

Urgent and emergency services

The same day emergency care (SDEC) had 11 cubicle (9 cubicles with door and 2 bays) which allowed patients access to a senior decision maker earlier in the pathway and expediated patient discharges. The area was protected and was not used for 'bedding' down patients overnight, at the time of the inspection it saw approximately 90 patients per day 7 days a week between 8am and 10pm. All patients that had been sent to the emergency department by a general practitioner or healthcare professional were seen in the SDEC area. These patients were triaged by an advanced nurse practitioner on arrival.

Daily specialty input including gastroenterology, cardiology and respiratory took place, trans ischemia attacks (TIA), cellulitis, deep vein thrombosis and respiratory clinics all ran from the SDEC area. Staff within the SDEC could admit patients directly to the necessary speciality team reducing the need for patients to be transferred to the medical or surgical assessment units.

A home first team within the SDEC supported urgent care patients and were able to undertake home first assessments as well as accessing diagnostic tests such as bloods and scans. At the time of the inspection a frailty service was in operation 5 days a week, 10 hours a day. Recruitment was underway so that the service could be provided 7 days a week. This meant that frail patients attending the service were seen earlier by specialists in elderly medicine and care initiated in preparation for admission if required.

A pilot urgent treatment centre had been taking place since September 2022 replacing the general practitioner service. The pilot service had a mixed model of staffing that included staff from the service as well as the local out of hours general practitioner service. The service ran between 8am and midnight. At the time of the inspection the service saw around 80 patients per day however it was envisaged that this could be increased to 140 once fully set up which would alleviate some of the pressure in the ED.

Is the service well-led?

Inspected but not rated

We did not rate the service. The previous rating of good remains.

Leadership

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 within the service were visible and approachable. This consisted of operational and clinical leaders, nursing manager and team leaders. Succession planning was in place and there was a framework for staff to develop their skills and take on more senior roles. Leaders undertook formal leadership and first line management qualifications.

Additional leadership roles were being created in recognition of the increase in demand and support required by the staff and the service worked with system colleagues such as A&E delivery boards, general practitioners, commissioning colleagues and urgent transformation boards to understand and prioritise its issues and challenges

Urgent and emergency services

Leaders were able to articulate their key challenges and priorities which largely focused around quality of care for patient with extended waits in the department.

Culture

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

Staff that we spoke with felt respected and valued. Regular drop-in sessions were in place for staff to speak with leaders, 2 wellbeing champions were in place within the service. The champions organised regular events and sessions for staff. Mental health first aiders and freedom to speak up guardians were also in place within the service.

Staff were included in decision making within the service and felt empowered to improve patient care which supported a culture of openness and trust. For example, staff collectively made suggestions which had been acted upon such as the specialist pressure relieving mattresses and the pathways being devised for the same day emergency care unit such as the headache pathway currently being created.

Staff that we spoke with felt that operating procedures such as high priority in triaging clerking, easy access to secondary investigations and specialist referrals contributed to the feeling that staff were valued.

One staff member commented how they had been involved in decision making within the service and that the leadership within the service was not just top down leadership. Whilst others told us that the retention of staff in the department was high because the service focused on the staff and gave them more training and development that the minimum requirements. The consultant body was visible, and an open-door policy with leaders was meaningful.

A monthly gazette (newsletter) was created and shared with staff to keep them informed of important updates but also contained light-hearted articles and provided details of how staff could seek help and support if they needed it. The November 2022 issue contained information about the new machines for non-invasive ventilation, harm free care, appraisal results, compliments and employee assist details.

Management of risk, issues and performance

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 identified and escalated risks and issues and worked hard to reduce their impact. A demand analysis had demonstrated the need for an additional triage nurse, and this had been actioned. Staffing was protected and was increased to reflect areas of escalation. Additional support towards harm free care had been implemented in recognition of patients waiting longer within the department and the same day emergency care and urgent treatment centre models were working to support the access and flow of relevant services.

