Bolton NHS Foundation Trust

Evidence appendix

Royal Bolton Hospital
Minerva Road
Farnworth
Bolton
BL4 0JR
Tel: <01204 390 390>
<http://www.boltonft.nhs.uk>

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Acute hospital sites at the trust

A list of the acute hospitals at Bolton NHS Foundation Trust is below.

Name of acute hospital site	Address	Details of specialist services provided at the site	Geographical area served
Royal Bolton Hospital	Minerva Road, Farnworth, Bolton, Lancashire, BL4 0JR	Critical care Diagnostic imaging End of life care Gynaecology Maternity Medical care Outpatients Services for children and young people Surgery Urgent and emergency care	Bolton, Salford and Ashton, Wigan and Leigh.

In addition the trust provides a range of community services from multiple locations.

(Source: Trust Website)

Is this organisation well-led?

Leadership

Board Members

The board chairman had completed his tenure but as a successor had not yet been recruited he was continuing to provide leadership one to two days per week. The recruitment process was continuing.

The chief executive officer was well established and had been in post since January 2014, having been the medical director since 2008 after joining the trust since 1998. She firmly believed in putting patients at the heart of everything and her main aim was to ensure the provision of high quality services and safe patient care.

The other senior team members demonstrated varied skills and experience. The nursing director and deputy chief executive officer had a vast wealth of experience within both nursing and operational management roles and professional responsibility for quality and patient safety. She also held the role as Director for Infection Prevention and Control.

The director for finance had a strong track record of delivery and the chief operating officer was also experienced. However, the medical director, an experienced consultant in critical care and emergency medicine, had joined the trust for his first medical director role in August 2018. The director for workforce was also in his first director role. The Director of Strategic Transformation had also recently appointed along with the Medical Director.

Of the seven executive board members at the trust, none were black and minority ethnic (BME) and four (57%) were female.

Of the seven non-executive board members one (14%) was BME and two (29%) were female.

Staff group	BME %	Female %
Executive directors	0%	57%
Non-executive directors	14%	29%
All board members	7%	43%

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

The team was supported by seven non-executive directors, one had very recently been appointed. The Non-Executive Directors we spoke to confirmed an open culture at board that allowed constructive challenge and they demonstrated a good understanding of the key areas of concern or potential concern. They were confident in the data presented to board for assurance and felt that it had received robust scrutiny and challenge before being presented to the board. They chaired or attended relevant committees. The trust had employed an external review of the board functions and the report was positive. It recognised the good challenging culture.

The directors had buddy wards and they would visit regularly each month both in the hospital and the community. Staff agreed that the team were highly visible.

The senior team demonstrated a cohesiveness which centred around the trust values of putting the patient at the heart of what they did and the passion to provide the best care possible for the people of Bolton.
The board had the experience, capacity and capability to ensure that the strategy could be delivered. There were clear development and succession plans in place although there were plans to improve the ability to succession plan through all grades of staff.

Fit and Proper Person Regulations

Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014 applies where a service provider is a health service body. The intention of this regulation is to ensure that the Trust has robust and thorough processes in place to make sure that people who have director level responsibility for the safety and quality of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

The trust had a fit and proper persons policy (version 1) that was current, and the pending review was underway.

We reviewed six files that encompassed both executive and non-executive directors. All files were in line with the Fit and Proper Persons Regulation. In addition to this we saw individual insolvency registers, director's registers with companies' house and fit and proper declarations by individual directors.

We noted that appraisals and competency based interviews were not held in the personnel files. These were either held in the human resources department or the chief executive officers (CEO) office. However, they could be requested as required.

One of the directors was new in post and we saw that they were receiving two weekly one-to-ones with the chief executive officer. This demonstrated that they were receiving good managerial supervision and support within their new role.

Vision and strategy

The strategy "Bolton 2030, a vision for Bolton's future" is an aspirational strategy for the Borough of Bolton. It is based upon a partnership, the Vision Partnership brings together hundreds of partners who have a stake in the Borough – public organisations, private companies, voluntary and community groups, and individuals. The range of people involved is huge, but they have a common interest in working together to achieve the best for Bolton.

It demonstrates the understanding of the strengths within the area and also the challenges faced. It links to the Greater Manchester strategy "Stronger Together" which sets out two key areas where partners can make a real difference – economic growth and reform of public services. The financial challenge is clearly articulated.

The Director of Strategy was working on the development of the new strategy.

Staff were aware of the vision and strategy and their role in achieving them.

The VOICE values (vision, openness, integrity, compassion, and excellence) are the key strategies that underpin delivery of the trust vision and have been in place since 2013/14.

Sustainability and Transformation Plans

The vision for the trust is based within the Bolton Locality Plan (2016 to 2021) which the statutory health and care organisations in Bolton have worked on jointly with wider stakeholders. The plan is designed to deliver real improvements in health and wellbeing for Bolton people and make services more sustainable for the future, in terms of money and patient care. It covers all areas of the integrated services.

The locality plan describes how they will all work together to make the best use of the collective skills and knowledge within the system, developing a population focused health and social care system that spans organisational boundaries, integrates care, builds on community assets working with neighbourhoods and focus relentlessly on improving health and wellbeing outcomes for that population.

The delivery of the locality plan is overseen through the System Sustainability & Transformation Board (SSTB). The SSTB incorporates the chairs of each of the strategy and planning groups, with a good mix of representatives across Bolton.

The Greater Manchester Health and Social Care Partnership (GMHSCP) has a shared vision across Greater Manchester to see the greatest and fastest improvement to the health and wellbeing of the 2.8 million people who live in Greater Manchester. Part of the vision is to standardise acute and specialist care. Bolton NHS Foundation Trust is fully engaged in the developments with partners in the north west sector of Greater Manchester.

The Bolton, Salford and Wigan Partnership made up of three CCGs and three Foundation Trusts in the north west sector of Greater Manchester continues to oversee the local implementation of the Healthier Together proposals. They are overseen by the Partnership Board, made up of executive officers from the six partner organisations.

There was an Operational Plan 1 April 2017 to March 2019 in place which linked the trust objectives to NHS Improvement (NHSI) Single Oversight Framework. It addresses the financial challenge moving forward, a clear approach to improving the quality of care supported by the trusts Quality Improvement (QI) Strategy 2017– 2020 which identifies the key areas of focus. It also identifies work with partners to develop realistic and aligned activity plans.

The work on the new operational strategy was supported by a new strategy team at the trust. The involvement of staff was to be an integral part of the process. The chief executive officer provided a strong leadership voice within the partnerships. There was a recognition of the areas where the trust excels, and they were utilising external support around the integrated model.

Culture

There was a culture which held patient safety at its heart. All members of staff that we interacted with demonstrated a caring attitude and a passion to deliver the best care for the people of Bolton.

The senior leadership team demonstrated an inspiring shared purpose which they strived to deliver. There was an open-door policy and they actively engaged with staff, people who used the service and their representatives and stakeholders. This enabled all levels of staff to adopt the same approach which had shaped a transparent, collaborative and open culture. This was supported through interviews with divisional leads and the findings of the core service inspections.

Leaders at all levels prioritised safe, high quality and compassionate care. Staff we spoke with felt respected, valued and supported by the supportive relationships they had with the senior team.

There was a culture of freedom to challenge that was supported by the interviews we conducted and the review of board and committee papers which demonstrated that challenge. The patient focus was supported through the use of patient stories at Board and Quality and Risk Committee.

Person centred care, supporting cares and staff as advocates were clear themes that showed the integrity within the culture.

Staff were clearly proud to work for the trust and expressed how they felt engaged, empowered and their sense of belonging to the organisation. This is supported by the 2017 NHS Staff Survey results where 22 key finding(s) were better than the average for similar trusts.

Staff development was available at every level and linked to appraisals, of which there was an 84% rate for all staff trust wide year to date (April to July 2018) and the same figure for the previous financial year. This is similar to the trust target of 85%. The NHS staff survey 2017 score was average for the quality of appraisals (with no significant change on the 2016 score). When looking at the percentage of staff receiving appraisals in the last 12 months the trust performed better than other trusts, also with no change compared to the 2016 staff survey.

Staff objectives were linked to the objectives within the trust vision. Education is available through various sources. There is an apprenticeship scheme and a talent management scheme. They were launching a new survey that will capture how staff are feeling monthly and report in to the workforce committee. They also triangulate data between sickness and recruitment to try and get a better picture.

During the inspection and well led review we witnessed a humility across the organisation. There was a palpable humility about the senior leaders which was also noted at divisional level. The staff and executives articulated that what they did was just to get the best for their patients.

Freedom to Speak Up Guardian

The Trust had seconded a member of staff to carry out the role of Freedom to Speak Up guardian two days per week. However, this role would be out to advert for a substantive post for 3 days per week in February 2019.

We saw a paper presented to the Workforce Assurance Committee in April 2018 setting out an overview of the role and the recent developments from the National Guardian Office as well as proposals and action plans for improving on their current position at that time. Following this we observed an update from the Workforce Assurance Committee in June 2018 which illustrated the actions that had taken place by the Freedom to Speak Up guardian in addition to progress against the action plan developed.

An example of an action noted was the addition of eight Freedom to Speak Up champions who were now in post. All were from different clinical specialities and included both male and female representatives. In addition to this there was a champion from a black and minority ethnic (BME) background.

All new staff had received national training and there was attendance at network meetings. There were monthly meetings with the Freedom to Speak Up guardian and champions as well as monthly meetings with the Director of Workforce who was nominated as the Executive Lead for Speaking Up. In addition to this the Freedom to Speak Up Non-Executive Director (NED) had an open invite to the meetings.

All concerns were unique and the process tailored to suit. There was open door access to the chief executive officer and support from the senior team. There had only been three cases reported by the Freedom to Speak up Guardian, a divisional lead said that the trusts open culture and having plenty of supportive people to turn to, was the likely reason for low use of the Guardian. The trust was testing the service by re-designing it and evolving the role into divisions so it did not sit with one person in the Trust.

There was a confidential hot line available to staff and staff could also email the Guardian or Champions. There had been four concerns raised in the last 12 months, three of which had been resolved and one was currently being monitored.

We noted that the Raising Concerns Policy (Version 5) was out of date and that it had been due to be reviewed in May 2015. However, we were told by the Freedom to Speak Up Guardian that the policy was currently under re-development to coincide with National Policy and monthly awareness sessions are being carried out across the Trust. During 2017/2018 a total of eight awareness sessions had been carried out with an average attendance of 15 members of staff.

Guardian of Safe Working Hours

The Guardian of Safe Working Hours protects patients and doctors from working unsafe hours. They are in post to ensure that junior doctors, particularly those on new contracts have their work schedules given to them on time.

The Guardian received and had completed external training to ensure that they were competent for the role. They had protected time to complete the role and alternate Mondays were devoted to this role.

There was a clear process in place to support doctors who worked above contracted hours. Time off in lieu was sometimes given or a fine was incurred. We were told that there had been one fine in the last 12 months.

We observed minutes from the junior doctor forums that were held every two months. These meetings were chaired by the Guardian and attendance was noted from the Director of Education and a representative from the Human Resources Department. Feedback was then given to the Medical Director. In addition to this, the Guardian of Safe Working Hours attended National forums twice a year and the North-West forum quarterly.

Quarterly reports were presented to the quality assurance committee which highlighted, for example, the number of trainees, exception reports from each department, rota gaps, locums used internally and externally and work breaches. There had been no breaches.

We reviewed a critical incident that had been reported regarding working hours, lessons had been learnt and shared via team meetings and emails. In addition, letters had been written to the individuals concerned and reflections and analysis undertaken.

Feedback received from the junior doctors for this service was positive, however this was only collated verbally and not documented to corroborate this at the time of inspection.

Staff Diversity

As of March 2018, the trust employed 5,298 people, of which 4,970 (93.8%) self-declared their ethnicity. Of these, 11.6% self-declared as BME and the remaining 88.4% self-declared as white.

Performance against four key indicators for the most recent and (where available) previous time period are in the table below.

Key indicator	Latest performance	Trust narrative
Percentage of staff in each of the agenda for change Bands 1-9 and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce **Clinical versus non-clinica**l staff comparison	See table below.*	"Analysis of the Trust workforce breakdown shows a gap between white staff and BME staff, with very few employees holding senior management positions in non-clinical roles. It is slightly more positive within the trust's clinical workforce from a BME background."

Key indicator	Latest performance	Performance for previous period	Trust narrative
Relative likelihood of staff being appointed from shortlisting across all posts	1.40	1.37	"White applicants are 1.4 times more likely to be appointed from shortlisting than BME applicants"
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	1.87	2.34	"This indicator demonstrates that BME staff are 1.87 times more likely to enter a formal disciplinary process than white staff. There has been a significant improvement with this indicator over last 12 months which is encouraging and a positive indicator that some of the case management controls put in place over this period has had an impact. However further work is required to eradicate the gap between BME and white staff."
Relative likelihood of staff accessing non-mandatory training and continuing professional development (CPD).	0.95	0.97	"This indicator shows that BME staff and white staff have equal access to non-mandatory training and CPD."

*The trust provided the following staffing data for 2017/18 by grade and ethnicity in their workforce race equality standard report. This gives information on 88.1% of the trust workforce.

Trust staffing data by ethnicity and grade – Clinical and non-clinical Staff

Staff grade	Proportion of total staff excluding staff not reporting ethnicity			
	White clinical staff	BME clinical staff	White non-clinical	BME non-clinical
Under B1	0.0%	0.0%	0.2%	0.1%
Band 1	0.0%	0.0%	0.0%	0.0%
Band 2	11.4%	1.1%	5.3%	0.5%
Band 3	6.0%	0.6%	3.9%	0.3%
Band 4	2.9%	0.4%	3.4%	0.3%
Band 5	14.1%	3.3%	1.6%	0.1%
Band 6	16.1%	1.6%	0.9%	0.0%
Band 7	7.9%	0.8%	0.5%	0.0%
Band 8a	2.5%	0.1%	0.5%	0.0%
Band 8b	0.6%	0.0%	0.3%	0.0%
Band 8c	0.2%	0.0%	0.1%	0.0%
Band 8d	0.0%	0.0%	0.0%	0.0%
Band 9	0.0%	0.0%	0.0%	0.0%
VSM	0.0%	0.0%	0.3%	0.0%
Total	**61.9%**	**7.7%**	**17.7%**	**1.4%**

(Source: Workforce race equality standard report 2017/18)

NHS Staff Survey 2017 – results better than average of acute trusts

The trust had 22 key finding(s) that were better than the average for similar trusts in the 2017 NHS Staff Survey:

Key Finding	**Trust Score**	**National Average**
Appraisals and support for development		
Key finding 11. Percentage appraised in last 12 months.	92%	86%
Key finding 13. Quality of non-mandatory training, learning or development.	4.11	4.06
Equality and diversity		
Key finding 20. Percentage experiencing discrimination at work in last 12 months.	9%	10%
Key finding 21. Percentage believing the organisation provides equal opportunities for career progression / promotion.	89%	85%
Errors and incidents		
Key finding 29. Percentage reporting errors, near misses or incidents witnessed in last month.	93%	91%
Key finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents.	3.90	3.73
Key finding 31. Staff confidence and security in reporting unsafe clinical practice.	3.75	3.67
Health and wellbeing		
Key finding 17. Percentage feeling unwell due to work related stress in last 12 months.	35%	38%
Key finding 18. Percentage attending work in last 3 months despite feeling unwell because they felt pressure.	49%	53%

Key finding 19. Organisational and management interest in and action on health and wellbeing.	3.72	3.63
Working patterns		
Key finding 15. Percentage satisfied with the opportunities for flexible working Patterns.	57%	51%
Job satisfaction		
Key finding 4. Staff motivation at work.	3.96	3.91
Key finding 7. Percentage able to contribute towards improvements at work.	75%	70%
Key finding 8. Staff satisfaction with level of responsibility and involvement.	4.01	3.89
Key finding 9. Effective team working.	3.86	3.74
Managers		
Key finding 5. Recognition and value of staff by managers and the organisation.	3.58	3.44
Key finding 6. Percentage reporting good communication between senior management and staff.	38%	33%
Key finding 10. Support from immediate managers.	3.84	3.76
Patient care and experience		
Key finding 2. Staff satisfaction with the quality of work and care they are able to deliver.	4.02	3.90
Key finding 32. Effective use of patient / service user feedback.	3.82	3.69
Violence, harassment and bullying		
Key finding 26. Percentage experiencing harassment, bullying or abuse from staff in last 12 months.	20%	24%
Key finding 27. Percentage reporting most recent experience of harassment, bullying or abuse.	50%	47%

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has two key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

Key Finding	Trust Score	National Average
Violence, harassment and bullying		
Key finding 22. Percentage experiencing physical violence from patients, relatives or the public in last 12 months.	15%	14%
Key finding 23. Percentage experiencing physical violence from staff in last 12 months.	3%	2%

(Source: NHS Staff Survey 2017)

Workforce race equality standard

The scores presented below are questions relating to bullying and harassment from the NHS staff survey, they are question 17b and key findings 25, 26 and 21 split between white, black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Notes:

- These scores are un-weighted, or not adjusted.
- For question 17b, the percentage featured is that of 'Yes' responses to the question.
- Key finding and question numbers have changed since 2014.

• In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	27%	26%	27%
		BME	20%	27%	27%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	19%	23%	24%
		BME	27%	29%	27%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	90%	88%	93%
		BME	72%	73%	88%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	6%	6%
		BME	20%	15%	14%

The trust showed a significantly different result between White and BME staff for the following question:

Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The trust board has approved the Patient, Family and Carer Experience Strategy; Equality and Diversity is mainstreamed and is integral in this strategy. The Patient Experience, Inclusion and Partnership Committee agree objectives for the year, in order to prioritise and develop the ambitions from the strategy.

The trust acknowledged the importance of supporting the development of black, minority ethnic staff. The Workforce Race Equality Standard report had prompted the trust to develop an action plan to support the inclusive development and engagement of black and minority ethnic staff group.

The trust had developed a Workforce Race Equality Standard Action Plan, when this was reviewed we found that actions were clearly dated and that all identified actions had review dates. The data indicated there had been an improvement in some areas for BME staff. However, there was still a need for the trust to further develop in some areas.

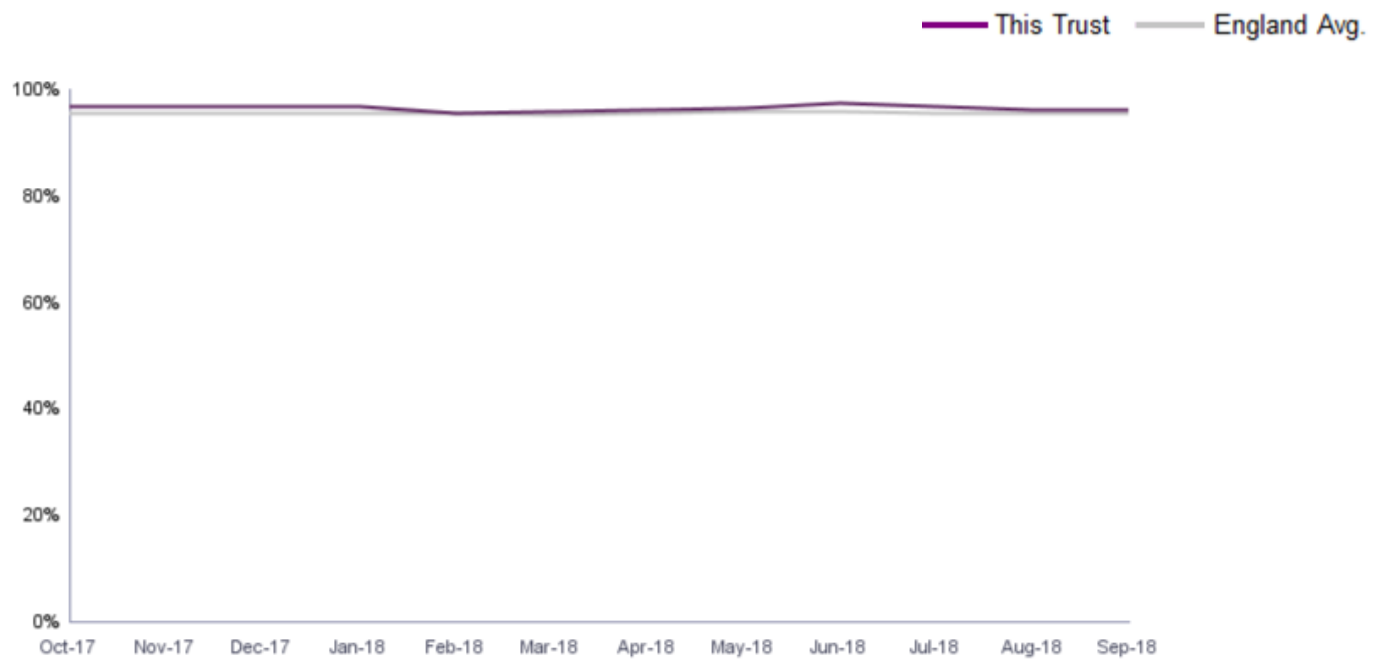
The trust was actively improving the number of nurse recruits from BME backgrounds through engagement at local schools and their local university. They also planned to deliver cultural awareness sessions for all staff.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback

on their experiences of care and treatment.