Agency staff induction had been amended to include harm free care designed with corridor care in mind. This was in response to a thematic review the service had undertaken in conjunction with the trust wide pressure care panel and as

a result, pressure alleviating trolley mattresses had been purchased and a bedding down standard operating procedure had been introduced for all patients in cubicles waiting for admission. These and other actions were tracked on an electronic tracker by leaders within the service but were also cascaded down to junior staff to encourage ownership and involvement in decision making and problem solving.

The service participated in groups and forums and maintained close daily contact with ambulance trust colleagues to try to reduce ambulance turnaround times as much as possible. They also provided clear guidance and support for staff on how to escalate increasing demand or unexpected incidents within the service. This included a major's department escalation card which was completed by the shift co-ordinator every 4 hours so that leaders within the service and the wider trust were aware of the building pressures and could take actions to reduce them as quickly as possible.

Waiting times including paediatric waiting times were monitored via divisional governance meetings where themes, trends and improvement work could be initiated.

A policy for business continuity set out actions staff should undertake in the event of an incident threatening the provision of the service. In addition to this a winter plan supported by the chief operating officer for the trust was in place and was reviewed by the executive board in November 2022.

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:

Royal Bolton Hospital Emergency department

- The trust must ensure that staff receive safeguarding training that is relevant and updated at appropriate intervals to keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13(2)
- The trust must ensure that it mitigates the risks to the health and safety of service users receiving care or treatment including patients with mental health illness waiting for assessment and/or admittance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(a)(b)
- The trust must ensure that risk assessment relating to the health, safety and welfare of people using their service are completed including ligature risk assessments in the waiting room where mental health patients wait for extended periods of time to allow for reasonable adjustments to be made. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation (12(2)(a)

Action the trust SHOULD take to improve:

Royal Bolton Hospital Emergency department

- The trust should ensure that patients both adult and children are triaged within the nationally set out timeframe.

Urgent and emergency services

- The trust should ensure that out of date equipment is not in circulation and that daily checks carried out are meaningful.

Medical care (including older people's care)

Inspected but not rated

In Medical Care we found that:

The service had enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff assessed risks to patients and acted on them.

Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Key services were available 7 days a week.

Staff treated patients 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 patients, families and carers.

Leaders ran services well using reliable information systems. Staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services. Managers were aware of risks to the service and mitigated these risks.

However:

In some of the paper “Do not resuscitate” records we saw there was not enough detail around the clinical decision with reasoning and clinical information. There was more appropriate detail in the electronic records.

The service planned care to meet the needs of local people. People could not always access the service when they needed it.

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which appeared clean and well-maintained. All the wards we visited had side rooms where patients could be isolated if they had an infectious disease. We saw that barrier nursing principles were used for these patients.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were plentiful supplies of PPE and infection prevention control audits were carried out every week. Hand hygiene audits carried out on wards: B3 were at 100%, D1 were at 98% and D2 were at 97% for the period June 2022 to November 2022. We saw that all staff were appropriately bare below the elbow.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that green stickers were used to indicate that equipment had been cleaned. There were patients with influenza who had been admitted to the acute medical units (D1 and D2) from the emergency department (ED). They had been tested in the ED and were isolated in the side rooms on D1 and D2 to protect other patients.

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.

Patients could reach call bells and staff responded quickly when called. All beds had oxygen and suction supplies. Suction was checked every day and recorded on the safety huddle sheets.

The wards we visited did not always have good line of sight of patients from the nurses' station. Staff tried to put the most poorly patients closer to the nurses' station, however all the bays had an allocated nurse so patients could be seen by the staff.

Staff carried out daily safety checks of specialist equipment which was documented on the daily huddle list. During the inspection of the emergency department we found that there were out of date items on some of the resuscitation trolleys. As a result of this all resuscitation trolleys across the division were checked.