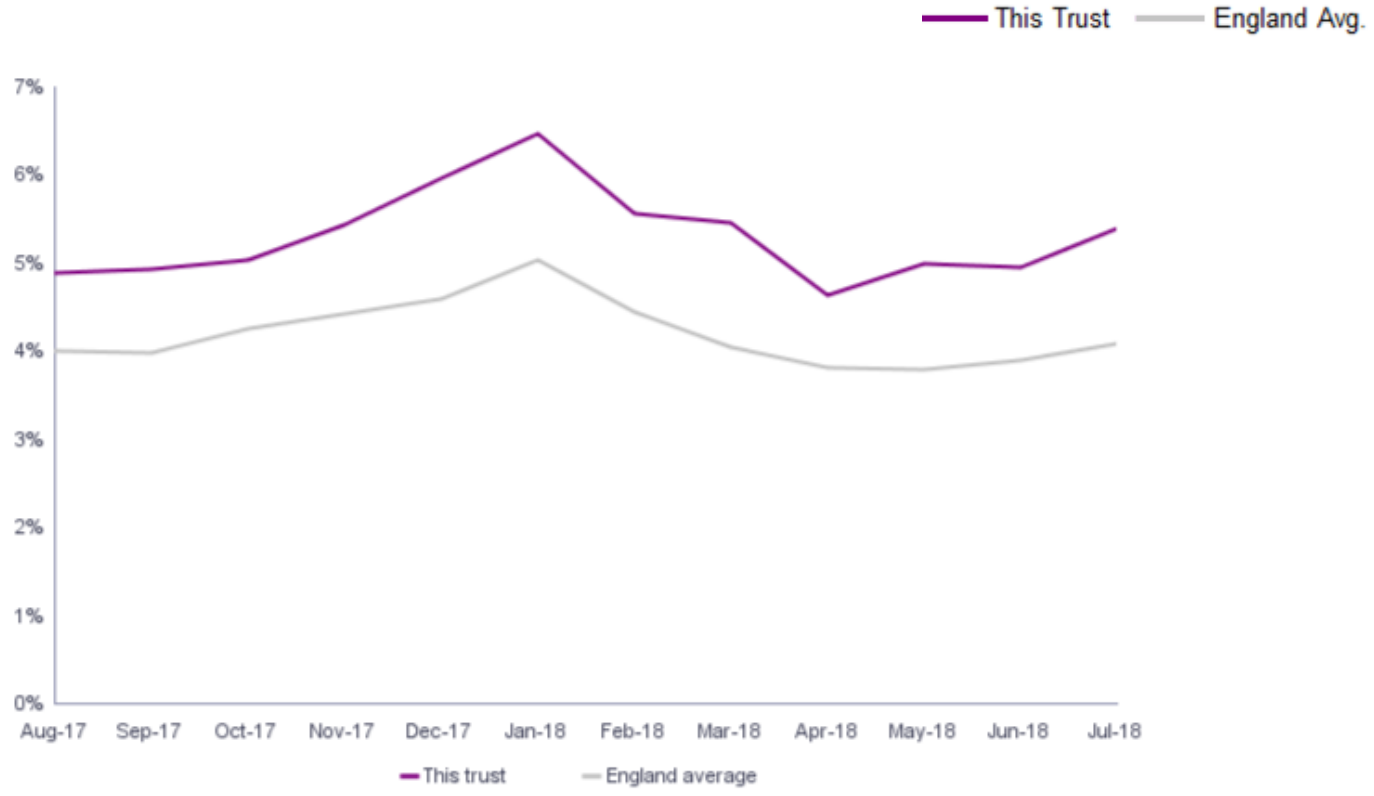
The trust scored close to or slightly better than the England average for recommending the trust as a place to receive care from October 2017 to September 2018.



(Source: Friends and Family Test)

Sickness absence rates

The trust's sickness absence rate from August 2017 to July 2018 was consistently higher than the England average. The trust's sickness absence rate followed a similar trend to the England average.



(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for the all indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance

There were clear systems for governance. There was good clarity on the coverage of director portfolios and the organisational accountability arrangements. The role of the board committees was clear, all of which were chaired by a non-executive director.

There was a structured approach to setting the cost improvement plan and the trust had made good use of Model Hospital and Getting it Right First Time (GiRFT) service improvement tools. There was a comprehensive approach to quality impact assessment of cost improvement schemes which were signed off by the director of nursing and the medical director. It was reported that cost improvements were not transacted against budget until the quality impact assessments had been completed. There was alignment between finance and quality with patient safety as the priority.
The systems allowed for clear escalation and the provision of assurance to the Board. There was an understanding of the areas for improvement and actions were in place to address these. The governance team were introducing a new system for the management of Central Alerting System alerts as they felt this required improvement. They were also reviewing the communication of learning from all areas of the governance system including complaints, incidents, deaths, coroner's report and claims.

Board Assurance Framework

The trust provided their Board Assurance Framework, which details nine strategic objectives, below:

1.1 Reduce healthcare acquired infections
1.2 For our patients to receive safe effective care (pressure ulcers, falls)
1.2 For our patients to receive harm free care (mortality reduction)
1.4 Staff and staffing levels are supported
2.1 To deliver the NHS constitution, achieve Monitor standards and contractual targets
4.1 Service and Financial Sustainability – delivery of control surplus of £10.1m
4.4 Compliance with NHS improvement agency rules
5.4 Achieving sustainable services though collaboration within the North West Sector of Manchester
5.5 Supporting the urgent care system

(Source: Trust Board Assurance Framework – 2017/19)

The Board Assurance Framework had clear links to the strategy. Executives update this monthly and there was a rolling process of more in-depth review of each item.

- **Management of risk, issues and performance**

Quality and performance were closely monitored, and all expected areas were covered by the relevant committees. Assurance was provided to the Board via the Quality Assurance Committee, Audit Committee, Systems Resilience Group, Workforce Assurance Committee and the Finance and Investment Committee. These were all supported by relevant committees and groups. The reporting arrangements for executive scrutiny were via the risk management committee, Quality and Performance Committee and exception reporting through to the board.

The executive team were all cited on the risks and performance issues at the trust, the process for escalating and de-escalating risk within the organisation was well understood by the operational and executive teams. Divisional leaders felt the governance and risk management processes were robust. We reviewed the risk registers and found that they articulated the risks and escalation could be seen.

The NHS Improvement report comparing October 2016 to March 2017 to October 2017 to March 2018 demonstrated that there was no evidence for potential under-reporting of patient safety incidents to the National Reporting and Learning System (NRLS). The reporting rate had increased. However, it was noted that on average 50% of the trust reports were submitted 50 day(s) after the reported incident date. The trust informed us that the length of time to report incidents to the NRLS fluctuates over time, the risk and assurance team during the period October 2016 to November 2018 experienced changes in practice and management that would have impacted on the approach to the time taken to reporting onwards to the NRLS. Stability in the team, leadership and enhanced working practices will ultimately see more incidents dispatched quicker to the NRLS, this work has commenced following the appointment of an experienced Clinical Risk Manager.

NHS Improvement has clear evidence that financial outcomes have been consistently strong over several years i.e. cash, capital and revenue plans being delivered in line with plans and national requirements. The trust finance team meet with NHSI in-year to talk through the risks and mitigations in year, the trust has consistently managed risk and mitigated effectively.

The management of the risk of infection was of a good standard. Systems were in place to monitor and improve with an improvement noted in the occurrence of key monitored infections.

Serious Incidents

Between August 2017 and August 2018, the extract from STEIS showed there were 61 serious incidents reported by the trust. At a core service level, the highest numbers of serious incident were reported in medical care with 28 incidents. Maternity, Surgery and CHS Adults each had 8 incidents reported. A breakdown of serious incidents by core service can be found below. For the same time period the RPIR data supplied by the trust only records 22 of these incidents. The trust confirmed that the PIR submission did not include falls or pressure ulcers.

However, we found that the risk management of serious incidents was responsive, and the right things were being done to keep people safe however follow up and analysis required some increase assurance across the divisions. This had been recognised by the trust and there were robust and achievable plans were in place to improve. It was planned that corporate governance would own this part of the process. The roles and responsibilities of this team were being clarified.

The process for review of serious incidents was of a good standard. Of the four serious incident reviews we looked at, all four were completed well although one contained less detail than the others in some areas. All met the requirements of Duty of Candour.

The trust recognised the need for improvement in corporate governance and analysis of incidents.

Safeguarding patients who lacked mental capacity in DNACPR decisions

At the core service inspection, we found examples of patients who lacked capacity when a Do Not Resuscitate order was put in place had not had review of the order. We highlighted this with the trust.

Review of the safeguarding, incident reporting and consent policies showed that they were of a high standard. Review of the Do Not Attempt Resuscitation Policy highlighted that it was a comprehensive policy which was in the process of review at the time of the inspection.

Finances Overview

	Historical data		Projections	
Financial metrics	**Previous Financial Year (2016/17)**	**Last Financial Year (2017/18)**	**This Financial Year (2018/19)**	**Next Financial Year (2019/20)**
Income	£318.7m	£324.2m	£323.6m	£331.3m
Surplus (deficit)	£3.9m	£2.4m	£1.6m	£0.0m
Full Costs	£304.5m	£321.8m	£322.0m	£331.3m
Budget (or budget deficit)	£2.7m	£2.2m	£1.6m	£0.0m

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Trust corporate risk register

The trust provided a document detailing their highest profile risks. A summary of the 15 risks scoring 16 or above is below.

Date risk opened	ID	Description	Risk score (current)	Next review date
02/05/2018	3152	Consultant numbers are threatened by the departure of a long-term consultant in June maternity leave. This will leave 8.4 WTE ED consultants with a corresponding lack of cover and leadership in the ED.	20	28/09/2018
06/06/2017	2701	Patients who require transfer to inpatient Mental Health beds often experience delays in transfer and remain in adult general inpatient beds for longer than required.	20	01/10/2018
14/05/2018	3158	Mobile X-Ray machines are breaching the National Dose Reference Level for all imaging, meaning that we are giving patients a lot higher dose of radiation than is acceptable. The doses with our mobile equipment are five times greater than with static equipment and are greater than the DRL, in one machine, by around 100%. This machine has been	20	25/09/2018

		taken out of action. We are unable to optimise this equipment, but we have no other way of imaging these patients.		
17/10/2016	2439	Risk to information systems from theft or damage to the hardware, the software, and to the information on them.	20	12/11/2018
09/04/2018	3105	Clinical risk to adult high acuity patients and ambulance turnaround times due to delay in delivery of the build including the extended adult resus, ambulance handover bay and extension to the front of ED for streaming/minors.	16	21/09/2018
31/07/2018	3282	Our main data warehouse server will no longer failover in the event of a fatal error, this will result in interruption of overnight loads and potential delay in reporting.	16	29/10/2018
20/03/2018	3170	The risk is that the Trust will be unable to achieve the cancer waiting times standard.	16	27/09/2018
30/05/2018	3189	A potential failure to deliver the planned level of income and cost improvements, resulting in failure to deliver IFM Bolton financial plan for 2018/19.	16	01/07/2018
14/02/2018	3038	Risk to patient safety, reputation and commissioner and regulator scrutiny due to an absence of a robust process for the timely assignment of impartial investigators for Serious Incidents.	16	31/08/2018
06/10/2014	1230	Risk to patient and staff safety, and potential reputational damage due to a significant number of key procedural documents being out of date on the intranet.	16	05/08/2018
26/03/2018	3087	The Trust Mortality Review Process does not drive improvement or fully meet the required standards.	16	24/08/2018
30/05/2018	3184	Unable to recruit suitably qualified and experienced personnel within the senior management team. (Exec to general management posts).	16	13/06/2018
30/05/2018	3185	Operational risk of delivery estates maintenance service and compliance with statutory legislation.	16	25/09/2018
20/09/2018	3376	Continuous upstream alarms with Alaris VP & guardrails infusion pumps.	16	No date
20/02/2018	3048	Potential to not achieve National target of 85% of identified staff being trained by March 2019.	16	22/08/2018

(Source: Trust Corporate Risk Register)

Performance

Committees were appropriately chaired and provided assurance to the Board. We saw from minutes that there was healthy challenge at the committees and Board and this was supported by interviews with the Chairs of two committees.

There was a range of performance information available to the board in the form of integrated performance dashboards, covering quality and safety, operational performance, workforce, finance and use of resources. In addition to these dashboards there were board assurance heatmaps

which covered infection prevention and control, harm free care, audit, patient experience, governance and staff development. Heatmaps were RAG (red, amber, green) risk rated which allowed the trust to monitor the performance of the wards or clinical areas and identify if there were any issues arising.

The quality performance management data was used to assess performance in relation to regional and national comparators for key quality indicators and the data was fed into the board assurance framework. In addition, a good level of financial information was available at board and sub-committee level with a clear statement of the financial position of the trust.

When looking at the trust composite indicator in the most recent iteration of CQC acute Insight the trust's composite indicator score places the trust within the middle 50% of acute trusts. The trust composite is a pilot indicator created from 12 specific indicators within Insight.

When looking at all trust-wide indicators within Insight the trust's performance was about the same as other trusts for all but five of the Insight Indicators.

The Director of Quality Governance reported utilising the CQC Insight dashboard as it provided clear, accurate and relevant data.

Information management

Historically, there had been a disruptive impact on the informatics department following the turnaround situation of the Trust in 2012. National guidance states that NHS Trusts should be spending 4% of their overall budget on informatics however, the Trust has been spending less than 1%. The Trust had re-focused on informatics and created four Chief Clinical Information Officer (CCIO) roles which had already had a positive impact in the Trusts vision "To facilitate exceptional patient care through informatics that is innovative, reliable, resilient, agile and for informatics to become a valued corporate asset".

The informatics department was split into two departments, Business Intelligence and Information Technology. Business intelligence dealt with the quality of the data and information technology the coding and quantity of the data. This was agreed by the board following the Trust re-structure in 2012 so that no bias on data quality could be incurred.

Business intelligence supported clinical services by running missing data reports from the previous day's activities. This was an invaluable resource as it enabled staff to complete patient data where possible. Error reports were also run off daily and when reviewed by the business intelligence team, individual staff members were contacted so that they were aware of the errors made. If training issues were identified then staff were directed to the relevant department for learning.

The trust was currently developing a Data Quality Strategy, which would focus on ensuring data was of a high standard. As part of this strategy audits would be undertaken to ensure adherence to relevant processes and outcomes. For example, an audit on benefits and realisation was currently being carried out. Data had been collated pre-planning stage so that no bias could be incurred. Results were not yet available.

The trust received assurance for information governance through board reports, internal audit reports and completion of the information governance toolkit. They had completed the information

governance toolkit for 2017-2018 and self-assessed as satisfactory in all areas. Data quality was reviewed as part of the annual quality report.

During our interview with the Chief Informatics Officer we were told that they were aware of the trusts' priorities and areas of development and they were confident in the quality of the data and welcomed challenge.

In July 2017, the Trust approved the digital trust programme to implement an electronic patient record and a range of associated technology and infrastructure improvements, which included an electronic observations system and a task management system. A digital transformation board had been established to provide robust governance to the implementation of these programmes.

On inspection, the Trust were in the process of implementing the electronic patient records system which would include electronic prescribing and medicines administration and this would be going live in May 2019. This was a key component of the trust information strategy and represented a major investment of their plan. The electronic patient record system would be implemented over the next two years in two phases across the hospital and community care setting.

The electronic observations system (Phase 1) was in place in all inpatient settings apart from maternity as this department was undergoing refurbishment and re-design. The electronic observations system supported clinical staff in their identification of at risk and deteriorating patients and assisted prompt escalation and response. Phase 2 of the electronic observations system would allow alerts to be sent via an i-bleep once the electronic patient record system was fully embedded within the trust.

The task management system had been implemented in February 2016 and its current stage of development was to have specialist hand held phones integrated within the system. This was an ongoing process which ultimately would replace the outdated pager system. The next step of this system was to link the alerts being created from the electronic observations system so that they are sent directly to the relevant clinical staff.

Further information technology developments were in progress, for example Wi-Fi streaming to enable patients to have access to television programmes, Wi-Fi access to iPads so that patients could order their own meals on the day thus improving patient choice and demand and a Wi-Fi access point so that any government or public health body could pick up their own Wi-Fi when in the Trust. These were all currently being piloted on the dementia and paediatric wards.

To address compliance with national audits the Trust was also implementing an open source electronic patient record for ophthalmology that is championed by NHS England and designed by clinicians.

A quarterly trust survey would be carried out particularly around the electronic patient record programme so that this could be continually monitored and improvements made where needed.

Lessons had been learnt from networking with local NHS trusts which not only improved learning within the Bolton team but further informed and enhanced the Trusts ongoing developments.

In addition to this, the Trust was now live with the 'Bolton Care Record'. This was a new confidential computer record that allowed health and social care professionals directly involved in

a patient's care to access the most up-to-date information about them. A patients medical and care records were shared between health and social care services which meant that a GP, a specialist at the trust, a district nurse or a social care professional could have access to the information they needed in a timely way.

A training programme was in place for all staff in the information technology department and the trust subscribed to the informative skills development network. In addition to the training, all staff in the department undertook project management which helped with the planning, organising and delineating of responsibilities specifically to the Trusts goals.

Training was delivered to staff outside the department in designated information technology rooms, on wards, via e-learning or individually face to face.

The Trust had not been affected by the NHS wide cyber-attack in 2017. A penetration test was carried out continuously in the Trust. Penetration testing is an authorised simulated cyber-attack on a computer system performed to evaluate the security of the system. The trust used an external programme for this testing which had proven to be an invaluable resource in their steps to ensure security was maintained.

The trust had effective arrangements in place to ensure that data or notifications were submitted to external bodies as required. Incidents were reported to the NHS incident reporting and learning system or the NHS strategic executive information system.

The trust clinical coding service provided coded clinical information to support mandatory national requirements and agreed local coding standards to the Greater Manchester Mental Health NHS Foundation Trust. We saw a fixed service level agreement in place for this service.

The information technology lead had received a scholarship from the College of Healthcare Information Management Executive (CHIME) to attend a global informatics event that was to be hosted in Orlando, Florida by the Health Information and Management Systems (HiMMS) society. During this event they would be sharing developments that were in place at the trust.

Engagement

The trust had a strong patient focus and they engaged well with the local community. They had an expansive programme to gain patient experiences which was underpinned by the Patient and Carer Experience Strategy 2016 – 18. The strategy aimed to develop a culture throughout Bolton NHS Trust that placed the quality of patient experience at the heart of everything they do, and always strive to exceed expectations with the belief that 'good enough' never is.

This was underpinned by seven missions which were simply articulated. The patient experience work was reported through the Patient Experience Group and the to the Quality Assurance Committee. They demonstrated a structured approach with evidence, escalation, action and updates. There was an abundance of programmes underway to support patients and carers.