We saw that there were mattress audits to check the surface and the integrity of the mattresses. On B3 and D1 the audit scored 100% for October and November 2022. D2 had only recently opened and had no audit results.

The service had enough suitable equipment to help staff safely care for patients. There was a library for equipment including information specific to bariatric equipment. On D2 we were told that if specialist equipment was needed this could be ordered and was delivered to the hospital within 4 hours.

Staff disposed of clinical waste safely. Sharps bins were not overfilled and were signed and dated and were fixed to the wall where appropriate.

There was a bladder scanner on B3 so that staff could check for urinary retention. Staff said that this was invaluable.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This was the National Early Warning Score (NEWS2). We looked at 6 patient care records and in all the records the NEWS observations had been recorded, the score calculated and if appropriate the patient had been escalated for review and treatment.

There was an electronic system that collated observations from patients and alerted staff to consider a diagnosis of sepsis. We saw an example where the system flagged that a NEWS score had been escalated and the patient was reviewed by a consultant in 18 minutes.

Medical care (including older people's care)

Staff completed risk assessments for each patient on admission to the wards. In the 6 records we looked at we saw that venous thromboembolism risk assessments had been completed and that pressure ulcer risk assessments had been completed and reviewed within 2 hours of admission. Falls risk assessments had been completed and there was evidence of daily ward rounds and reviews from senior clinicians.

There were mandated checklists for venous thromboembolism and sepsis in the clerking ward proforma on the information systems and this delivered prompts to the ward if these were not completed. This supported the prevention of deterioration from venous thromboembolism and sepsis. Doctors reported that nurses were competent and quick in the recognition of deteriorating patients and that consultants were responsive to any requests to review patients.

The acute frailty medical unit (D2) had been open since October 2022. At the time of the inspection it was open 7 days a week but was nurse led at weekends. If patients were admitted to the unit at weekends they had to be seen and clerked in the ED by a consultant before being admitted to the ward.

Patients were assessed in the ED to see if they met the criteria for the unit. There was a focus on discharge and any potential discharge issues would be highlighted straight away. The ward team worked with the discharge planning team and the admission avoidance team to try to reduce the length of stay for the frail patients and prevent deconditioning and other issues that could result in a prolonged stay and a complex discharge.

There was a nursing huddle every morning on D2. All patients were discussed in this handover with information including NEWS scores, infection control, any safeguarding concerns and information about do not resuscitate status. This huddle was documented for each patient and at the bottom of the documentation was a section for the checking of controlled drugs, suction, crash trolley, and battery checks. The link nurses for diabetes and falls for the day were noted in the documentation. The meeting was attended by the nurse practitioners from ED to support continuity of care.

Doctors reported that nurses were competent and quick in the recognition of deteriorating patients and that consultants were responsive to any requests to review patients. Doctors in training who we spoke with on D1, D2 and B3 all reported that it was easy to contact consultants in hours for deteriorating patients. Out of hours, nurses could post electronically to the medical on call team.

There were consultant led ward rounds in the mornings and a catch up for doctors in the afternoon. Following the ward rounds there were multi-disciplinary team meetings where all patients were discussed.

Patients admitted to the wards had an “avoiding levels of harm assessment” (ALOHA). The score from the assessment was used as a guideline to help to identify a patient’s risk to themselves and to others. All patients had a risk assessment completed on admission and this was updated every day if the condition of the patient changed or if they were transferred to another ward.

The risk assessment looked at evidence of cognitive impairment including delirium, dementia or learning disability, physical violence to staff and others, mobility, falls history, exit seeking, non-concordance with treatment, postural hypotension and mental illness. This gave a score with 0-2 low risk, level 3 moderate risk requiring 24- hour bay tagging and level 4 high risk requiring 24-hour close observation.