The trust had strong and widespread links with Healthwatch, local trusts, CCG equality lead, parents of children with learning disabilities and carers. They also linked with young people on the Princes Trust and involved them in activities within the trust.

The relationship with the Clinical Commissioning Group was embedded and was value driven and population focussed. There was a shared agenda and the trust articulated healthy relationships with the commissioners and other system partners.

There is a Patient Experience Inclusion Partnership Committee, (PEIPC) with representation from external partners including HealthWatch that ensures that the voice of patients and carers is heard across the organisation. Whilst there is a particular focus on 'Patient Story' contribution at various committees including Board of Directors and Quality Assurance Committee it is the contribution of a number of new posts that have ensured that the patient voice is well heard including Enhanced Care Lead/Advanced Specialist, Dementia Lead Specialist Nurse who lead on the implementation of John's Campaign.

There was a clinical walk around every Friday to speak with carers, they provide hot food for carers staying in the hospital and provide free parking. They actively encouraged carers to participate in the care delivery during their relatives stay in hospital.

Service users were involved in the decisions regarding the extended urgent and emergency care unit and the new midwifery led service where the colours for the rooms were decided through collaboration on social media.

The Council of Governors provided the formal patient voice. They told us that the trust was very responsive to areas of concern they raised and gave examples. They had improved relationships with the Non-Executive Directors who now attended their meetings. The governors are also involved in the recruitment of senior staff. They told us that the openness and transparency was fantastic, and that senior management were very approachable. Governors in the community setting felt included in the movement forward. They all felt well supported by the Company Secretary.

Engagement with staff at the trust was acceptable. The Trust regularly surveyed staff views through face-to-face interventions including the Chief Executive Listening Lunches. These were held monthly with specific staffing groups and led by the Chief Executive. The sessions highlighted that they needed to do more to increase senior leadership visibility, improve communications, raise awareness of development opportunities and improve access and performance of the IT systems.

Staff engagement levels were regularly reported to the Workforce Assurance Committee and Executive Board. A range of interventions had been implemented at a Trust-wide and local level to help increase staff engagement. Moving forward they will be using a new survey tool (Go Engage) to enable them to explore more deeply how staff are feeling and have a more tailored and evidence-based approach to their staff engagement work.

There were 21 staff side representatives in the trust but not all have protected time to conduct their duties. They meet with the chief executive officer and human resources monthly. They felt that relationships were starting to improve with the change in senior leadership within workforce. A number of examples were shared regarding the management of sickness which although within process did not allow any additional reasonable adjustments in specific cases. There was also criticism of the freedom to speak up process which was felt to lack authenticity. They were hopeful

that the introduction of champions would improve the situation and include staff from across all the protected characteristics. They welcomed the appointment of a board champion for BME.

External engagement was seen to be of a high standard. The future strategy and vision had required open and frank partnership working. The trust had good working relationships with external agencies.

Learning, continuous improvement and innovation

The trust promoted an open culture and encouraged learning. There was a strong focus on patient safety and learning from when things went wrong and when they went well. There was strong collaboration and support and a common focus on improving quality of care and peoples experiences.

Audit activity was clearly demonstrated with the trust active in relevant national audits across all directorates. Research activity was underpinned by the Research Strategy, supported by the research department and monitored through the Research Committee, minutes from the April 2018 meeting demonstrated that the trust had exceeded their recruitment targets. The trust was trying to identify a clinical space for research activity.

It was also noted that there was a formal expectation for innovation and quality improvement. Ideas from staff were encouraged, shortlisted and winning ideas were tried and adopted if successful. These were not classed as formal cost improvement programmes but often there was a cost saving.

The trust introduced a ward accreditation system ‘Bolton Scheme of Accreditation’ (BoSCA) in 2016 which had been well received by staff. It is a multidisciplinary system of care accreditation to provide assurance regarding the quality of care delivered, leadership and the environment. Advancement through the levels actively encouraged improvement and there was a sense of pride attached to the achievements. It was closely linked to the ward heatmaps and progress was received by the executive team members.

In 2016 the Trust enhanced the nursing audit programme to create ACE Wednesday (Audit Care Environment). In 2018 the Trust signed up to 'Always Events' which is in the development stage and overseen by Patient Experience Inclusion Partnership Committee.

There were areas for improvement and the corporate governance team were addressing these through a corporate analysis of information to further enhance learning and improvement. There were also missed opportunities for learning in the mortality review process and learning from deaths.

Learning from Inpatient Deaths

The trust had a policy for the review of deaths within the trust, however on review it was not in line with the latest guidance from the Royal College of Physicians and the National Mortality Case Record Review, (2016) or the National Guidance on Learning from Deaths from the National Quality Board (March 2017).

From the review of six cases randomly chosen from the previous six months we found that the process was not consistently applied. As part of the review we looked at one case of a patient with learning disabilities.

The review showed that the process did not include the use of structured judgement reviews. The process included all inpatient deaths and did not apply the criteria for the identification of cases for review. Initial triage was not independent and was not carried out in a structured way.

One of the cases we reviewed was referred back to the trust for further review, as we felt that all learning had not been gained from the case.

We raised our concerns with the trust who explained that they were aware of the limitations of the current process. The medical director was new in post and openly acknowledged the lack of robustness and efficacy of the current process. He had highlighted this as an area for urgent improvement. He articulated his plan for improvement to ensure that the trust met the expectations of national guidance. This included training regarding the use of structured judgement reviews and updating of the policy and process.

However, it was noted that there had been significant input into the bereavement service which offered a high quality of care. They had been recently tasked with identifying any deaths were the relatives or carers expressed concern about the care the patient had received.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance (last financial year)
What is your internal target for responding to complaints?	3	100%
What is your target for completing a complaint	35	96%
If you have a slightly longer target for complex complaints please indicate what that is here	60	96%
Number of complaints resolved without formal process in the last 12 months?	1,158 (September 2017 to September 2018)	N/A

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

There was a current complaints policy in place. It was clear and stated a 3 day contact timescale and a 35 day timescale for responding to complaints. However, this may be extended to 60 days if the complaint included the wider system. The trust had a good record for meeting these timescales.

All complaints were triaged and allocated to a handler who would contact the complainant to explain the process.

Learning from complaints was shared through the divisional leads and the governance meeting, Weekly Incidents, Inquests, Claims, Complaints Action Meeting (WIICAM) which included incidents, inquests, complaints and compliments. There were also two quarterly reports pertaining

to the management of complaints. We also noted that serious incidents could be identified through the complaints process to ensure appropriate investigation were applicable.

We reviewed nine complaints, one was on-going, and one had been reopened. All demonstrated a compassionate approach to responding and final letters included full apologies. Action plans for improvement were in place.

We found that patients were at the heart of complaints management and they were handled in a sensitive manner.

Number of complaints made to the trust

The trust received 296 complaints from September 2017 to September 2018. Medical care received the most complaints with 72.

Core Service	Number of complaints	Percentage of total
Medical care (including older people's care)	72	24.3%
Surgery	60	20.3%
Urgent and Emergency care	50	16.9%
Maternity	38	12.8%
Outpatients	22	7.4%
Gynaecology	17	5.7%
Adults Community	15	5.1%
Diagnostics	6	2.0%
Other	4	1.4%
Children, Young People and Families	4	1.4%
Community inpatients	3	1.0%
Critical care	2	0.7%
Services for children and young people	2	0.7%
Community adults	1	0.3%
Total	**296**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Main themes from complaints received at trust level related to clinical treatment (56%), delays in diagnosis/test results/treatment, communication and attitude of staff.

The trust had internal targets for responding to complaints, these were 3 days for initial response, 35 working days for completing a complaint and 60 working days for completing a complex complaint.

On average the trust took 35.7 days to close a complaint between July 2017 and June 2018 which is similar to the trust target of 35 days.

Compliments

The trust provided compliments data for the period from November 2017 to October 2018.

Over these 12 months the trust received a total of 14,134 compliments, of which the largest number (9,960) were for maternity services. The breakdown of compliments by core service is shown in the table below.

Core service	Number of compliments	Percentage of total
Maternity	9,960	70.5%
Community children, young people and families	2,086	14.8%
Outpatients	722	5.1%
Services for children and young people	608	4.3%
Critical care	320	2.3%
Surgery	220	1.6%
Gynaecology	136	1.0%
Diagnostic imaging	50	0.4%
Medical care	32	0.2%
Total	**14,134**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The following table shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Additional information
Joint Advisory Group on Endoscopy (JAG)	JAG accreditation was achieved for Endoscopy on 07/08/2018
Anaesthesia Clinical Services Accreditation (ACSA)	ACSA accreditation received June 2017
Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189	• Microbiology accredited to UKAS ISO 15189 on 12/03/2018 • Blood Sciences (Antenatal Screening, Blood Transfusion Clinical Chemistry, Haematology, Immunology, Molecular biology, Serology & Phlebotomy) Accredited to UKAS ISO 15189 on 28/09/2018 • Histopathology, Non-Gynae Cytology, Andrology and Mortuary Services Accredited to UKAS ISO 15189 on 26/09/2018
Human Tissue Authority	Lab Medicine - HTA (Human Tissue Authority) Assessed in June 2018, received report, submitted action plan to address shortfalls, awaiting outcome
Improving Quality in Physiological Services Accreditation Scheme (IQIPS)	Adult Audiology (UKAS Ref 7916) 08/05/2017
The Quality Surveillance Team (QST), formerly National Peer Review Programme – for Cancer Services	Participate in and submit every year to the Quality Surveillance Team.
Greater Manchester Critical Care & Major Trauma Network	The aim of the Networks approach is to provide assurance to the Network Team, Operational Delivery Network Board and Commissioners that Critical Care Units within Greater Manchester

	are providing the highest level of quality critical care against the published specification and that clinical practice is consistent and variations in patient experience are minimised.
General Pharmaceutical Council (GPhC) inspection	Bolton NHS FT has two pharmacies registered with the GPhC. An unscheduled inspection of registerable activities (sale of over the counter medicines, private prescriptions/emergency supplies and supply to the hospice) took place on 27/06/2018 of the Bolton One Pharmacy only.
Breast Screening QA visit	Multidisciplinary quality assurance visits are an integral part of the quality assurance in breast screening, and are conducted according to national guidelines. These aim to improve the quality of the breast screening programme and provide support to the teams within.
Royal College of Ophthalmologists - Service Peer Review	Peer review undertaken by the RCOphth 16-17/08/2018

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

- Royal Bolton Hospital emergency department

The department consists of a four-bedded adult resuscitation room, which is currently being increased to six beds, and 17 other majors cubicles and area for four ambulatory patients. There is also a minors area with seven cubicles.

The department has a mental health assessment room and a separate ear, nose and throat and eye room.

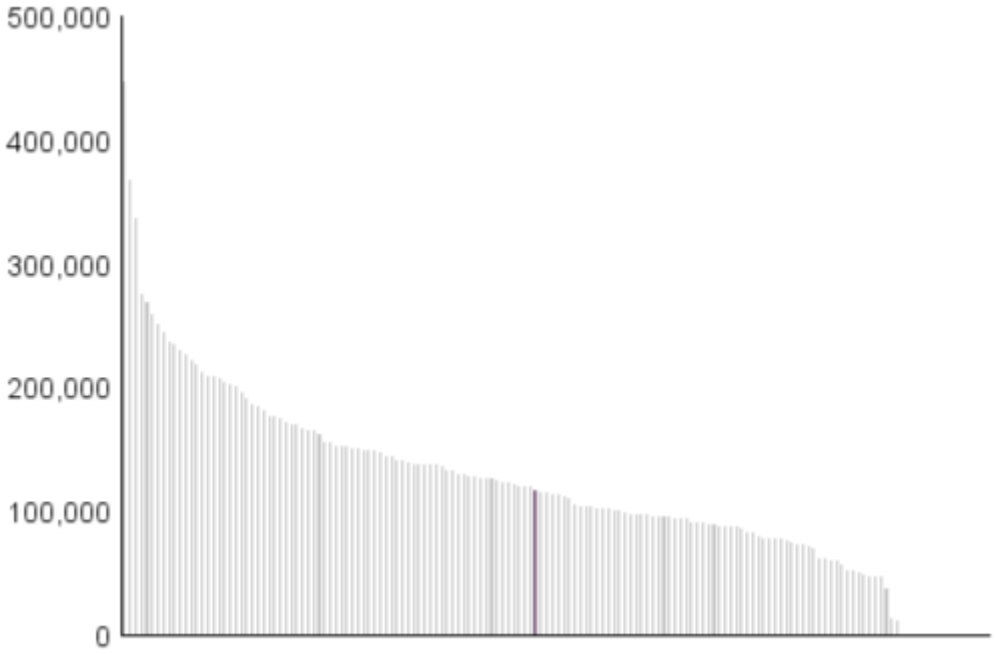
The paediatric emergency department is audio-visually separated and has its own reception, waiting room, triage room, five assessment rooms, two observation cubicles and a two-bedded paediatric resuscitation room.

The department is not a designated trauma unit, but receives some major trauma cases.

(Source: Routine Provider Information Request (RPIR) – Sites tab; Acute RPIR - Context tab; trust website)

Activity and patient throughput

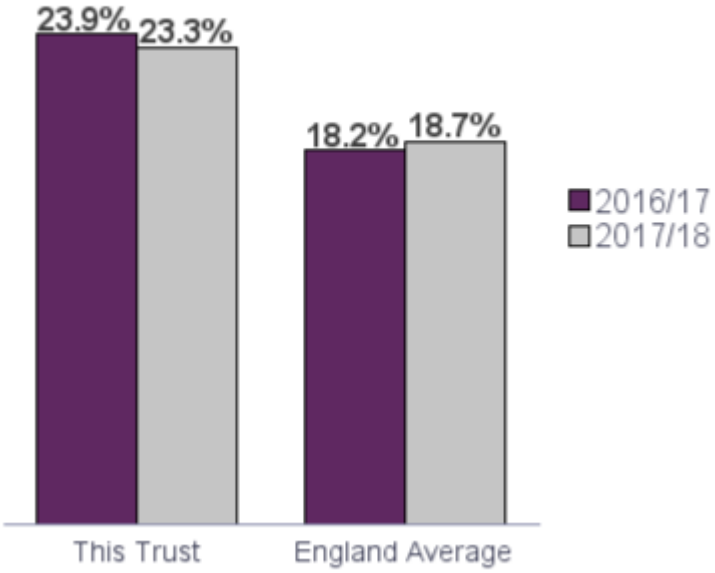
Total number of urgent and emergency care attendances at Bolton NHS Foundation Trust compared to all acute trusts in England, July 2017 to June 2018



From July 2017 to June 2018 there were 115,451 attendances at the trust's urgent and emergency care services as indicated in the chart above. This equates to an average of 324 attendances each day.

(Source: Hospital Episode Statistics)

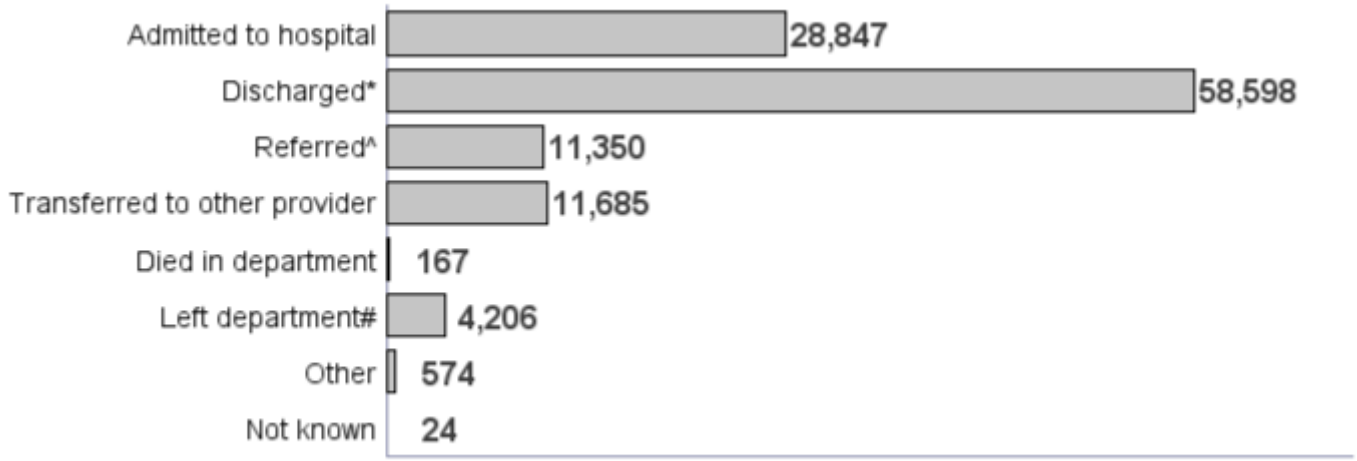
Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission decreased in 2017/18 compared to 2016/17. In both years the percentage of attendances resulting in an admission was higher than the overall England percentage.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from July 2017 to June 2018



* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

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

Training was either e-learning or face to face depending upon the topic. Staff monitored individual training compliance by logging into their personal electronic profile.

A practice educator monitored and delivered training to staff in the department. The practice educator ran weekly reports to identify staff who were approaching deadlines or out of date with training and prompted them to complete this.

Training compliance was linked to pay and study leave, both of which could be revoked if training was not completed.

Mandatory training completion rates

The trust set a target of 85% for completion of basic life support, conflict resolution, information governance and medicine management training. The trust set a target of 95% for completion of all other mandatory training modules.

A breakdown of compliance for mandatory training courses as of July 2018 for qualified nursing staff in urgent and emergency care is shown below:

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Equality and diversity	123	128	96.1%	95%	Yes
Blood transfusion	102	108	94.4%	95%	No
Basic life support	120	128	93.8%	85%	Yes
Fire safety 2 years	117	128	91.4%	95%	No
Conflict resolution	115	127	90.6%	85%	Yes
Medicine management training	121	136	89.0%	85%	Yes
Information governance	111	128	86.7%	85%	Yes
Infection prevention (level 2)	113	136	83.1%	95%	No

In urgent and emergency care the trust had an overall training compliance rate of 90.5% for qualified nursing staff. Training completion targets were met for five of the eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as of July 2018 for medical staff in urgent and emergency care is shown below:

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Equality and diversity	18	18	100.0%	95%	Yes
Blood transfusion	17	18	94.4%	95%	No
Conflict resolution	16	18	88.9%	85%	Yes

Information governance	14	18	77.8%	85%	No
Basic life support	13	18	72.2%	85%	No
Fire safety	12	18	66.7%	95%	No
Infection prevention (level 2)	16	27	59.3%	95%	No
Medicine management training	15	27	55.6%	85%	No

In urgent and emergency care the trust had an overall training compliance rate of 47.7% for medical staff. Training completion targets were met for two of the eight mandatory training modules for which medical staff were eligible. The lowest completion rates were for fire safety (66.7%), infection prevention level 2 (59.3%) and medicine management (55.6%).

The trust found data quality issues with their training completion data for moving and handling (inanimate loads); this module is therefore excluded from the analysis above.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The clinical director oversaw mandatory training for medical staff and said that not having a practice educator overseeing rates did result in lower rates. However, reminders were issued and medical staff were aware that study leave was revoked if training was not completed on time. The practice educator confirmed that where possible assistance was provided to monitor and prompt medical staff with training.

During the inspection the practice educator also confirmed that rates had improved since July and were now 95% for both nursing and medical staff.

Staff also completed training in dementia care and sepsis which included the use of sepsis screening tools and care bundles which formed part of the nursing documentation.

Safeguarding

Staff understood how to protect patients 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.

Safeguarding training was mandatory. Drop in sessions took place weekly which covered a range of topics including vulnerable adults and children, trust processes, and wider issues including domestic abuse, female genital mutilation, managing allegations, consent, mental health and learning disabilities. Extra workshops covering domestic abuse, child sexual exploitation, human trafficking and substance misuse were also provided.