Patients who were at risk level 3 and 4 could be supported by the enhanced care and support team (ECAST). This was a multidisciplinary team comprising of specialist nurses, occupational therapists and support workers who provided

enhanced care and support. They provided support including activities, personal care assistance, assistance with eating, distraction therapies and music and arts and craft therapies. The band 6 nurses in the ECAST team helped with medication compliance and nursing interventions for patients with challenging and intense behaviour including if required, the use of Deprivation of Liberty Safeguards (DoLS).

The ECAST team met with the mental health liaison team every week to identify the most challenging patients and provide support.

In some of the paper "Do not resuscitate" records we saw there was not enough detail regarding clinical decision with reasoning and clinical information. There was, however, much more detail in the electronic records.

Nurse staffing and allied health professional staffing

The service had enough nursing, allied health professional and support staff with the right qualifications, skills, training and experience to keep patients 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 and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. The number of nurses to patient ratio was about 1:5. The trust had recruited a number of international nurses who were working on the wards but who were currently supernumerary to the staffing numbers.

The trust had recently recruited about 50 health care assistants to support care across the trust. Some of these health care assistants had been assigned to the medical wards.

Sickness levels for the medical wards were about 5.5% and there was a 3.4% vacancy rate.

On D2, managers were still adjusting staff levels and skill mix to meet the acuity of the patients as the ward had only been open for a month at the time of the inspection. They had 5 registered nurses on day shifts with 4 health care assistants and at night there were 4 registered nurses and 3 health care assistants. They had 4 international nurses who had just started on the ward.

There was a full-time physiotherapist, an occupational therapist and an assistant to support the patients on D2. There was also a dedicated pharmacist and pharmacy technician for the ward.

Staffing was an item on the directorate risk register as staffing was a fluid situation. Managers were aware that staffing levels could change quickly and there needed to be contingencies in place.

The ward D2, could get support from the ECAST team if they had complex patients on the ward. They could support the nurses and the allied health professional in personal care, falls prevention, assistance with feeding and concordance with medicines. We saw on the inspection that members of the ECAST team bay tagging patients at risk of falls.

On B3, the complex frailty ward, there was an over-establishment of staff and the ward had 2 international nurses who had joined the team but were currently supernumerary to the staffing numbers. The ward had good retention rates and we spoke to a nurse who had come to work on the ward following their nurse training as they had enjoyed their time there as a student. The ward had dedicated physiotherapy and occupational therapy support.

In the discharge lounge there were 2 registered nurses and a health care assistant to cover the service 7.30am to 8pm and 2 registered nurses to cover the weekend when the service was open 9am to 5pm. There was always a band 6 nurse on duty in the discharge lounge.

Medical staffing

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

There was a pool of 11 doctors in training who worked across the acute medical units, the clinical decision unit and the same day emergency care centre.

The acute medical unit (D2) for frailty had been set up in October 2022. Managers and medical staff were reviewing and changing medical, nursing and allied health professional staffing to reflect the acuity of the patients on the ward. On D2 there were 2 consultants, 2 senior house officers (SHO's), a physician associate and a specialist registrar. The ward was not reliant on locum staffing. Doctors we spoke with said the medical staffing levels were right for the acuity of the ward.

The specialist registrar post was not always filled but the post was supernumerary because of the consultant availability.

The SHO's on the ward reported excellent training and ward organisation and said there was good staff retention. Other doctors in training in the hospital were keen to work on the ward.

There was no ward round at weekend, but all patients received a consultant review in the ED before being admitted to the ward.

If the junior doctor was the shift doctor other doctors could be pulled from the other medical wards so that resources were shared across the wards.

On B3, which was a complex frailty ward, there were 2 consultants and 2 doctors in training from a pool of 3. There was sometimes a specialist registrar, but this was infrequent. The doctors in training said that they had really good communication with the consultants.

On D1 which was the acute medical unit there were 2 consultants and 2 doctors in training. Junior medical staff told us that they always finished on time.

All doctors in training we spoke with said that they were well supported by the consultants and always had access to them. They were supported in their personal lives and with any mental health challenges.

doctors in training we spoke with liked working at the trust, they received a full induction and were supported in their training requirements.