Thirty-three safeguarding champions (staff with a specialist interest) received bespoke training on safeguarding and dementia, information sharing for high risk cases and The Care Act 2014.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of July 2018 for qualified nursing staff in safeguarding training for level two in urgent and emergency care is shown below.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Safeguarding adults (level 2)	123	136	90.4%	95%	No

Safeguarding children (level 2)	122	135	90.4%	95%	No

The 95% target was not met for the safeguarding training modules for which qualified nursing staff were eligible. However, by the time of our inspection we saw improvements had been made with 97% of nursing staff compliant. Managers also confirmed nurses completed safeguarding children (level three) and compliance was 98%.

For safeguarding adult training the figure was 94% (provided for both nurses and medical staff together)

A breakdown of compliance for safeguarding training courses as of July 2018 for medical staff in urgent and emergency care is shown below.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Safeguarding children (level 2)	16	27	59.3%	95%	No
Safeguarding adults (level 2)	15	27	55.6%	95%	No

The 95% target was not met for the safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

However, during our inspection we confirmed that medical staff also completed level three training which superseded level two. At the time of our inspection, only 75% had completed this training but the department was on a trajectory to achieve 100% by March 2019.

Staff we spoke to understood the process for documenting, recording and reporting safeguarding concerns. However, nursing staff explained that where staff did not have concerns, no record of this was made in the patient's record. This posed a risk that if details of a concern were omitted by mistake, staff may mistakenly think there had been no concern.

The service had introduced a form to make sure specific details relating to cases of domestic abuse were recorded and streamline the process. This was shared with local police and children's services.

Nurses told us consultants made the effort to feedback to them directly if they raised concerns about children with them.

Supervision for cases took place on a quarterly basis, where staff discussed case studies with the consultant lead for safeguarding, trust safeguarding team and nursing and medical staff.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and premises clean.

All the areas we inspected were visibly clean and tidy. Managers described cleaning as 'everybody's responsibility'.

A senior nurse led on infection control and there was a team of infection control champions (nurses with interests in a particular topic) in the department. They attended infection control meetings and oversaw day to day management of infection prevention in the department.

We saw posters for staff displaying the correct levels of personal protective equipment depending upon the situation. Gel dispensers and sinks with soap were available throughout the department and we saw staff use these routinely.

Curtains around bays were disposable and replaced every three months to help prevent cross contamination.

We saw good practice relating to hand hygiene, including staff bare below elbows, no nail varnish and use of hand gel. Hand hygiene technique was displayed around the department to help remind staff and visitors how to clean hands effectively. Hand hygiene audits were done to make sure staff were maintaining good practice. The results were displayed for patients, staff and visitors to see. Results were 90% for August, September and October 2018. Managers used light boxes which showed staff areas of dirt on their hands. Senior nurses were responsible for helping staff improve where required.

The service also monitored the cases of infection in the department. Between September and October 2018 there were no cases of Clostridium Difficile, Meticillin-sensitive Staphylococcus aureus (MSSA) or Meticillin-resistant Staphylococcus aureus (MRSA).

There was a process for deep cleaning trolleys weekly and flow charts to help staff allocate the right patients to side rooms to prevent the spread of infection.

Domestic staff cleaned the department regularly using trust cleaning schedules. A daily checklist was in place and overseen by a coordinator. Checklists included cleaning patient tables, commodes and suction units. Cleaning products were locked away to prevent unauthorised use. Keys were held by designated staff. ‘I am clean’ stickers were added to equipment to identify when cleaning had been completed and items were ready for use again. We saw these being used during our inspection.

Weekly walkarounds and monthly environmental audits were done to confirm cleaning standards were being maintained. These looked at whether areas were visibly clean and clutter free, whether toilets and commodes were clean and ready for use, whether sharp needles were properly disposed of and whether staff were wearing aprons appropriately. The average results between August and October 2018 were 83%. These were displayed for staff, patients and visitors to see. Feedback was also displayed to help improve results.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

During our last inspection we identified that the paediatric department exit doors posed a risk that young children could exit the department easily because of automatic doors which led onto a main thoroughfare and another set of doors which were left open.

At our latest inspection we saw that the doors remained in place, however some changes had been made and further changes were imminent. The thoroughfare was now used only by ambulances and the automatic doors were locked at 9pm. Nurses confirmed that small gates were closed which blocked off the open doors at night. Additionally, a system was due to be installed the week after our inspection which would require swipe access or intercom entry.

During the last inspection we also saw that there was no assigned room for mental health patients. Following this inspection, we saw this had been rectified. The room was designed to keep people safe and complied with quality standards set by the Royal College of Psychiatrists psychiatric liaison accreditation network. The room included sturdy comfortable seating, no

ligature points or blind spots and a strip panic alarm around the room.

Despite this we found a toilet used by mental health patients which posed a risk. There were several points which could be used as ligature points including a door hook, light pull cord, paper towel dispenser and plastic rail. Managers took immediate steps to remove the door hook and ordered a ligature free light pull cord but the paper dispenser and rail remained in place.

We also saw that since the last inspection an area for young people had been added which was not present previously. This meant young people could spend time watching television or playing computer games in an area which met their needs.

Since our last inspection the adult department had been expanded. The majors area now had five additional bays and an area to accommodate four ambulatory patients rather than a bay. Further changes were in progress with an ambulance handover area being built at the time of our inspection.

The paediatric department resuscitation area would be undergoing refurbishment over the next two weeks. This would help create space in the current area. Appropriate plans were in place to make sure the move would be done safely.

Equipment was stored correctly off the floor and in store rooms. Linen was stored neatly in a separate, visibly clean storage room.

We checked trolleys containing resuscitation equipment throughout the department. All equipment was within expiry date and records showed that daily checks were completed correctly.

Other equipment required for specific procedures was stored in trays in each area. These were checked annually or after use. In between checks they were sealed and dated to indicate when to re-check. One tray used for emergency C-section procedures had sterile gloves which were out of date, despite checks confirming items were suitable for use. We highlighted this to staff who immediately removed and replaced the items. Despite this, all other items we reviewed were within expiry date. We saw staff work together to find an alternative solution to mitigate the risk of the issue recurring which included having sterile gloves of each size openly available rather than stored in the trays.

Fridges containing medicines at low temperature were checked daily to ensure they maintained suitable temperatures. Records we checked showed that fridges were checked some but not all the time and there was some inconsistency about the way records were completed. For example, some staff noted ‘min’ or ‘max’ on the document, whereas others noted the actual temperature. This made the records difficult to interpret. Additionally, the records required three spaces completing each day (to indicate the minimum, maximum and actual temperature) but this was not always done. For example, on five dates recorded in December 2018 we found two dates had only one three spaces completed. In November, 28 dates out of 31 were recorded with the remaining dates missed, an additional four dates had only two spaces completed and two dates had only one space completed.

Room temperatures where medicines were stored should also be monitored daily. Whilst we saw evidence that these had been monitored in the past, more recently there were gaps in records. For example, in the extended majors area we saw only seven dates recorded in September and no dates recorded in October or November 2018. A senior nurse confirmed that the process for recording the temperature had changed in September and concluded this may have caused the process to cease.

Bins containing used needles and other sharp objects were correctly signed and dated which helped staff determine when they should be replaced. However, in cubicles in the paediatric area

we saw bins with open lids which posed a risk that children may access them. However, there was no incidents or harm recorded.

Arrangements for managing specimens kept people safe. Clinical staff tested urine samples using designated equipment. Other specimens were sent for testing using a secure pod system. If the system broke down, porters took over the task.

Two housekeepers worked in the department and took responsibility for ordering and maintaining equipment stocks.

Assessing and responding to patient risk

Staff monitored risks for patients and acted to mitigate these when necessary. They used tools to identify risks and acted to manage them. These included using national systems to monitor patients' conditions and completing risk assessments.

In our previous inspection we identified that risks for mental health patients were not being documented by staff. Senior medical staff confirmed that formal risk assessments were now in place. We saw that these assessments were detailed, comprehensive, personalised and sensitive. Staff completing them had access to records held by the local mental health NHS trust which meant they were informed of any care local patients may be receiving in the community and could update the local team that the patient had attended hospital that day.

We saw that other assessments were used for patients to record and act on risks of reduced skin integrity, falls, safeguarding vulnerability or delirium (confusion). We saw evidence that appropriate risk assessments were completed in patient records during our inspection.

National systems helped staff to assess, prioritise and monitor patients. These included baseline clinical observations; a nationally used triage system and an early warning score (EWS) system. Triage systems aim to reduce risk by triaging patients and seeing them in order of clinical priority, rather than order of attendance. The EWS system uses clinical observations to produce an overall score to indicate how unwell a patient may be. To accurately calculate a EWS, a range of clinical observations should be completed.

Early warning scores were available for children and adults and helped staff identify patient deterioration promptly. In the adult department these were recorded on paper and entered onto the system. In the paediatric department observations were entered onto a handheld electronic device which automatically downloaded them onto the emergency department system. This then calculated an early warning score and indicated when the next set of observations should be completed based on this.

Streaming to a primary care service located close by, was done by triage staff between the hours of midday and midnight every day. This enabled the department to safely send people to more appropriate services than the emergency department if required.

Managers confirmed that any children who left the department without being seen were flagged and contacted to see why they left. The child's GP was also contacted to ensure they were aware.

Children presenting to the paediatric department with any sign of illness were automatically screened for sepsis. A sticker was completed and fixed to the child's record to show an assessment had been completed. For injury, staff worked through an injury algorithm instead.

Staff reduced the risk of allergic reaction in patients by checking if they had allergies during triage

assessment. This was noted in the patient record.

An alarm system was available for reception staff to alert clinical staff if patients deteriorated suddenly while waiting to be seen. We saw staff respond immediately when the alarm was activated during our inspection.

Reception staff used set criteria to immediately highlight patients arriving to nursing staff, who may be seriously unwell. These included any patients with chest pain over 30 years of age, patients with shortness of breath or uncontrollable bleeding. These patients were given a red card to hold which made them clearly identifiable.

Security staff were based in the department between 7.30pm and 8am each day to help keep patients and staff safe.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all five of the Emergency Department Survey questions relevant to safety.

Question	Score	RAG
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	7.4	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.7	About the same as other trusts
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.7	About the same as other trusts
Q33. In your opinion, how clean was the emergency department?	8.6	About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.7	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Median time from arrival to initial assessment (emergency ambulance cases only)

The trust's median time from arrival to initial assessment was worse than the overall England median in eight of the 12 months from October 2017 to September 2018. In the remaining four months performance was similar to or slightly better than the England average.

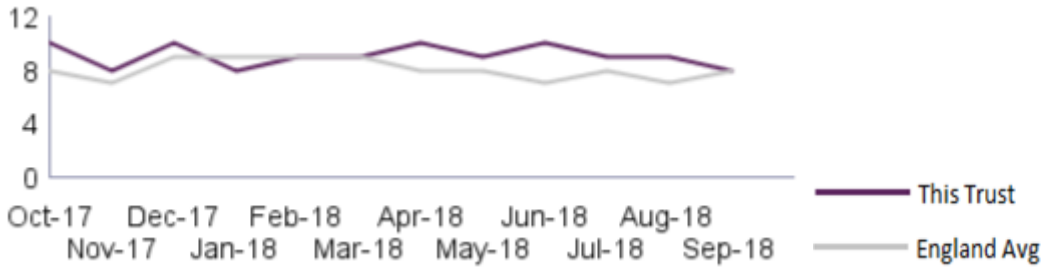
The trust's performance over this period was quite consistent, varying from eight to 10 minutes, while the England average varied from seven to nine minutes. There were no clear trends in performance.

In October 2017 the trust's median time to initial assessment was 10 minutes compared to the England average of eight minutes.

In September 2018 the trust's median time to initial assessment was eight minutes; this was the same as the England average.

We reviewed adult and paediatric patients' records and found a mixed picture. In the five adult patients' records, assessment times ranged from between 21 and 51 minutes. However, the four paediatric patients' records showed times of between four and six minutes.

Ambulance – Time to initial assessment from September 2017 to August 2018 at Bolton NHS Foundation Trust



(Source: NHS Digital – A&E quality indicators)

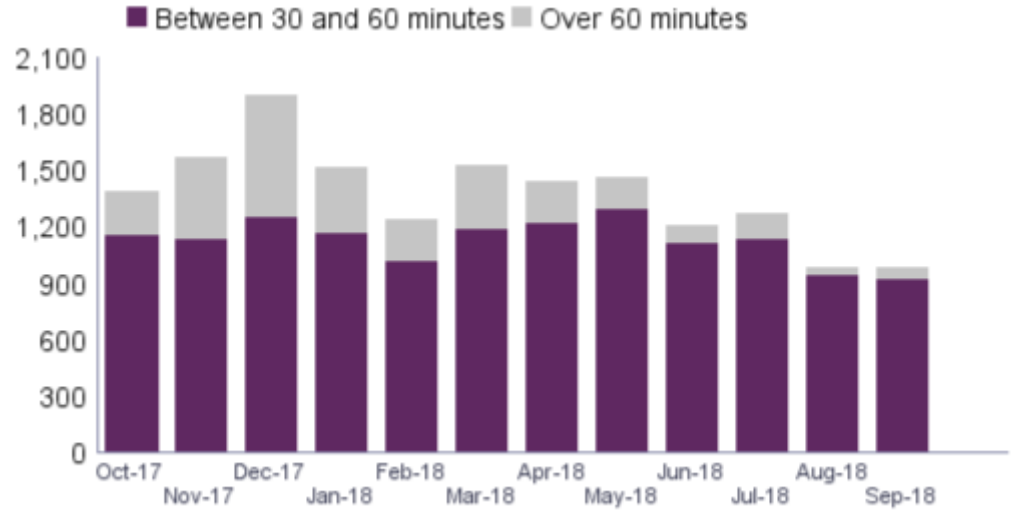
Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Royal Bolton Hospital

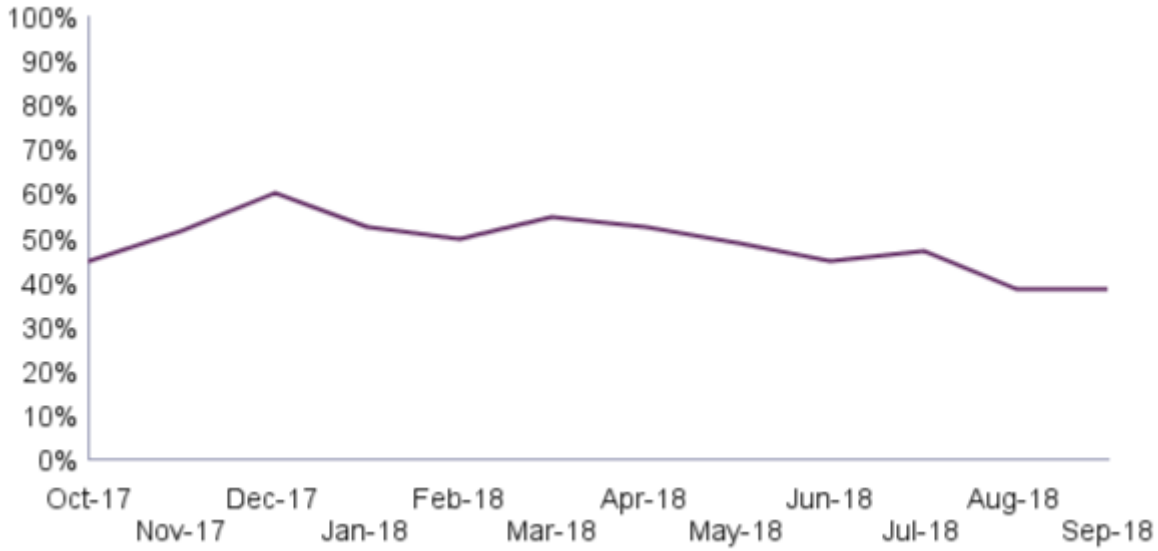
From October 2017 to September 2018 there was an overall trend of improvement in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Bolton Hospital.

There was a deterioration in performance from 44.6% in October 2017 to 60.2% in December. This probably reflected winter pressures. This was followed by a trend of improvement until August 2018 (38.3%).

Ambulance: Number of journeys with turnaround times over 30 minutes – Royal Bolton Hospital



Ambulance: Percentage of journeys with turnaround times over 30 minutes – Royal Bolton Hospital



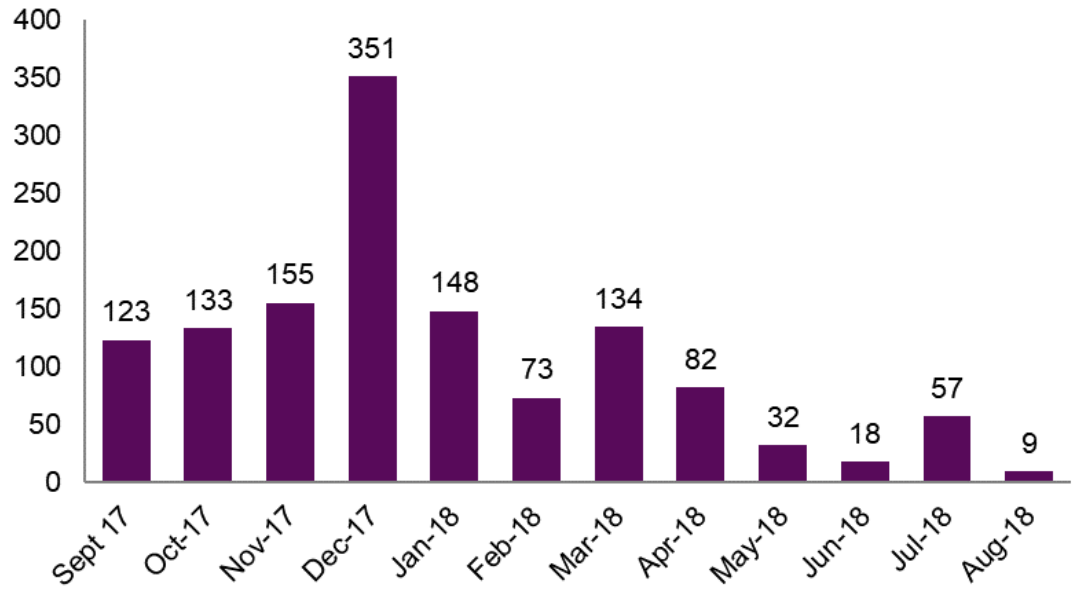
(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From September 2017 to August 2018 the trust reported 1,315 “black breaches”. The highest numbers of breaches were reported in the months from September 2017 to January 2018, and in March 2018. This probably reflects winter pressures. There were far more breaches reported in December 2017 than any other month.

The trust ascribed all these breaches to there being no capacity to handover due to lack of flow.



(Source: Routine Provider Information Request (RPIR) – Black Breaches tab)

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people free from avoidable harm and to provide the right care and treatment.

The service worked based on a minimum one nurse to two patients in the resuscitation area and one nurse to four patients in the majors area.

Emergency nurse practitioners and nurse associates cared for patients in the minor injury area and advanced nurse practitioners supported medical staff caring for patients in the majors area. A consultant nurse was employed in February 2018 to help oversee nurses in the department.

In the paediatric area, two paediatric nurses each shift supported medical staff caring for children in line with national guidance.

Support staff including healthcare assistants worked alongside nurses, taking blood samples and electrocardiograph readings and assisting with other general tasks.

Staffing reviews were done in readiness of the planned unit expansion, using recognised assessment tools by the Royal College of Nursing. Increases were made to nursing numbers based on the results. For example, nursing numbers were increased from nine to 12 during the day and eight to 11 at night.

The trust reported their qualified nursing staff numbers as below as of March and June 2018.

Site	March 2018			June 2018		
	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate
Royal Bolton Hospital emergency department	111.1	113.6	97.9%	120.0	123.1	97.5%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 2.0% for qualified nursing staff in urgent and emergency care. This was lower than the trust target of 6.0%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 10.0% for qualified nursing staff in urgent and emergency care. This matched the trust target of 10.0%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 4.8% for qualified nursing staff in urgent and emergency care. This was higher than the trust's target of 4.2%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From August 2017 to July 2018, the trust reported that 3.0% of qualified nursing staff hours in urgent and emergency care at Royal Bolton Hospital were filled by bank staff and 7.1% were

filled by agency staff. In addition, 3.6% of qualified nursing hours were not filled by bank or agency staff to cover staff absence.

Over the same period, the trust reported that 11.8% of nursing assistant staff hours in urgent and emergency care at Royal Bolton Hospital were filled by bank staff, while 0.1% were filled by agency staff. In addition, 5.4% of nursing assistant hours were not filled by either bank or agency staff to cover staff absence.

Staff group	Bank		Agency		Unfilled		Total hours available
	Hours	%	Hours	%	Hours	%	
Qualified nurses	3,562	3.0%	8,442	7.1%	4,338	3.6%	119,632
Nursing assistants	4,107	11.8%	34	0.1%	1,888	5.4%	34,716
Total	**7,669**	**5.0%**	**8,476**	**5.5%**	**6,226**	**4.0%**	**154,348**

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Handover

Handover took place twice daily in both the adult and paediatric department. These were verbal but recorded on paper and stored, should they be needed for future reference. During handover, nurses shared information about patients, incidents, complaints and compliments received.

Medical staffing

The service deployed enough medical staff with the right qualifications, skills, training and experience to keep people free from avoidable harm and to provide the right care and treatment.

Doctors worked in the department 24 hours a day. Consultants worked between the hours of 9am and 10pm and on an on-call basis after that.

The trust reported their medical staff numbers as below as of March and June 2018.

Site	March 2018			June 2018		
	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate
Royal Bolton Hospital emergency department	40.7	54.9	74.1%	41.0	54.9	74.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 24.0% for medical staff in urgent and emergency care. This was higher than the trust target of 6.0%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Managers confirmed that middle grade recruitment had been problematic nationally. However, since the previous inspection they had recruited three GPs, two of which had converted to middle grade roles.

They had also undertaken alternative staffing initiatives such as employing advanced nurse practitioners and physician associates to backfill vacancies. They had also reviewed middle

grade pay in comparison to other providers and matched it.

All these initiatives had helped improve the picture since our previous inspection where we had identified that consultants were backfilling gaps in the middle grade rota. This was no longer an issue. Managers reported that this practice had now reduced from an average of 38 backfilled shifts per month to just three in October 2018.

Managers told us there were rarely any gaps in the rota and random dates we reviewed confirmed this.

Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 43.7% for medical staff in urgent and emergency care. This was higher than the trust target of 10.0%. However, the trust confirmed that this figure incorporated medical staff on planned rotational programmes which, when they moved on to other services, skewed the figure.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 1.7% for medical staff in urgent and emergency care. This was lower than the trust's target of 4.2%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The trust was unable to provide the total number of hours worked by all medical staff in urgent and emergency care at Royal Bolton Hospital from August 2017 to July 2018. The trust was also unable to report the number of hours left unfilled by bank or locum staff to cover staff absence. This is because medical staff at the trust were not on a central roster over this period. The trust report that they have a plan in place to move their medical staff onto roster to enable reporting on hours worked and fill information.

Therefore, it was not possible to calculate the percentages of medical staff hours worked by bank and locum medical staff. Instead only the raw numbers are available.

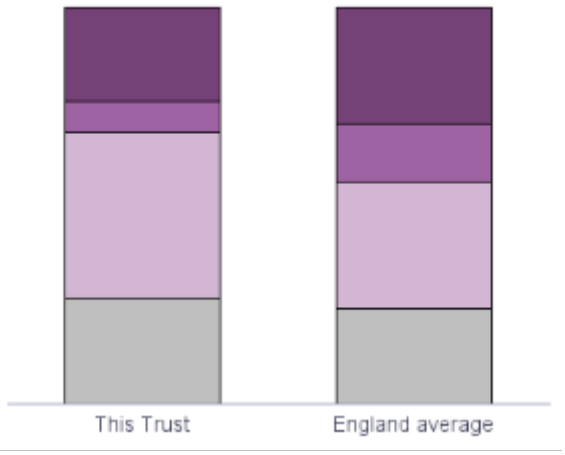
From August 2017 to July 2018, the trust reported that 11,610 medical staff hours in urgent and emergency care at Royal Bolton Hospital were filled by bank staff, while 10,252 medical staff hours were filled by locum staff.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Staffing skill mix

As of July 2018, the proportion of consultant staff reported to be working in urgent and emergency care at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff was reported to be higher than the England average.

Staffing skill mix for the 42 whole time equivalent staff working in urgent and emergency care at Bolton NHS Foundation Trust.



	This Trust	England average
Consultant	24%	29%
Middle career^	8%	15%
Registrar group~	42%	32%
Junior*	27%	24%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.

Records were a mixture of paper and electronic with paper records scanned onto patients' records afterwards. Staff knew where to find the information they required on each patient record.

The trust had plans to introduce fully electronic records into the service in 2019. For now, portable devices to record clinical observations had been introduced in the paediatric emergency department which linked directly to patients' records.

We reviewed 10 patients' records during our inspection. These were legible and accurate and contained the right details about each patients' care including the presenting complaint, allergies, pain and clinical observations. Doctors and nurses wrote individual notes about care as well.

Staff carried personal ID stamps with them and we saw evidence of names, and GMC numbers stamped and countersigned on records.

Documentation audits were completed monthly by reviewing 10 patient records. Results showed mixed results and no specific trends. In the paediatric emergency department results averaged 93% between September and November 2018. For one month the results fell to 84% due to missed times and dates on some entries. Managers confirmed that reminders were issued at handovers and we saw improvement in this area the following month. In the main emergency department, we saw results average 94% between September and November 2018.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

Staff used an up to date policy to help them store, prescribe, dispense and administer medicines.

Medicines were stored securely throughout the department. Keys to access medicines were held by designated staff.

We checked a range of medicines in different areas of the department. Intravenous fluids were appropriately labelled and stored in cupboards. However, in the paediatric emergency department we found fluids in the resuscitation area and the door to the room unlocked. This posed a risk of unauthorised entry and tampering. The trust responded by applying a swipe access pad after the inspection but we have not seen this.

Medicines were stored neatly and were within expiry date. Controlled drugs were checked daily to help make sure stock levels were correct. Records of checks were generally complete with some minor omissions. For example, in the majors area we saw two checks missed in November and one date missed in September 2018.

Doctors prescribed and dispensed medicines in line with their registration. Nurses with prescribing rights could prescribe and dispense a limited range of medicines. Nurses without prescribing rights issued a small number of medicines such as paracetamol using Patient Group Directions (PGDs). Patient group directions allow healthcare professional to supply and administer specified medicines to pre-defined groups of patients without a prescription. We reviewed a sample of patient group directions which were all signed and up to date.

The trust had an antimicrobial stewardship committee which advanced nurse practitioners and medics were involved with. Information from there was disseminated to nursing staff to help make sure they were aware of the latest antibiotic guidance.

Pharmacy staff visited the department daily to check stock and expiry dates and remove any out of date or unwanted items.

Incidents

The service managed patient safety incidents well. Staff managed incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Incidents were reported electronically on the trust's intranet system. Staff showed us how they reported incidents and gave examples of the types of incidents that should be reported. They told us they received feedback following incidents.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2017 to October 2018, the trust reported one incident classified as a never event in urgent and emergency care. This concerned a wrong site administration of nerve block in May 2018.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SI) in urgent and emergency care which met the reporting criteria set by NHS England from November 2017 to October 2018.

There was one SI each of the following types:

- Adverse media coverage or public concern about the organisation or the wider NHS
- Surgical/invasive procedure incident (this was the never event described above).

Both SI's were reported to STEIS within 14 days of occurrence.

(Source: Strategic Executive Information System (STEIS))

Mortality was reviewed monthly to help make sure any issues were identified and addressed swiftly. Managers confirmed that this had helped focus work on areas including managing the deteriorating patient and taking regular observations.

Safety Thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors and managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or urinary tract infections in patients with a catheter in urgent and emergency care from September 2017 to September 2018.

(Source: NHS Digital)

Managers confirmed that safety thermometer results were not being displayed due to the building work but there were plans to display results once the build was completed at the end of December 2018. In the meantime, the results were discussed at monthly performance management meetings to help make sure any issues were discussed and action taken to improve results if necessary.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

People's care and treatment was planned and delivered in line with up to evidence-based guidance and standards set by the National Institute of Health and Care Excellence, The UK Resus Council and the Royal College of Emergency Medicine.

Guidance was reflected in departmental clinical pathways such as those for fractured neck of femur and sepsis.

Over the last six months the department had adopted guidance from the Royal College of Emergency Medicine to undertake hourly comfort rounding. This was incorporated into mandatory documentation to help make sure staff adhered to it which was being audited monthly to monitor compliance with the process.

New or updated guidance was sent directly to the business manager, matron and clinical director. Managers had to confirm that guidance had been received and reviewed using an electronic acknowledgement. Relevant updates were then disseminated to the staff in the department.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients cultural and religious needs and other preferences.

Breakfast, lunch and dinner were provided for patients in the department. Some provision was available for visitors.

For lunch sandwiches were available meeting a range of needs including vegetarian, halal and gluten free. For more specific needs such as vegan or celiac patients, housekeepers contacted the hospital kitchen who provided a meal which met these requirements.

In between these times nurses offered patients and visitors refreshments and toast if required.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 7.4 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

For patients experiencing pain, different medicines including paracetamol, codeine, ibuprofen, morphine and ketamine were available.

In records we reviewed we saw evidence that pain was discussed during initial assessment and pain relief provided.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 8.1 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

Question – Effective	Score	RAG
Q31. How many minutes after you requested pain relief medication did it take before you got it?	6.9	About the same as other trusts
Q32. Do you think the hospital staff did everything they could to help control your pain?	8.1	About the same as other trusts
Q35. Were you able to get suitable food or drinks when you were in the emergency department?	7.4	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

During our previous inspection we identified that although audits were undertaken the service did not have any formal action plans to address poor results. Following this inspection, we saw significant improvement. The service had introduced a consultant lead for audits. Action plans were now in place following national audits and we saw evidence of staff analysing results, making changes and then re-auditing to make improvements.

The service generated a list of completed audits alongside expected audits due to complete in 2018, in order of priority.

Audit results and required improvements were displayed in easy to read format on noticeboards for staff to review in the department. The board also displayed good practice to provide positive feedback as well.

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Royal Bolton Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:

- Adults 16 years and over: 40-50mg prednisolone for 5 days
- Children 6-15 years: 30-40mg prednisolone for 3 days
- Children 2-5 years: 20mg prednisolone for 3 days

This department: 81.0%; UK: 52%.

The department was in the lower UK quartile for three standards:

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 10.0%; UK: 25%.

- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
- Adults 16 years and over: 40-50mg oral prednisolone or 100mg hydrocortisone IV
- Children 6-15 years: 30-40mg oral prednisolone or 4mg/kg hydrocortisone IV
- Children 2-5 years: 20mg oral prednisolone or 4mg/kg hydrocortisone IV

- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 0.0%; UK: 19%.

- Standard 5b (fundamental): within 4 hours (moderate). This department: 4.8%; UK: 28%.

The department's results for the remaining three standards were within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

This audit was listed on the audit plan as high priority and likely to be completed again in 2018.

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, Royal Bolton Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 26.7%; England: 11%.

The department was in the lower UK quartile for two standards:

- Standard 2 (developmental): Consultant reviewed: fever in children under one year of age. This department: 0.0%; UK: 8%.

- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 4.0%; UK: 12%.

The department's results for the one remaining standard was within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

Consultants responsible for governance and overall management confirmed that actions were in place to remind staff to obtain consultant sign off for particular cases, to try to improve care for these patients. These included discussing the requirements at departmental induction, and handover as well as giving triage staff a list of the patients who required consultant review. Additionally, the service opted to increase the patient groups who required consultant review to proactively manage the associated risks.

This audit was listed on the audit plan as high priority and likely to be completed again in 2018.

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Royal Bolton Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 96.0%; UK: 69.1%.

The department reported a result of 0.0% for six standards, and was therefore in the lower UK quartile for all six:

- Standard 3: O_2 was initiated to maintain SaO_2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 0.0%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 0.0%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 0.0%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 0.0%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 0.0%; UK: 44.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 0.0%; UK: 18.4%.

The department's result for the one remaining standard was within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

Considerable work had been done to improve and maintain good sepsis care for patients. Monthly audits were undertaken by reviewing 30 patients' records. The results showed marked improvements. For example, between July and September 2018, 96% of patients were appropriately screened for sepsis and all of those requiring antibiotics had them administered within 60 minutes.

Any issues identified during the audit were recorded as minor or major errors. Individual feedback was provided for staff who did not provide correct care. If feedback was given twice, retraining was provided. A record was kept of all feedback which showed results always improved after written feedback. No staff had required retraining.

This audit was listed on the audit plan as high priority and likely to be completed again in 2018.

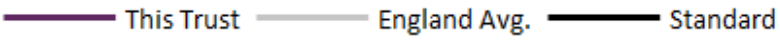
Additional audits were commencing in January 2018 which included pain in children, and fractured neck of femur care. An audit of head injury and adherence to national guidance as well as management of pregnancy loss in the department was already in progress at the time of our inspection.

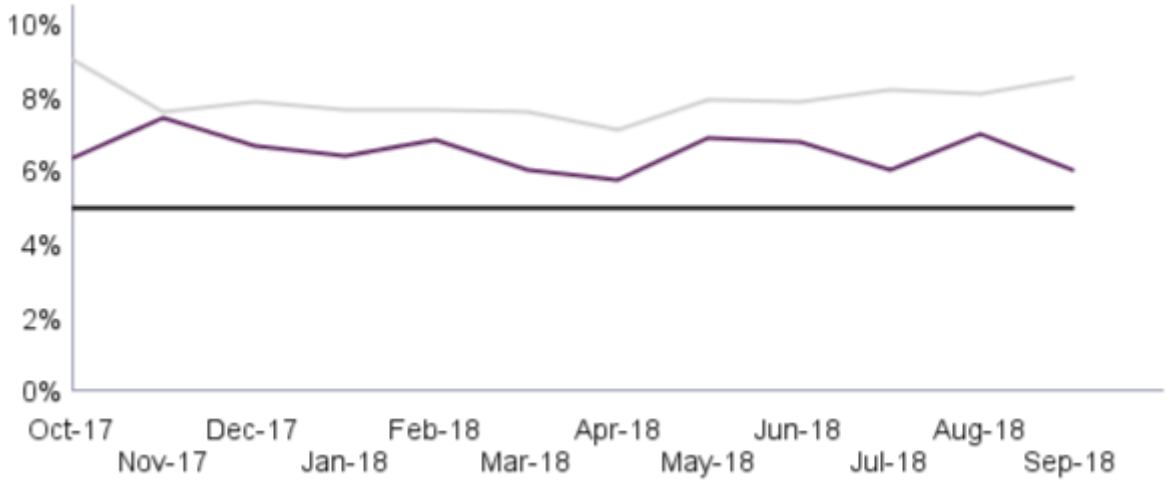
Unplanned re-attendance rate within seven days

From October 2017 to September 2018, the trust's unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%, but consistently better than the England average.

The trust's performance over these 12 months was variable with no clear overall trend.

Unplanned re-attendance rate within seven days - Bolton NHS Foundation Trust





(Source: NHS Digital - A&E quality indicators)

The service described some of the work they had done to lower re-attendance rates. After analysing the issue, they identified many reattenders had mental health, or drug and alcohol problems. They worked with local police, ambulance and drug and alcohol teams and a psychologist to provide alternative support for these patients. Care plans were developed for 67 patients and attendances were reduced by 20%. One patient who had previously attended over 500 times came back to thank staff after they facilitated a drug rehabilitation programme.

Competent staff

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

Staff worked hard to ensure skills were maintained in important areas including sepsis, life support, identifying deterioration, limb and wound care and major incident management.

Sepsis training covered triage, red flags, sepsis six indicators, early warning score indicators, neutropenic sepsis, risk factors and case study.

We saw evidence that study days, simulations and a 'skills week' were held to help train and refresh knowledge in colleagues. Staff were collectively involved in these sessions. The skills week included 176 different training sessions with sessions held across each day in areas including suturing, splints, burns and limb assessments.

During our previous inspection we were not assured that all staff were trained in intermediate life support skills. During our latest inspection we saw improvements in training records which provided the assurance we required.

All staff in the main department trained in adults and paediatric intermediate life support and senior nursing staff went on to train in advanced adult and paediatric life support when ready. We saw evidence that senior staff were up to date or had dates scheduled to be booked on to courses to refresh advanced life support.

Staff in the paediatric emergency department were all trained in advanced paediatric life support unless they had joined in the last year, in which case they were booked to undertake this training.

New starters received appropriate induction. This included a two-day trust induction if new to the

trust, followed by departmental induction. Here staff received a minimum two weeks' protected time to learn about equipment, medical gases, computers and policies in the department. They also learnt to manage specific skills such as care of the dying, and patients in all areas of the department and beyond, such as intensive care.

Newly qualified nurses undertook a 12-month preceptorship period, which included support from the trust and compulsory study days covering key clinical skills in areas such as medicines and clinical care.

Staff also trained in courses which enabled them to cascade training to their colleagues. This meant that if practice educators were absent training could continue.

Nurses undertaking triage duties only trained in triage competencies after a minimum 12 months experience.

Clinical staff rotated between the main and paediatric emergency department which allowed them to maintain adult and paediatric skills.

There were opportunities to develop careers in emergency or advanced nurse practitioner roles. Nurses in these roles told us they were given good support and protected time to study and gain new skills.

Appraisal rates

In our previous inspection appraisal rates for nurses or medical staff did not meet the trust target because appraisers were often called away to provide clinical duties. Following this inspection, we saw an improvement.

From August 2017 to July 2018, 85.4% of staff in urgent and emergency care at the trust received an appraisal compared to a trust target of 85%. The target was met for both qualified nursing staff and medical staff.

Staff group	Staff who received an appraisal	Number required	Completion rate	Target	Met Yes / No
Qualified nursing staff	121	139	87.1%	85%	Yes
Medical staff	23	27	85.2%	85%	Yes
Support to doctors and nursing staff	41	49	83.7%	85%	No
NHS infrastructure support	20	25	80.0%	85%	No
Total	**205**	**240**	**85.4%**	85%	Yes

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

Clerical staff supported patients, clinical and management staff every day. They worked in the

reception area at all times. In the mornings they also worked in the majors area where they made telephone calls to loved ones and completed preparations for patient admissions.

A play specialist worked with staff to help calm and reassure children in the paediatric emergency department.

A trust specialist learning disability nurse supported staff in the department. Nurses told us they could ask the nurse to come and care for patients on a one to one basis whenever needed during working hours.

Physiotherapists and occupational therapists formed the Home First Team. They worked with staff in the department to try to discharge patients who would benefit from being at home with the right support rather than in the department.

Age UK supported staff and patients in the department providing a befriending service to patients following discharge. They helped make sure that patients' post was collected and fridge was stocked ready for discharge. They could also help patients build up social links with other people.

Seven-day services

Services were available for patients to access whenever they were needed.

The service was available 24 hours a day, seven days a week, 365 days a year.

Porters worked in the department 24 hours a day, seven days a week to help transfer patients to the right place.

The Home First team were available seven days a week between 8am and 10pm to help get patients home with suitable support rather than delay their stay unnecessarily in the department.

Physiotherapists worked in the minors area seeing patients with limb injuries, between 8am and 5pm Monday to Friday.

An alcohol team was available to help patients manage substance misuse. They were available seven days a week between 9am and 5pm.

The Mental Health Liaison Team were available 24 hours a day, seven days a week to support patients with mental health needs. This included children.

Streaming to primary care services was available seven days a week between midday and midnight.

Security staff worked each night in the department from 7.30pm until 8am to help make sure patients and staff were kept safe.