At the focus group we held, a consultant told us that there was good staff retention as it was a great place to work. They had trained at the trust and returned there following their training as they had enjoyed their time training there.

There was an issue with recruitment of acute medical consultants. However, the trust had recruited several geriatricians to support the increasing numbers of frail patients admitted to the trust.

Medical care (including older people's care)

Is the service effective?

Inspected but not rated

Patient outcomes

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

The service participated in relevant national clinical audits. However due to the pandemic the results of these audits had not been published in a time frame relevant to this inspection.

There were audits of compliance with guidance from the National Institute of Health and Care Excellence.

For the period February 2021 to January 2022, length of stay (LOS) at trust level for non-elective medical patients was 5.9 days which was in line with the England average of 6 days. Medical patients LOS was 5.5 days (England average 5.4 days); in geriatric medicine LOS was 6.2 days (England average 8.8 days) and in respiratory medicine LOS was 9.6 days (England average 7.6 days).

For the period February 2021 to January 2022, the average length of stay for elective patients across the trust was 16.1 days which was higher than the England average of 6.4 days. In general medicine the LOS was 7.3 days (England average 7.2 days).

From January to December 2021, the relative risk of readmission for elective and non-elective admissions were largely similar to the England average.

Staff were collecting data and measuring outcomes for the newly opened D2 frailty acute medical unit. The key performance indicators (KPI's) that they had set were reduction of length of stay by 0.5 days, to improve discharge times before 10am, to reduce readmission in 30 days, to reduce drug spending by promoting de-prescribing and a reduction in locum spend. These KPI's were red, amber and green rated. Since the pilot had gone live in October 2022 discharges by 10am were at 6% which was rated amber (same as expected) and discharges by 12am were at 17% which was green (showing improvement). Locum spend was amber (same as expected) and drug spend was green (showing improvement). The average length of stay on the complex care wards was 14.5 days in October 2022 which showed an improvement on the LOS in September 2022 which was 18.7 days.

The enhanced care and support team had developed KPI's for their service. Some of these were based on guidance from the National Institute of Health and Care Excellence and all related to the Care Quality Commission inspection framework. These included reduction of the risk scores for patients scoring at level 3 and 4 on the avoiding level of harm assessment (ALOHA), reduction in violence and aggression incidents for patients who had been referred to the team, and a reduction in falls incidents relating to patients referred to the team.

Medical care (including older people's care)

There has been a decrease in falls incidents from a high of over 6 falls per 1000 bed days in February 2022 to just over 4 per 1000 bed days in October 2022. Violence and aggression incidences had fallen to the lowest level in October 2022 for the period May 2022 to October 2022 with a steady decrease in numbers from April 2022. The numbers of patients with a level 3 and 4 risk score had remained about the same and was rated amber. The team had revised their KPI's after their first 6 months and agreed new KPI's which were more quantifiable. Actions were in place for the team.

Each ward had KPI's which were monitored weekly and monthly. Infection control compliance was reviewed every week and every month there were audits on the environment, medicines, nutrition, falls and equipment. The outcomes of the audits were fed back to staff at monthly staff meetings. They were also given performance data and the top spends on their wards. There were boards in public areas of the wards showing the results of audits.

The trust had a quality accreditation scheme for the wards and results were shown on the white boards on the wards. D1 and D2 were at bronze level and B3 was at silver level at the time of the inspection. Action plans were in place to address any gaps in services.

A pressure ulcer quality improvement project was in place across the trust to reduce the incidence of pressure ulcers. This had been launched in October 2022 with the aim of reducing hospital acquired category 2 ulcers by 50% by July 2024 and to eradicate all category 3 and 4 pressure ulcers by July 2023.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held daily multidisciplinary meetings (MDT) on all the wards we visited, Monday to Friday, to discuss patients and support their care.