Health Promotion

Staff worked to promote the health of patients in the long term, engaging with national agendas.

We saw evidence that staff identified smoking and drinking habits during assessments and gave advice to patients about limiting excessive consumption to aid recovery and promote health.

Patients we spoke to told us staff discussed this with them whilst under their care.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked capacity to make decisions about their care.

A trust policy provided staff with information about consent processes and the principles of the Mental Capacity Act 2005. The policy also included information about obtaining consent from patients with communication or learning difficulties.

Mental Capacity Act and Deprivation of Liberty training completion

Training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards is covered within the trust's safeguarding adults level 2 training module. As of July 2018, this module was completed by 75.7% of staff within urgent and emergency care, including 90.4% of qualified nursing staff and 55.6% of medical staff. Therefore the 95% target was not met overall, or for either of these two staff groups.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Qualified nursing staff	123	136	90.4%	95%	No
Medical staff	15	27	55.6%	95%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

Consent in the department was obtained on either a verbal or an implied basis. If patients were not well enough to provide consent, staff discussed care or treatment with loved ones or made life saving decisions in the patient's best interests.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

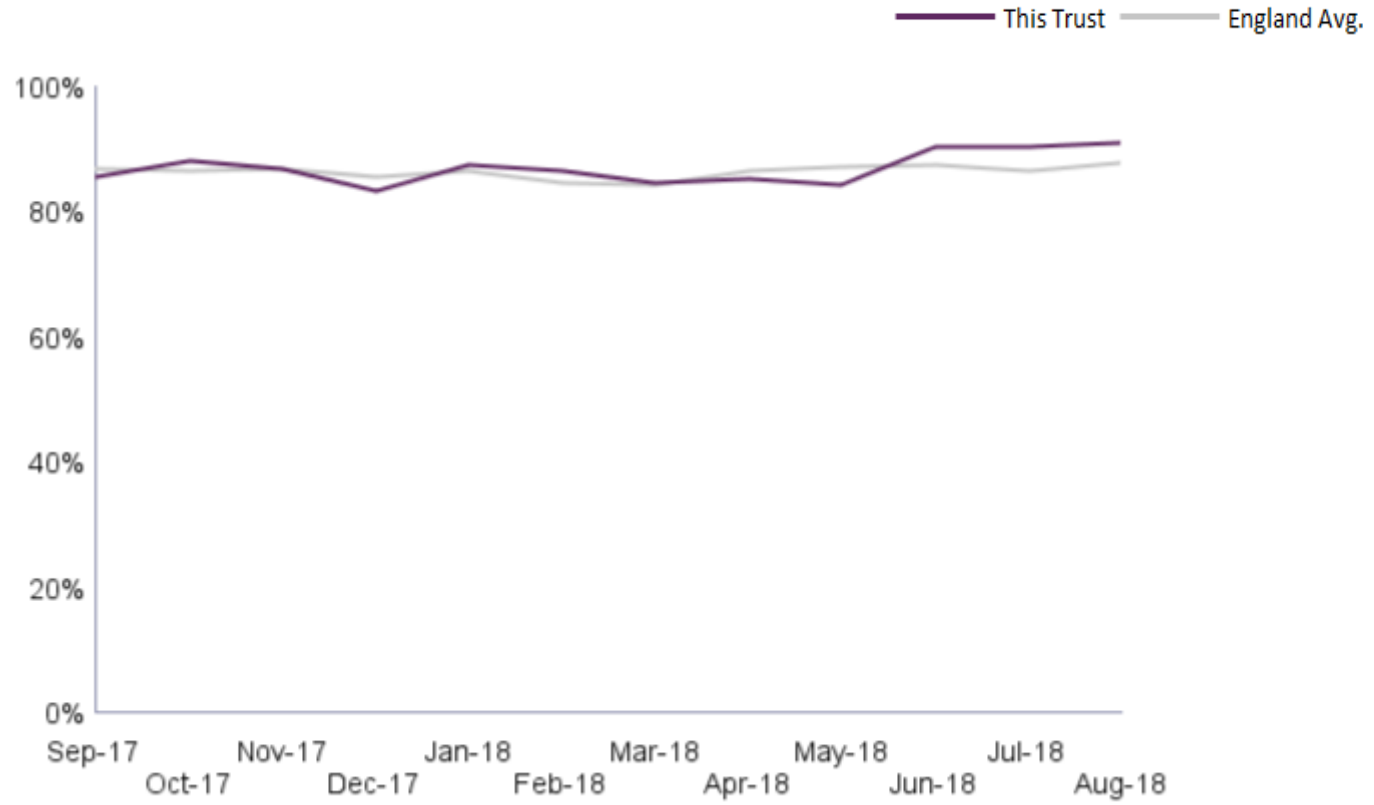
The trust's urgent and emergency care Friends and Family Test performance (% recommended) was mostly quite similar to the England average from September 2017 to August 2018.

There was an overall trend of improvement in the trust's performance over these 12 months, and in June, July and August 2018 the trust outperformed the England average.

In September 2017 the trust's performance was 85.7% compared to the England average of 86.9%.

In August 2018 the trust's performance was 91.1% compared to the England average of 87.7%.

A&E Friends and Family Test performance - Bolton NHS Foundation Trust



(Source: NHS England Friends and Family Test)

We saw examples of staff maintaining patients' dignity and privacy. Porters made sure patients were fully covered with blankets before moving them out of cubicles. Housekeepers carefully selected the right drinking cups for patients; china cups for those able to hold a cup, or lidded cups for those at risk of spills. In triage, assessments and treatment areas, curtains and doors were closed so that staff could speak to patients privately.

Feedback from the trust's monthly survey supported what we saw. One patient said, 'all the staff treated me with dignity and respect'. Another said staff were 'fully respectful and polite'.

Nurses were assigned to areas which helped make sure patients were cared for by the same person. Patients told us staff introduced themselves by name.

Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw feedback from patients from October 2018 which said: 'I was frightened but felt in safe hands'.

Patients we spoke to confirmed this feedback. They said that they did not feel rushed and that doctors and nurses introduced themselves by name. One patient told us they had had 'the best treatment'.

We saw examples of support for bereaved families. Play workers were specially trained to provide support to families at difficult times. Staff provided special boxes so loved ones could store items to help remember their loved ones. Siblings were included with special boxes available for them.

Staff in the paediatric department told us they supported children by speaking to them directly,

playing with them, using toys such as bubble machines to engage them and using techniques to help them share their feelings and ideas.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Emergency Department Survey 2016

The trust scored better than other trusts for four of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 20 questions.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	3.1	About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.9	About the same as other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.7	Better than other trusts
Q14. Did the doctors and nurses listen to what you had to say?	9.1	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	9.2	Better than other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	9.1	About the same as other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	8.1	About the same as other trusts
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	9.1	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.4	About the same as other trusts
Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?	9.5	Better than other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.4	About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	9.2	About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.7	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	6.7	About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.6	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	8.6	About the same as other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	9.3	Better than other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.3	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	4.9	About the same as other trusts

Question	Trust 2016	2016 RAG
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	5.0	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	4.3	About the same as other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	6.4	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.8	About the same as other trusts
Q45. Overall….	8.3	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patients surveyed by the trust in October said that staff were 'very courteous, helpful and explained everything fully'. They also said, 'the doctors were very jolly'.

Staff had tags available to give to patients' carers, which clearly identified them. This enabled them to stay with patients and meant staff could include them in discussions about the patient's care with greater awareness.

Patients we spoke to confirmed these findings, telling us that they had not felt rushed when asked questions and that loved ones did 'not feel left out' and were 'included in decisions and acknowledged all the time'.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The local population was predominantly white British ethnicity but there were also patients from Asian and Polish ethnic minority groups.

Facilities and premises were appropriate for the services being delivered but these were being expanded to better meet local peoples' needs.

While building work was in progress some areas of the department were experiencing loud noise and limited space near the main doors and ambulance arrival area. Whilst this caused some disruption to service the staff managed it well for patients and no issues were raised during our inspection.

The reception area was clearly visible and waiting areas had enough seating for those waiting. Televisions were available which displayed wait times.

From waiting areas patients were either seen by minor injuries staff or triaged by nurses. Minor injuries staff had the ability to see patients and immediately treat and discharge them using strict criteria which helped maintain flow and keep waiting time down for patients.

In the paediatric emergency department children could play or relax in brightly light and decorated areas. Curtains were colourful and displays on walls in cubicles and main areas were engaging.

For those waiting, snacks and cold drinks were available from vending machines in communal areas.

Meeting people's individual needs

The service took account of patients' individual needs.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all three questions relevant to the responsive domain in the Emergency Department Survey 2016.

Question – Responsive	Score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.7	About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last?	7.4	About the same as other trusts
Q20. Were you given enough privacy when being examined or treated?	9.3	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

A mental health diversion team were now present in the department between midday and 2am and available to help care for patients with mental health needs who may not require care in the department but did need support. A Mental Health Liaison Team were also available on site to attend to patients who required a greater level of assessment or intervention than the diversion team could provide. Staff told us the response time for RAID was good. RAID responded to both adults and children, however the numbers of attenders had risen.

A relatives' room was available for loved ones to spend time in a quiet space. The room had soft furnishings but no soft lighting or windows and no refreshments, although these could be provided by staff if required.

During our previous inspection in 2016 we identified that there were no areas of the emergency department designed for those living with dementia. During our latest inspection we saw improvements. The department now met the needs of patients' living with dementia but work was on going to further enhance provision. A bay was designated especially for patients in a quieter section of the majors area. Whilst this was visible from the nurses' station it was not directly in view. Here there were historical pictures on the wall and a 'reminiscence box' was available containing dominoes, historical newspapers and books, and colouring books. Senior nurses told us that a dementia champion nurse post was temporarily vacant but recruitment was in progress.

Washbags were available for carers containing toothbrushes, wipes and other toiletries.

Wheelchairs were available for patients with mobility problems.

Hearing loops were available for patients with hearing problems, however, this had been temporarily switched off due to confidentiality issues.

Translation was available for patients whose first language was not English. This was available via telephone in the first instance although face to face interpreters were available if required. Some were available from within the trust.

A butterfly scheme was in use for patients approaching the end of life. Nurses explained that patients and families were moved to side rooms and butterfly posters were displayed on the door.

This helped make sure staff could facilitate as quiet an environment as possible outside the room.

Plans were being put together to run a frailty service from the emergency department. This plan was in progress by an advanced nurse practitioner and geriatricians in the trust, to develop a pathway to care for frail elderly patients from the point of entering the department to arrival on an assessment ward where patients and loved ones could then receive further assessment and signposting to other support services.

During our previous inspection we highlighted an issue with the glass screens in use in the reception area. These limited the communication between reception staff and visitors and caused staff to have to lean forward which they reported was uncomfortable. During this inspection we saw that this remained an issue. We witnessed several patients telling reception staff they could not hear them and staff struggled to be heard through the screens. We saw evidence that the trust had reviewed other options but so far, no action had been taken to make improvements.

Access and flow

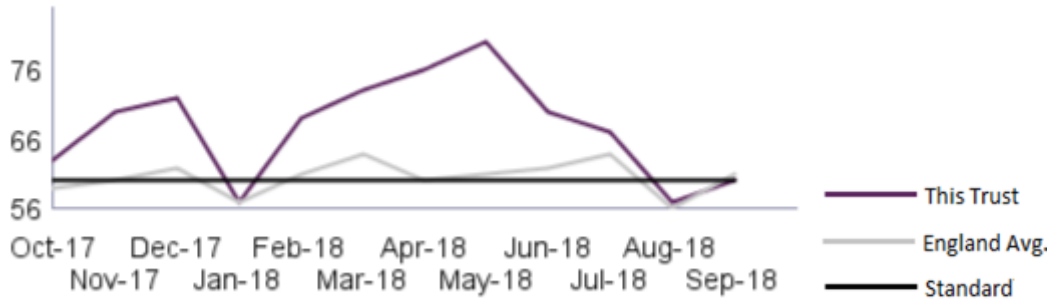
People could access the service. The service was still not meeting national targets and waiting times had not always been in line with good practice. However, managers were cited on this and had made changes which brought about some improvements since the last inspection.

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. Over the 12-month period from October 2017 to September 2018, the trust met the standard in three months: January, August and September 2018. These were also the only months when the trust's performance was similar to the England average. The trust performed worse than the England average in the other 10 months.

The trust's performance for this metric was quite variable with no clear overall trend.

Median time from arrival to treatment from September 2017 to August 2018 at Bolton NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

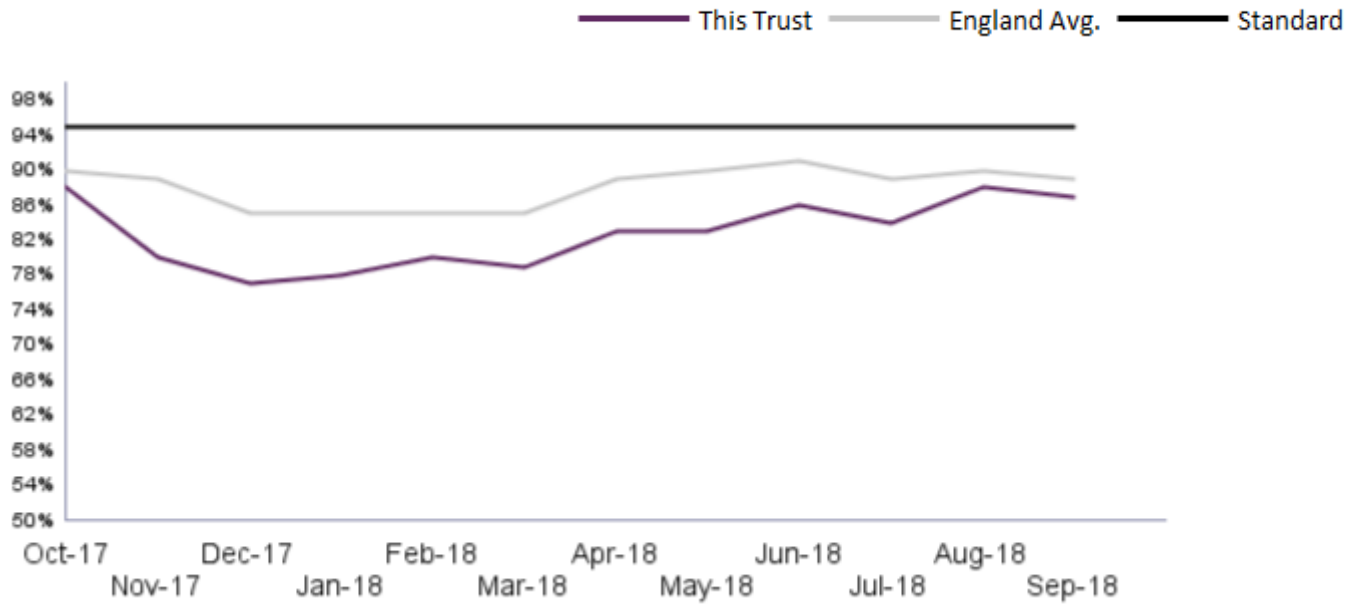
From October 2017 to September 2018 the trust consistently failed to meet the standard, and

consistently performed worse than the England average. This was also identified as an issue during our previous inspection in 2016.

There was a pronounced deterioration in the trust's performance from 88.8% in October 2017 to 76.9% in December. This probably reflected winter pressures. This was followed by a steady trend of improvement through to August 2018 (88.2).

This paralleled the trends in England performance over this period.

Four hour target performance - Bolton NHS Foundation Trust



(Source: NHS England - A&E Waiting times)

During our inspection managers provided figures for the period between October and mid December (14th) 2018. These showed some improvement in October (91%) followed by a decline in November (84%) and December (80%). However, the figures were an improvement when compared against the previous year.

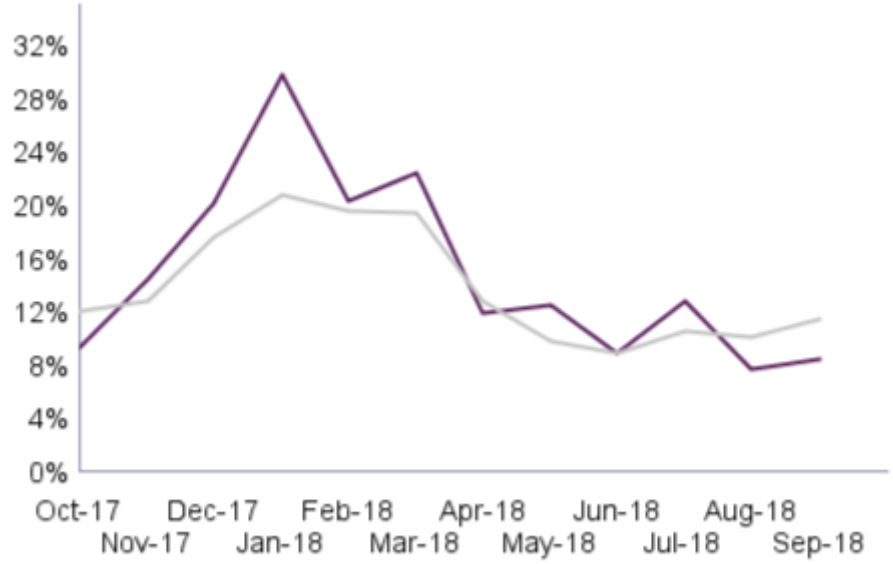
Percentage of patients waiting more than four hours from the decision to admit until being admitted

From October 2017 to September 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average in seven out of 12 months. In the remaining five months the trust's performance was better than, or very similar to, the England average.

As with four hour target performance, there was a pronounced deterioration in the trust's performance during the winter of 2017/18. Performance deteriorated from 9.4% in October 2017 to 29.8% in January 2018. This was followed by a trend of improvement through to August 2018 (7.6%). In both August and September, the trust outperformed the England average performance (10.1% and 11.5%, respectively).

The trust's performance paralleled the trends in England performance over this period.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Bolton NHS Foundation Trust



The table below shows the number of patients waiting more than four hours from the decision to admit to being admitted:

Month	Number of patients waiting more than four hours to admission
October 2017	228
November 2017	358
December 2017	487
January 2018	679
February 2018	414
March 2018	507
April 2018	269
May 2018	290
June 2018	195
July 2018	282
August 2018	161
September 2018	184

(Source: NHS England - A&E SitReps).

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from October 2017 to September 2018, 23 patients waited more than 12 hours from the decision to admit until being admitted. Most of these waits, 18 out of 23, occurred over the five-month period from January to May 2018.

The highest numbers of patients waiting over 12 hours were in January and March 2018 (both five), and April and May 2018 (both three).

The table below shows the number of patients waiting more than 12 hours from the decision to admit to being admitted:

Month	Number of patients waiting more than 12 hours to admission
October 2017	0
November 2017	0

December 2017	1
January 2018	5
February 2018	2
March 2018	5
April 2018	3
May 2018	3
June 2018	1
July 2018	2
August 2018	0
September 2018	1

(Source: NHS England - A&E Waiting times)

Figures provided by managers during the inspection showed that delays for patients remained low, with three patients waiting more than 12 hours from the decision to admit to being admitted between October and mid December (14th) 2018.

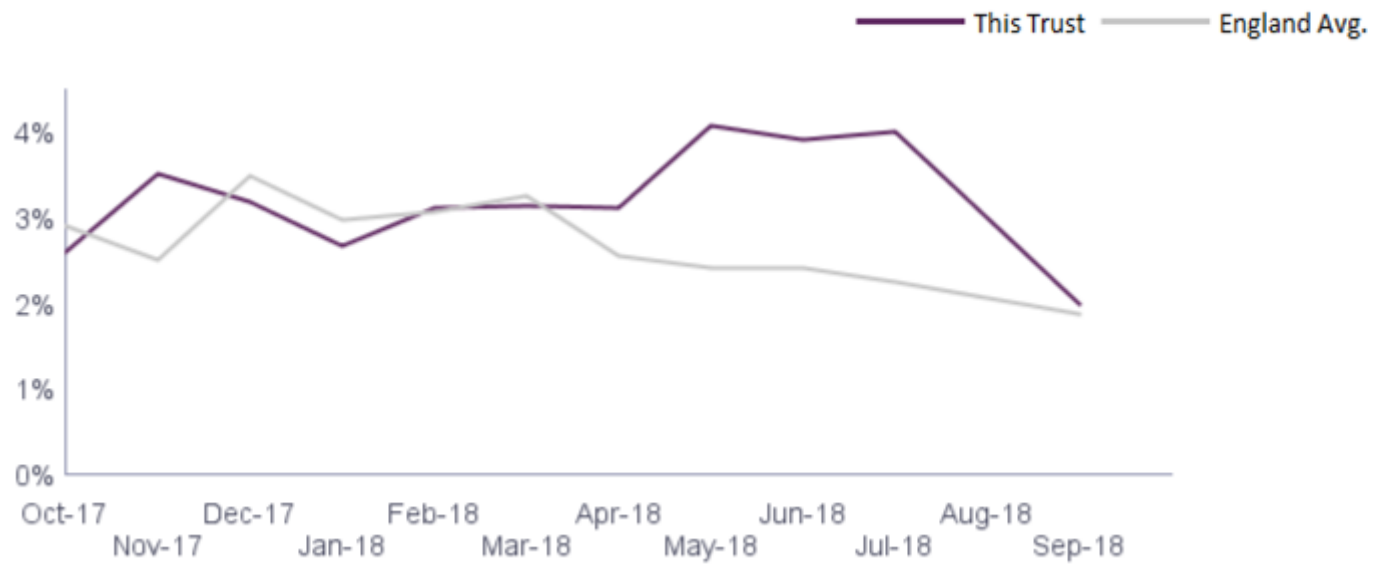
Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

From October 2017 to September 2018 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average in seven out of 12 months.

In the remaining six months, the trust's performance was a little better than, or very similar to, the England average.

The trust's worst performance was over the three-month period from May to July 2018.

Percentage of patient that left the trust's urgent and emergency care services without being seen - Bolton NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

Managers confirmed that work had been done to reduce the number of patients leaving without being seen. They identified many patients left due to unknown wait times so had recently introduced television screens which displayed wait times and the number of patients in each area but had not yet had time to measure its efficacy.

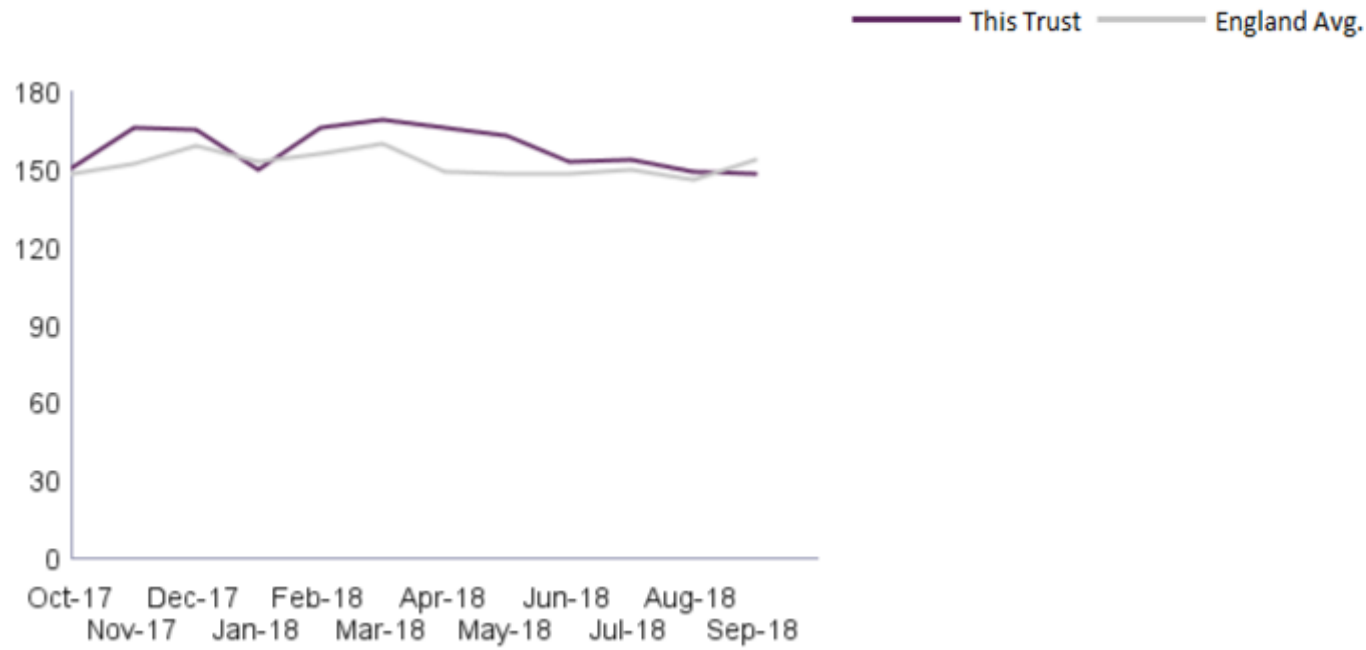
They also introduced some services to try to help patients as early as possible once they arrived in the department. For example, the Mental Health Liaison Team were based in the department. They saw patients with mental health needs who might better receive the help they need at home. They triaged patients and if appropriate, facilitated discharge and more suitable support services, which limited unnecessary waiting times in the department.

Median total time in A&E per patient (all patients)

From October 2017 to September 2018 the trust's monthly median total time in A&E for all patients was higher than the England average in all months except January and September 2018.

Over these 12 months there was little overall change in the trust's performance against this metric.

Median total time in A&E per patient - Bolton NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

Whilst we identified issues with access and flow during our inspection in 2016, we saw proactive work to make improvements and there were signs of improvement in our latest inspection.

The service had welcomed a review by the emergency care intensive support team in December 2017– a clinically led NHS team that reviews services makes recommendations. Following this, work streams were implemented and ECIST gave feedback in January 2018. They cited improvements in areas including ambulance handover, working relationships to overcome flow challenges and discharge constraints, timeliness of medicine reconciliation and hospital wide patient flow best practice.

Through these workstreams the service had established practices in place to better manage flow and improve patient care by the time of our inspection.

These included introducing a 'fit to sit' area for ambulatory majors patients to stay rather than using a bay and streaming ambulance patients straight to wards when senior review was in place at initial assessment. Medical teams had started to 'pull' patients through into medical wards, rather than emergency department staff having to request beds. This proactive approach freed

beds more efficiently. Streaming to primary care services was also in place between midday and midnight from triage areas.

‘Flow huddles’ took place twice daily with a bed manager, site coordinator, senior manager and shift leader. Here they reviewed activity and looked at expected figures for the day to try to plan ahead.

A daily ‘winter assurance’ meeting was held in the department. Here managers, matrons and consultants from across the division met to briefly discuss issues including occupancy, attendance, performance, incidents, length of stay (particularly anyone over 2 days on medical assessment unit), regional performance and medical staffing.

Managers now reported that flow was being managed more proactively within the trust which reduced the blockages on wards and enabled the department to admit patients to wards that required a bed.

Hospital wide bed meetings took place four times daily, which focused on escalation. Managers had started to bring nurses along to bed meetings had helped increase accountability within the department and improve the team approach to managing flow. Managers felt there had been a shift in how the hospital viewed flow, with a greater sense of collective responsibility more now than ever before.

There was a clear escalation policy for staff to use when activity rose. Staff knew the triggers for escalation, for example, having 26 patients in majors, 12 patients waiting for a bed or four ambulances waiting for handover. Actions included informing managers in the trust, pulling clinical staff away from administrative duties and into the department and liaising with the local ambulance service NHS trust.

Specific triggers helped all hospital staff manage this flow in a succinct way. For example, if bed capacity reached 90% the director on call was asked to review and report to the executive team.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and leaned lessons from the results, and shared these with all staff.

Staff used an up to date complaint policy to manage, investigate and learn from complaints. A consultant led on complaints. Having a lead in place meant trends could be identified because one person was aware of all of them. The consultant fed information to the manager and clinical director to make sure they were aware of important issues. So far, this year, no trends had been identified.

Formal complaints were investigated by consultants, managers, matrons or team leaders before being approved by the division. Informal complaints were either dealt with verbally by staff at the time the issue occurred, or via the Patient Advice and Liaison Team who aimed to deal with minor issues within 24 hours.

Staff we spoke to told us they were asked to produce statements to help with complaint investigations. Daily handovers included information about complaints.

Patients we spoke to told us they knew how to make a complaint should they wish to. However, none of the patients we spoke to wanted to raise concerns about the care they had received.

Summary of complaints

From September 2017 to August 2018 the trust received 50 complaints about urgent and emergency care. For the 43 complaints that had been closed at the time of data submission, the trust took an average of 35.7 working days (mean) to investigate and close these complaints. This was slightly over the trust response target of 35 working days.

The seven complaints that had not yet been closed had been open for an average of 21.1 working days at the time of data submission. This was in line with the policy statement that complaints should be responded to within 35 working days.

The breakdown by subject can be seen in the table below.

Subject	No. of complaints
Clinical care	31
Delay in diagnosis/test results/treatment	9
Attitude of staff	4
Communication	3
Admission arrangements	1
Waiting times	1
Medication	1
Total	**50**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

During the inspection, managers told us that this data was incorrect because it contained figures for more than the emergency department. They provided refreshed figures which showed that between September 2017 and September 2018, 47 complaints were received. The breakdown of subject can be seen in the table below.

Subject	No. of complaints
Clinical care	23
Delay in diagnosis/test results/treatment	8
Attitude of staff	4
Communication	3
Wrong diagnosis	6
Waiting times	1
Medication	2
Total	**47**

Number of compliments made to the trust

The trust was unable to supply compliments data for urgent and emergency care.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

However, staff and managers told us compliments were received and discussed daily during handover.

Is the service well-led?

Leadership

Managers at all levels had the right skills and abilities to run the service and provide high quality sustainable care.

Divisional directors of nursing and operations reported to directors, who were directly accountable to the Chief Executive Officer.

Divisional directors had experience in clinical and regulatory management. They managed the service business manager and matron who both had significant experience managing clinical services.

From here the service was split into medical, allied health professionals, and nursing staff management, though the teams worked closely together.

Consultants supervised medical staff, and senior nurses managed teams of nurses and assistant staff. Reception staff had their own supervisor.

Nurses, doctors and support staff said senior leaders visited the department regularly and were approachable and friendly. The medical director worked clinically in the department every week and most mornings the chief operating officer visited to check how staff were following the night shift.

Vision and strategy

The service had a futuristic vision for what it wanted to achieve and workable plans to turn it into action.

This was to build the health of residents and by doing so contribute to the local area making it a vibrant, welcoming place, with successful businesses.

The vision was based on health outcomes such as improved wellbeing and longevity, achieved by working with the community and delivering care which was financially sustainable. It was underpinned by three principles aimed at growth and prosperity, protecting the vulnerable and working in partnership with others.

A set of values were placed at the heart of the trust and staff we asked could explain them to us. One nurse told us they were encouraged to apply them to situations and they were included in the appraisal process. They centred around openness, integrity, compassion and excellence and we saw evidence of them in use during our inspection.

A five-year trust strategy (2016-2021) outlined how this would be achieved through initiatives including department expansion, reduction of readmission for specific patient groups and work with commissioners to help redirect some patients to more appropriate services.

Other service strategies such as winter and improvement plans helped the service navigate their way through challenging times and introduce new ways of working successfully. Managers felt these plans had helped improve services.

Culture

Managers promoted a positive culture that supported and valued staff, and created a sense of common purpose based on shared values.

Following management changes over the last year, staff described a cultural change. For example, financial responsibility for training courses and a focus on quality when doing daily housekeeping duties was noted during our inspection.

It was evident that staff worked cohesively and were positive about their colleagues. They described a culture where they felt safe enough to raise issues and concerns and we saw examples where staff were nurtured having had poor experiences in other workplaces.

Staff we spoke to described the department as ‘friendly’ with a ‘lovely team’. Another told us ‘I love it here’.

We saw examples of positive feedback which helped nurture this positive culture. This included issuing ‘favourable event’ letters and giving chocolates or flowers for good documentation completion.

A consultancy agency had helped managers focus on resilience for staffing. They conducted sessions with staff about self-care and talent management.

Staff were familiar with the principles of the duty of candour. This is a legal obligation to be open and honest when things go wrong.

Governance

The service used a systematic approach to continually improve service quality and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

The service fed into committees including quality assurance and integrated performance management. This helped make sure the focus was always maintained in these areas.

Governance meetings were held monthly where risk, incidents, performance complaints and a patient story were shared.

Departmental meetings were also held each month and for staff working at lower levels. Other weekly drop in meetings were hosted by senior nurses for any staff members to call in and discuss queries or concerns. A forum meeting also took place for band six nurses to attend.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with the expected and unexpected.

The service used a risk register to record risks and actions to mitigate them. The register recorded the issue, controls needed and actions to implement them as well as target dates to help keep progress on track.

The service promoted risk management to all staff. A consultant led on governance and we saw a noticeboard for staff which displayed an explanation of risk and governance. The board also displayed the key items listed on the risk register and described a case study serious incident, explaining what happened versus what should have happened. By explaining the details in a simple format, staff could review it, understand the impact it had in terms of risk and governance and take ownership to prevent a recurrence in the future.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

During our last inspection we identified that there were limited numbers of computer terminals in the department and that staff struggled to access these during busy periods. Following this inspection, we saw improvements with additional terminals added.

Staff knew how to access information and navigated their way around systems used in the department with ease.

Engagement

The service engaged well with patients, staff and the public to plan and manage appropriate services and collaborate with partner organisations effectively.

At the time of our inspection the service had organised a focus group with members from a range of groups including lesbian, gay, bisexual and transgender (LGBT) communities, deaf, ethnic minority and learning disability groups. Managers wanted to show them the department and ask how they might improve services for them. The matron told us the visit had been a success with some useful suggestions from the visitors that they would be able to action. These included displaying rainbow signs to help make LGBT visitors feel more welcome, and liaising with a deaf visitor about how to contact an interpreter.

We saw promotional material around the department encouraging the public to complete the Friends and Family questionnaires. Staff told us patients received a text following discharge from the department which asked them about their experience and provided useful feedback.

Engagement with staff also took place. Closed social media pages were used so that staff could be contacted collectively using more modern methods. Formal staff meetings were not taking place at the time of our inspection. Managers explained these were difficult to arrange given activity in the department and had been cancelled at short notice in the past. To avoid this, senior nurses ran informal drop in sessions twice weekly instead.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

By introducing a ‘fit to sit’ ambulatory section into the majors area staff could increase the capacity without impacting significantly on the flow of the department. This had helped make significant improvements in patient care and meeting targets.

The service had made significant changes to the approach to measuring outcomes and monitoring the care and treatment being provided for patients suffering with sepsis. This helped staff monitor improvement over time and identify areas where improvement was needed quickly and effectively using a supportive approach.

Medical care

Facts and data about this service

Royal Bolton Hospital has 306 medical inpatient beds located across 13 wards and units. There are also four other wards and units without inpatient beds:

Ward/unit	Speciality or description	Inpatient beds
Discharge lounge	General medicine	-
Endoscopy	Diagnostic and therapeutic service, including bowel screening delivered by the surgical directorate	-
Coronary care unit	Cardiology	8
Clinical decision unit	Acute medicine	14
Ambulatory care unit	Acute medicine	-
Ward A4	Complex discharge	22
Ward B1	Acute frailty unit	23
Ward B2	Bedded escalation area	-
Ward B3	Complex care	21
Ward B4	Bedded escalation area	-
Ward C1	Cardiology	25
Ward C2	Haematology/complex care	26
Ward C3	Gastroenterology	26
Ward C4	Diabetes	27
Ward D1	Medical assessment	26
Ward D2	Medical assessment	22
Ward D3	Respiratory medicine	27
Ward D4	Respiratory medicine	27
Ward H3	Stroke medicine	24

Medical specialties provided at Royal Bolton Hospital include cardiology, diabetes, elderly care, gastroenterology, haematology, respiratory medicine and stroke services.

(Sources: Routine Provider Information Request (RPIR) Sites tab)

The trust had 25,500 medical admissions from July 2017 to June 2018. Emergency admissions accounted for 17,193 (67.4%), 565 (2.2%) were elective, and the remaining 7,742 (30.4%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 13,044
- Gastroenterology: 5,454
- Geriatric medicine: 3,130

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

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

Mandatory training was provided through the trust by a mixture of face to face and electronic learning sessions. The training covered a range of core skills and additional clinical skills specific to clinical roles and are detailed in the table below. The education department provided managers and staff with reports and prompts prior to mandatory training becoming overdue so staff could be allocated training sessions to attend.

In addition, clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia.

Mandatory training completion rates

The trust set a target of 85% for completion of basic life support, conflict resolution, information governance and medicine management training. The trust set a target of 95% for completion of all other mandatory training modules.

A breakdown of compliance for mandatory training courses as of July 2018 for qualified nursing staff in medical care is shown below:

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Equality and diversity	309	322	96.0%	95%	Yes
Conflict resolution	297	321	92.5%	85%	Yes
Basic life support	297	322	92.2%	85%	Yes
Information governance	297	322	92.2%	85%	Yes
Fire safety 2 years	294	322	91.3%	95%	No
Blood transfusion	241	268	89.9%	95%	No
Infection prevention (level 2)	296	341	86.8%	95%	No
Medicine management training	275	341	80.6%	85%	No

In medical care the trust had an overall training compliance rate of 90.1% for qualified nursing staff. Training targets were met for four of the eight mandatory training modules for which qualified nursing staff were eligible.

Compliance for nursing and clinical support staff was monitored by ward managers using an internal electronic system. Compliance with mandatory training was recorded on the performance heat map for each ward each month and was visible in staff areas on the governance notice boards.

Compliance was reported at a divisional level on a monthly basis through the divisional performance meetings. The ward managers were responsible for providing a rationale if training was not in line with the trusts targets. Training compliance was taken into consideration as part of the ward accreditation scheme and affected the overall rating for the ward.

A breakdown of compliance for mandatory training courses as of July 2018 for medical staff in medical care is shown below:

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Equality and diversity	61	63	96.8%	95%	Yes
Blood transfusion	45	49	91.8%	95%	No
Basic life support	52	63	82.5%	85%	No
Fire safety 2 years	51	63	81.0%	95%	No
Conflict resolution	47	60	78.3%	85%	No
Information governance	46	63	73.0%	85%	No
Infection prevention (level 2)	54	83	65.1%	95%	No
Medicine management training	51	83	61.4%	85%	No

In medical care the trust had an overall training compliance rate of 77.2% for medical staff. Equality and diversity was the only training module where the relevant completion target was met, Training targets were not met for any of the other seven mandatory training modules for which medical staff were eligible. The lowest completion rates were for information governance (73.0%), infection prevention level 2 (65.1%) and medicine management (61.4%).

The trust found data quality issues with their training completion data for moving and handling (inanimate loads); this module is therefore excluded from the analysis above.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Compliance for medical staff was low against the trusts target. The senior medical team told us they had identified this was an issue and had engaged with the medical teams to drive improvement. Medical staff had been told that they were unable to attend additional study days if they had not completed their mandatory training. Following the inspection, the trust provided additional data which demonstrated that the current overall compliance rate for medical staff had improved and was 88.1%.

Compliance with mandatory training for medical staff was monitored by senior medical staff and reported to the divisional performance meeting on a monthly basis.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had access to training on how to recognise and report abuse and they knew how to apply it. However, training compliance rates for medical staff were low against the trusts target.

There was a safeguarding team within the trust who had oversight of all safeguarding cases, within the team there were safeguarding lead nurses. Staff had access to the trusts policy on safeguarding and contact details for the team via the trusts intranet. Staff we spoke with could provide examples of safeguarding cases and were aware of how to make referrals and access the team for advice.