We attended an MDT meeting on D2 the frailty acute medical unit. The meetings were held every day at 11.30 am and each patient was discussed. The meeting was consultant led and included attendance from doctors in training, physiotherapists, pharmacists, specialist nurses, social workers, the advanced nurse practitioner for frailty, representatives from community services and the community discharge team.

The meeting we attended had strong leadership with a flat hierarchy. All members were encouraged to participate. The meetings were recorded, and tasks were allocated to group members.

The discussions about the patients were patient focused and included information about their family situations, their carers, and any social issues relating to discharge.

We saw that pharmacists liaised with community pharmacists to support care and treatment of patients.

Seven-day services

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

Consultants led daily ward rounds on all wards Monday to Friday. The frailty acute medical unit was opened in October 2022 and was consultant led Monday to Friday and nurse led at weekend. The staff told us the intention was this would become a 7-day service dependant on outcomes and staffing.

Medical care (including older people's care)

Nurses on D2 were able to discharge patients at weekend if appropriate.

All patients admitted to the acute medical wards at weekend were clerked and reviewed by consultants in the emergency department before being admitted to the wards.

There was an out of hours medical on call team which covered all the medical wards. This comprised of 2 specialist registrars, 3 senior houses officers and 2 advanced nurse practitioners.

Diagnostic tests were available 24 hours a day, 7 days a week.

The discharge lounge was open 7 days a week to support patient discharge from across the trust.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed on the wards we visited that staff treated patients well and they were kind to them.

We spoke with 4 patients during our visit to the medical wards. All said that their confidentiality had been respected and that staff were courteous and respectful. They said that staff always introduced themselves prior to consultation and they were treated with kindness and compassion.

The patients told us that staff had provided psychological and emotional support and we saw that staff comforted patients when they were upset.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed at the multi-disciplinary team meetings that staff were non-judgemental about all patients including those living with dementia or mental health problems. Care was patient centred.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Medical care (including older people's care)

Staff made sure patients and those close to them understood their care and treatment. During the multi-disciplinary meeting on D2 we saw that discussions about care and treatment always took account of the wishes of the patients and their relatives. Staff were tasked with speaking to patients and their relatives following the MDT about the outcomes of the meeting.

The MDT involved details about patients and their carers' circumstances, the levels of support they were currently receiving, and the level of support needed for a safe discharge. There were discussions about end of life treatment and the preferred place of care. We saw that end of life patients were discharged quickly when preferred place of care had been agreed.

Documentation that we saw gave details of discussions between staff and patients and their relatives.

We spoke with 4 patients during the inspection. They were all very positive about the treatment that they had received during their stay in the hospital. They all told us that they had been involved in the decision making as well as their relatives.

We saw that D2 and B3 had conducted the friends and family survey. In October 2022, 100% of the patients surveyed recommended the wards.

We saw, from reviewing a patient story, how a patient could be supported by the enhanced care and support team (ECAST) during their hospital stay. For one patient, an issue was that they would refuse treatment if they felt that they hadn't been involved in decision making. The ECAST team had supported the patient to identify the triggers to their aggressive and challenging behaviour. This enabled a safe discharge after a long length of stay.

The trust surveyed patients about discharge processes and used the information to help to improve patient discharge.

We saw that staff were compassionate with the treatment of a married couple who were admitted to the ward. They found accommodation so that they could be together. The family were very thankful.

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the 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.

Some of the hospital estate was not designed for current service requirements but managers and staff worked to address any issues with the estate to ensure that services were safe**.**

Managers planned and organised services, so they met the changing needs of the local population. We saw that the frailty acute medical unit had been set up to meet the needs of the population of older people with complex conditions to try to facilitate faster, safer discharge.

There was a discharge lounge to facilitate speedy discharge for patients. Some services in the community were managed by staff at the hospital; this provided seamless care and supported patients and their relatives in their homes if appropriate.

The trust worked closely with partners in the community and the local authority to support admission avoidance and caring for patients in their own homes.

The service had systems to help care for patients in need of additional support or specialist intervention. There was an enhanced care and support team to support patients with complex needs. They worked with ward staff and the mental health liaison team to identify those with the greatest needs.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Access and flow

People could access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times through the risk register which identified areas where performance was not meeting national targets and actions were taken to try and address the delays.

There was an emphasis placed on safe discharge as soon as patients arrived on the frailty acute medical unit D2. There were assessment criteria for the ward to safely discharge patients. The daily multi-disciplinary team meetings on the ward meant that discharge was discussed for all patients and the support that would be needed for a safe discharge. The dedicated therapy team was able to order appropriate equipment which arrived in a timely manner, and to put together care plans to support the patients. The pharmacy team did a medicines review for each patient and a review of how patients were taking their medicines to provide them and their carers with advice if appropriate. Patients could be referred to the same day emergency centre (SDEC) for follow up by the medical team if necessary.

We were told that ward-based therapists in the hospital could refer directly to reablement services in the community and these referrals would be picked up within 24 hours.

The enhanced care and support team worked towards supporting patient discharge. They worked with complex patients to develop a patient care passport to support a safe and effective discharge. This enabled care providers to understand the patient's interests, preferences and any reasonable adjustments they needed to make for a safe discharge.

The trust told us that there were 6 patients who had a combined length of stay of over 500 days, one patient's stay was over 250 days. By using the patient care passport and providing enhanced care the team were able to support 5 discharges within 7 days of getting involved with the patients.

The team would escort patients to their care home and help them to settle in and they followed them up, this helped to prevent readmission to the hospital.

There were bed meetings every day at 9am, 1pm, 4pm and 7pm. The meeting we attended was well attended by all hospital specialities and there was community representation. The meeting was led by the lead manager for

unscheduled care and all divisions provided an update on their current bed situation with the emergency department reporting on attendances, any breaches and any ambulance waits. Staffing levels of nursing and medical staff were discussed, and contingencies were put in place if necessary. The infection prevention control nurse gave an update on any patient with a contagious infection and the need for side rooms. There were allocated actions for managers which were documented. Outliers (patients who were receiving care in a ward setting that was not of their speciality) were discussed and actions for the outliers were noted. The meeting also noted the number of patients with no right to reside who were medically fit for discharge to an appropriate care setting.

Following the 9am meeting there was a call to NHS England at 10am to update them of the current bed situation and any access and flow issues.

Data showed that there were no patient moves at night (from 10pm to 8am) on D1 and D2. On B3 there had been 8 bed moves at night in October 2022 and 1 in November 2022.

There was a discharge lounge for patients which cared for between 20 to 35 patients a day. It was open from 7.30am to 8pm Monday to Friday and 9am to 5pm at weekends. These hours reflected the times that pharmacy services were available in the hospital. It was staffed by 2 registered nurses and a health care assistant Monday to Friday and 2 staff at weekend. There was always a band 6 nurse on duty in the lounge.

There were chairs in the lounge and patients who came to the lounge were dressed. There were side rooms if necessary. Patients were checked before discharge for cannulas, received their medicines to take home and staff checked any community and district nurse referrals.

In the mornings the service generally saw discharges from the emergency department with ward discharges later in the day. The lounge was located near out-patient services so patients who required transport from clinics could also wait in the lounge there. Food and drinks were available to patients if required.

A charity was based in the hospital, which was commissioned by the trust, to support patients and their relatives on discharge and when they arrived home. There were plans to expand these services to in reach into the emergency department to identify patients who might benefit from some support.

There was a discharge vehicle to take people home. There had recently been a procurement exercise for patient transport services that were now available up to 2am and from 6am. There were volunteer drivers from the charity to take appropriate patients' home.

There was an integrated discharge lead for the trust and an integrated discharge team which included nurses, social workers, community assessment officers and integrated discharge team navigators. There were also out of area workers to support patient discharge for patients who did not live in the local authority area. The integrated discharge team lead also managed community therapy services and the reablement team was part of the team portfolio, but team members were employed by the local authority.