The therapy teams provided examples of safeguarding referrals they had made. Examples included details of how the team had linked in with the trust safeguarding team within the hospital and the wider multidisciplinary team in the community who were involved in patients care.

The service treated predominately adult patients above the age of 18. Clinical staff received safeguarding children and adults training level one and two every two years. Safeguarding training included 'Prevent' training (which is to train staff in the recognition of radicalisation) and female genital mutilation.

Children age 16 and above were occasionally treated on the medical wards, if it had been identified that it was the most appropriate place for them to be cared for. This was mainly on wards D1 and D2 which were the medical assessment wards. Band seven nurses and matrons received safeguarding children level three training. This meant that staff had access to a level three trained nurse if a child was being treated on the ward. This met with the national guidance. Staff told us that if a child was being treated on the ward the procedure was to inform the safeguarding team and the paediatric matron. A stamp is added to the patients notes to identify they are under the age of 18.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of July 2018 for qualified nursing staff in medical care is shown below.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Safeguarding children (level 2)	308	341	90.3%	95%	No
Safeguarding adults (level 2)	304	341	89.1%	95%	No

In medical care the trust had an overall safeguarding training compliance rate of 89.7% for qualified nursing staff. The 95% target was not met for either of the two safeguarding training modules for which qualified nursing staff were eligible. The level two safeguarding training course includes all elements of level one training so staff completing level two would also be compliant for level one.

A breakdown of compliance for safeguarding training courses as of July 2018 for medical staff in medical care is shown below.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Safeguarding children (level 2)	52	76	68.4%	95%	No
Safeguarding adults (level 2)	54	83	65.1%	95%	No

In medical care the trust had an overall safeguarding training compliance rate of 66.7% for medical staff. The 95% target was not met for either of the two safeguarding training modules for which medical staff were eligible. The level two safeguarding training course includes all elements of level one training so staff completing level two would also be compliant for level one.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The safeguarding training compliance for nursing staff was close to the trust target of 95%. However, the compliance for medical staff was low against the trusts target.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

There were hand washing stations and alcohol gel available for staff and visitors on the entrance to the ward and in bays and side rooms. We observed staff undertaking regular hand washing. There was personal protective equipment available for staff outside side rooms and bays including disposable aprons and gloves and we saw that staff used it. In clinic rooms we observed wipeable chairs and staff had access to detergent wipes for use between patients. We observed staff adhering to bare below the elbow guidelines.

Patients were screened for infections as part of the admission process. Patients who had been identified as an infection risk were prioritised for side rooms to isolate potential infection risk. The service used yellow warning signs on side room doors to indicate to staff and visitors that a patient was an infection risk, this prompted additional precautions to be taken when entering the room. The electronic patient record system flagged patients who had been identified as and infection control risk. Wards had a dedicated infection control nurse, who attended the ward daily to review high risk patients and ensure the appropriate precautions and treatment were in place. Staff told us they had good links with the infection control team and would make contact for advice.

The infection control team carried out regular audits. There were monthly environmental and hand hygiene audits and weekly audits of patients with diarrhoea in line with the trust's principles of suspect, isolate, gloves, handwashing and test. Senior nursing staff told us that audit results were positive. Audit results were monitored and reviewed monthly by the infection control committee. Ward managers cascaded the results and improvement plans to staff through team meetings and safety huddles.

We reviewed the environmental audits for the areas we visited from September to November 2018. We saw that compliance was between 74 and 100%. The clinical decisions unit had achieved the lowest compliance rate of 74% for October and November 2018. The wards with the highest compliance rates were D1 and the coronary care unit who had achieved 100% on two consecutive months. Senior nursing staff told us that improvement action plans were provided to wards if they did not achieve 100% compliance, however we did not see evidence of this.

We reviewed the audit results for patients with diarrhoea. We saw that compliance was assessed against four standards these were; was infection suspected in a timely fashion in line with the colostrum difficile policy, was the patient isolated in a timely fashion (within two hours), does the patient have an accurate stool chart and has a sample been sent for analysis in a timely fashion. The audit data showed an improvement in compliance for each standard between December 2017 and November 2018. Between September 2018 and November 2018, the compliance rate for all standards was between 82.7% and 96.9%.

Infection rates were reported divisionally on a monthly basis as part of the performance heat maps. These included, Clostridium difficile (C-Diff), Methicillin-susceptible Staphylococcus aureus blood stream infections (MSSA BSI's) and Methicillin-resistant Staphylococcus aureus (MRSA). We reviewed the Heat maps for October and November 2018 for wards B1, B3, C3, D1, D2 and H3. We saw that there had been no unit acquired infections reported. Infection rates had shown an improvement since the last inspection.

The areas we visited were visibly clean. The service used 'I am clean' stickers for equipment and furniture, these were visible and dates were current. We observed disposable curtains in use which were clearly labelled with the replacement dates and were within date.

The endoscopy unit had been newly designed and built since our last inspection. The design was

in line with joint advisory group on gastro intestinal endoscopy standards and had a flow of clean to dirty through the unit. Flexible endoscopes entered and left the unit through a clean to dirty system. The trust had a hospital sterilisation and decontamination unit who were responsible for the cleaning and decontamination of the flexible endoscopes, this was undertaken in line with national guidance.

Environment and equipment

The service had suitable premises and equipment and looked after them well. However, the design and layout of some wards meant that some patients were not always visible to nursing staff.

Staff felt they had access to the equipment they needed and told us there were no issues in obtaining specialist equipment for specific patients this included pressure relieving and bariatric equipment.

Equipment was maintained by the trusts own medical engineering company. Equipment maintenance was recorded and monitored using an electronic system which provided a planned maintenance schedule for each item of equipment. Maintenance of equipment was planned in line with Medicines and Healthcare Products Regulatory Agency Guidelines for Managing Medical Devices 2015, manufacturers recommendations and national patient safety alerts. We observed that equipment in all areas we visited contained maintenance stickers to indicate when they were due to be re-tested and were within the specified re-test dates.

Specialist equipment used in the endoscopy unit was serviced and maintained by the equipment manufacturer. The unit manager had oversight of the maintenance of the specialist equipment. We were told there was no issues with the maintenance of endoscopy equipment.

Resuscitation equipment was available in all of the areas we visited. Resuscitation trolleys were accessible and stored in accordance with Resuscitation Council (UK) guidelines. Resuscitation drugs boxes were stored in tamper-evident containers. We reviewed the daily checks for resuscitation trolleys in all of the areas we visited and found that checks had consistently been completed. We observed the equipment contained on the trolleys and found that they were within maintenance re-test dates and manufacturers expiry dates. However, we found two resuscitation trolleys that had sharps bins on that had not been dated.

The Endoscopy unit had been newly built in 2017. Patient waiting areas contained comfortable seating and televisions. The waiting areas and corridors contained wall art of a countryside scene staff explained it was to represent the journey patients were taking through the unit. The unit had been designed in line with joint advisory group for gastro intestinal endoscopy recommendations. The unit was accessed from the main patient waiting area using secure swipe pass access. This meant the unit was only accessible to authorised staff, patients attending for treatment were escorted by a named nurse. Waiting areas within the unit for patients who were prepped for their procedure were segregated into male and female areas, this was replicated in the recovery area. There were four procedure rooms which had illuminated signage to indicate when a room was in use and restrict access. We were told that there were no procedures requiring radiation undertaken on the endoscopy unit.

Waste was appropriately segregated into domestic and clinical waste. Bins were foot pedal operated and available in bays, side rooms and controlled areas. The ward areas we visited had designated waste rooms where waste was securely stored and appropriately segregated prior to collection.

Ward areas which provided accommodation for patients with complex needs were secured and accessed for staff by secure swipe access or via an intercom system for visitors. This was to prevent the risk of patients leaving the ward who may be confused and wander some. The hospital was aging and some wards did not look as modern as others, however the environment was well maintained. Wards provided accommodation in a mixture of bays and side rooms. The majority of storage areas were locked and secure by keypad or swipe card access. We observed hazardous cleaning substances stored in additional locked cupboards inside store rooms. This was in line with health and safety best practice guidance on the control of substances hazardous to health.

Ward D1 was one of the assessment wards. We observed the area behind the main nurse's station where there were patient toilets and shower facilities and found it was cluttered. There were two storage rooms in this area which were unlocked and the doors were propped open. In one of the rooms there was an oxygen cylinder stood on the floor which was not secured there were no other hazardous items in the rooms accessible to patients. One of the patient toilets and handwashing rooms in this area of the ward contained surplus equipment such as Zimmer frames and blood pressure monitoring machines. There was a risk the cluttered area posed a hazard to patients with mobility problems.

However, staff identified issues with the layout of some of the wards from a patient safety and accessibility aspect. Staff identified that some of the side rooms were located on entrance corridors and were not visible from the nurse's station. We saw that this was the case on ward D1, B1 the frailty unit and C3. Staff mitigated the risk to patients by using those rooms for patients who had been identified as low risk and independently mobile. On ward D1 the entrance to bay two and bay six was not wide enough to accommodate a bariatric bed. This was on the divisional risk register.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Risk assessments were completed as part of the admissions process and covered falls, venous thromboembolism (a condition where blood clots form), pressure areas, using waterlow scores, nutrition and mental health assessments. We reviewed 18 patient records and saw evidence of completed risk assessments. In the main we saw that care plans, as a result of high risk scores, had been implemented. However, we found that two of the records we reviewed had not initiated care plans as a result of high risk pressure scores, we raised this with staff at the time of the inspection who took appropriate action.

The service used national early warning scores (NEWS2) which meets with the updated guidance released in December 2017. The early warning scores were recorded on an electronic system which had been recently introduced into the medical division. Nursing staff used electronic handheld tablets to input observations and the system calculated the observation scores automatically to give an overall early warning score. We saw that the assessment used a colour coded system of green, amber and red to indicate if a patient was showing signs of deteriorating or was acutely unwell. Staff had access to a paper key chart to inform them of what the colours represented and prompt action they need to take. The system automatically changed observation frequency to one hourly for patients who were flagging as at risk. Staff had received training on the system prior to its implementation in their ward areas. Agency staff received training from the trust prior to undertaking a shift at the trust.

Staff we spoke with were positive about the new observation system and felt it was easy to use. Staff were aware of how to identify deteriorating patients and could describe the process and policy for escalating patients who were showing signs of deterioration, this included increasing the frequency of observations and escalating patients to a doctor. Between the hours of 7.00am and 7.00pm Monday to Sunday patients were escalated to the doctor on the ward for review, outside of those hours staff escalated to the doctor on call for their ward. The trust had a critical care outreach team who were available to staff for acutely unwell patients and would undertake a review of the patient.

We observed multidisciplinary board rounds and patient handovers. We saw that patient's risks were discussed and reviewed, this included early warning scores, falls, pressure areas and infection control risks. Patients were discussed in order of their risk status and so the patients which were high risk were discussed first.

The trust had a sepsis policy and was using the sepsis six toolkit for identify and responding to patients suffering from sepsis. Clinical staff received training on sepsis. There was regular monitoring in place for sepsis screening and treatment implementation which was undertaken as part of the monthly key performance indicator audit which reviewed 10 patient records. We reviewed the key performance indicator audit results for October and November 2018 for ward B1, B3, C3, D1, D2 and H3, we saw that compliance was between 86.2% and 93.9%.

Staff told us that when patients flagged on the electronic early warning scores as suspected sepsis, the electronic system automatically directed them to the electronic sepsis screening tool and it was mandatory for staff to complete this. We saw that patients who had been identified as suspected sepsis on ward B3 had a completed screening tool and appropriate action had been taken.

All staff received basic life support training as part of their annual mandatory training. Nursing staff received intermediate life support training. In addition to this the band six and band seven nurses on the coronary care unit had received advanced life support training.

The service had 24-hour access to mental health liaison, if they were concerned about risks associated with a patient's mental health. Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide through the mental health liaison service. Staff described close working relationships with rapid assessment interface discharge team (RAID) and learning disability specialist nurse. Staff could escalate concerns to the matrons when they felt a patient may require one to one observations to maintain their safety, to ensure staffing was adequate to meet all patient needs.

Nurse staffing

Whilst the service did not always have enough nursing staff, staffing was monitored and reviewed to mitigate the risk to patients. Nurses had the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The service monitored nurse staffing regularly. Nurse shift fill rates were reported as part of the wards performance heatmap on a monthly basis. Matrons told us that rosters were planned six weeks in advance so that they could proactively fill shift gaps. Matrons held a weekly roster meeting where they monitored and reviewed gaps in staffing. On the day absences were reported to matron level and discussed as part of the bed management meetings.

Staffing numbers were displayed in the areas we visited and showed planned staffing against actual staffing figures for each shift. During our inspection we observed that staffing mostly

reflected the planned figures, although in some areas we saw that the staffing was down by one registered nurse on the daytime and late shift. We did not observe shortfalls in staffing for night shifts.

The trust reported their registered nursing staff numbers as below as of March and July 2018.

Site	March 2018			July 2018		
	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate
Qualified nursing staff	306.9	360.1	85.2%	316.2	367.0	86.2%

(Source: Routine Provider Information Request (RPIR) –Vacancy tab)

We reviewed the percentage of registered nurse shifts reported in October and November 2018 for wards B1, B3, C3, D1, D2 and H3. We saw that the average percentage of shifts covered during the day were 88.2% and at night were 98.3%. However, we saw that on some shifts unqualified staffing percentages were above 100% which indicated additional unregistered staff available. Matrons and ward managers told us there had been an improvement in staffing and reported that in November 2017 there were 120 whole time equivalent vacancies across the medical division and at the time of our inspection they reported 24 whole time equivalent vacancies.

However, nursing and health care assistant staff on the assessment wards and the coronary care unit told us they were often moved to support other wards who did not have enough staff. Matrons and ward managers told us that the acuity of the patients on the ward was considered before staff were moved. Nurse staffing was on the divisional risk register.

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 14.4% for qualified nursing staff in medical care. This was higher than the trust target of 6.0%.

The vacancy rate was higher than 30% for three reporting units: dermatology (37.5%), ward C3 (gastroenterology, 37.5%) and complex care (30.5%).

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The service had a focus on staff retention. Senior nursing staff explained that they had introduced development opportunities for staff which included shadowing opportunities, attendance of leadership courses, the introduction of mentor roles, rotational posts and through encouraging staff to lead on improvement projects. Matrons and ward managers told us that they had felt and improvement in that ward managers were able to have two to three management days per week, they were able to release staff to attend courses and they described an improvement in ward audit figures.

It was acknowledged that recruitment and retention was an ongoing focus and that some areas had higher vacancies than others. There was a rolling recruitment process in place and the service had introduced exit interviews for when staff took internal transfers to another ward. A matron told us this was to identify how improvements could be made for teams working in those areas and identify potential issues.

Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 10.3% for qualified nursing staff in medical care. This was higher than the trust target of 10.0%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 5.6% for qualified nursing staff in medical care. This was higher than the trust's target of 4.2%.

The highest sickness rates were reported for general diabetes (23.3%), admission avoidance (15.0%), rheumatology (14.6%) and ward D4 (respiratory medicine, 11.1%).

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From August 2017 to July 2018, the trust reported that 6.9% of qualified nursing staff hours in medical care at Royal Bolton Hospital were filled by the trust bank, this provided some continuity of staffing. A further 10.7% were filled by agency staff. In addition, 6.5% of qualified nursing hours were not filled by bank or agency staff to cover staff absence.

Over the same period, the trust reported that 21.4% of nursing assistant staff hours in medical care at Royal Bolton Hospital were filled by bank staff, while 116 shifts (0.02%) were filled by agency staff. In addition, 6.3% of nursing assistant hours were not filled by either bank or agency staff to cover staff absence.

Staff group	Bank		Agency		Unfilled		Total hours available
	Hours	%	Hours	%	Hours	%	
Qualified nurses	35,628	6.9%	55,531	10.7%	33,923	6.5%	518,361
Nursing assistants	107,462	21.4%	116	0.02%	31,702	6.3%	502,440
Total	**143,090**	**14.0%**	**55,647**	**5.5%**	**65,625**	**6.4%**	**1,020,801**

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

We were told that on the medical assessment units D1 and D2 there was a high use of agency registered nurses and bank health care assistants. This was attributed to a high sickness rate and current vacancies. Agency staffing allocation was managed by the matrons and we were told that they made sure that there was a combination of permanent staff on shift with agency staff. We were told patient safety was a focus when allocating staffing and the financial implications of using agency staff was not considered over patient safety.

There was a winter pressure ward which was used when additional beds were required in the hospital. At the time of our inspection the ward was closed and undergoing renovation. There was a lead matron for winter pressures and workforce. We were told that permanent staff had been recruited for the winter pressure ward. The team consisted of a band 7 ward manager, two band 6 nurses, three band 5 nurses and seven healthcare assistants. At the time of our inspections these staff had been seconded to other ward areas. Ward managers who had the seconded staff on their ward explained that they did not feel an impact in staffing when the winter pressure ward was open, however at the time of our inspection we did not see that these areas had more staff than had been planned.

Beds were planned to be opened as a staged plan from December 2018 to March 2019 with initial staffing requirements predicted for eight beds increasing to 16.

Nursing handovers were undertaken at the beginning of each shift. In addition, there was a daily

safety huddle and two multidisciplinary board rounds. We saw that discharge planning; care planning and patient risks were discussed.

Medical staffing

Whilst the service did not always have enough medical staff, staffing was monitored and reviewed to mitigate risk to patients. Medical staff had the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust reported their medical staff numbers as below as of March and July 2018.

Site	March 2018			July 2018		
	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate
Royal Bolton Hospital	87.5	103.0	85.0%	89.1	103.7	86.0%

(Source: Routine Provider Information Request (RPIR) –Vacancy tab)

As part of seasonal/winter planning there were 1 whole time equivalent consultant and 2 whole time equivalent junior doctor posts.

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 13.8% for medical staff in medical care. This was higher than the trust target of 6.0%.

The trust reported that its establishment of 0.3 WTE medical staff rehabilitation management was vacant in every month over this period.

Otherwise the highest annual vacancy rates were reported for medical staff in dermatology (69.1%), diabetes and endocrinology (21.3%) and complex care (18.2%).

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 21.0% for medical staff in medical care. This was higher than the trust target of 10.0%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

We discussed the high turnover rates provided with the clinical leads. We were told that the above data was not reflective of the workforce turnover. We were told that there had been an increase in medical posts within the division to expand the workforce and felt this may have altered the figures provided. We were told that turnover of medical staff was not a concern.

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 1.2% for medical staff in medical care. This was lower than the trust's target of 4.2%.

The highest sickness rate was reported for medical staff in the integrated skin service (12.3%), general diabetes (9.4%) and diabetes and endocrinology (4.4%). These were the only reporting

units that reported sickness rates higher than the trust's target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The trust were unable to provide the total number of hours worked by all medical staff in medical care at Royal Bolton Hospital from August 2017 to July 2018. The trust were also unable to report the number of hours left unfilled by bank or locum staff to cover staff absence. This is because medical staff at the trust were not on a central roster over this period. The trust report that they have a plan in place to move their medical staff onto roster to enable reporting on hours worked and fill information.

Therefore, it was not possible to calculate the percentages of medical staff hours worked by bank and locum medical staff. Instead only the raw numbers are available.

From August 2017 to July 2018, the trust reported that 3,624 medical staff hours in medical care at Royal Bolton Hospital were filled by bank staff, while 24,660 medical staff hours were filled by locum staff.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Medical staffing was reviewed regularly to identify potential gaps in rosters and plan staffing in advance. The trust had a focus on using internal staff to cover shifts as bank and had agreed a higher rate of pay for these staff to reduce agency fees. We saw that the service had approved an additional consultant role and two core trainee doctor roles form December 2018 to March 2018, which had been identified as required to support winter pressures. These were long-term temporary contracts which were going out to bank and agency recruitment.

Medical staff we spoke with told us they had no concerns with medical rotas. Medical staff felt the rotas provided them with a good work life balance. Staff told us if they worked additional hours due to unexpected staffing issues they could claim their time back.