There were about 100 community beds available for patient discharge, 60 intermediate care beds, 22 discharge to assess beds and spot purchase beds as necessary. These beds were spread across several locations across the borough to support patient choice and so that if there were any infection prevention control issues that might prevent admissions there were other options for discharge.

Medical care (including older people's care)

There was an admissions avoidance team located in the community who worked with the ambulance service to help with supporting patients at home and avoiding admission to the hospital. This team would support any discharges that happened later in the day by providing a first visit before carers could go into the home or a welfare visit to ensure that patients had everything they needed on discharge.

There was a hospital at home model which could manage deteriorating patients in their place of care. This operated from 8am to10pm, 7 days a week. The team consisted of advanced nurse practitioners and therapists.

The trust had started to develop virtual wards, initially for respiratory patients, and then for frailty patients. This project involved working with a neighbouring trust. The trust was working on respiratory pathways in partnership with primary care for early supported discharge. Pathways included acute respiratory infection, and conditions such as chronic obstructive pulmonary disease, pneumonia and bronchiectasis. The frailty pathways were for falls and fragility fractures.

Home intravenous therapy including intravenous antibiotics could be administered and we saw that patients were given appointments to attend the same day elective care service (SDEC) for follow up treatment.

There was a collection point for prescription medicines outside the hospital. Patients could be discharge without medicines and collect them later. A code was sent to a mobile phone so that patients could access their medicines from the secure machine located just outside the hospital.

Is the service well-led?

Inspected but not rated

Leadership

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.

We saw that there was strong leadership on the wards we visited. Ward managers understood the pressures on the services and were focused on providing safe care and treatment. There were regular ward meetings on-line where issues including performance and finance were standard agenda items so that staff knew and understood the priorities for their ward.

We spoke with staff who told us how they had been supported in their development by the trust. Doctors and nurses told us how they had returned to the trust following their training because of the positive leadership at the trust and because of its culture. A locum junior doctor told us that they had received training whilst working for the trust.

Senior managers were visible on the wards and staff knew who they were. Senior nursing staff had good relationships with senior managers, and we saw that senior managers knew who staff were, including junior staff and were aware of any relevant personal issues that might affect their work.

Medical care (including older people's care)

Consultants told us that they had good relationships with senior management. They told us that they listened to them and worked with them to develop safe care and treatment for their patients. The frailty acute medical unit model had been developed by senior medical staff. This meant that there was buy in from medical, nursing and allied health professionals to address the challenges that affected the trust.

Medical staff, including consultants, were aware of the contributions of nursing and allied health professional staff and worked to further develop these staff to meet the needs of the service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There was a risk register for the division, which was up to date, with a description of the risk, the control measures, review dates, the owner of the risk and the person with the responsibility for the risk.

Staff were aware of the risks to the service and could verbalise them. We saw that risk was discussed at staff meetings.

There was information available to managers and clinical staff so that they were aware of risks to the service.

There were links from the operational and divisional risk registers to the strategic risk register and strategic priorities of the trust. There was a risk management group that reported into the quality assurance committee of the board. The committee received reports from the wards and there was a quality dashboard that they received every month giving details of performance and risks to the service.

The trust had contingency plans for unexpected events including a plan for winter pressures.

Outstanding practice

We found the following outstanding practice:

The Enhanced Care and Support team provided an outstanding service to patients with complex needs on the wards and supported them through to a safe discharge.

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 SHOULD take to improve:

Medical wards

Medical care (including older people's care)

- The service should ensure that the paper “do not resuscitate” orders contain the appropriate clinical information as reflected in the electronic records.

Our inspection team

The team that inspected the services comprised 2 CQC lead inspectors, 1 CQC inspector, 2 specialist advisors and an offsite inspection manager. The inspection team was overseen by Karen Knapton, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation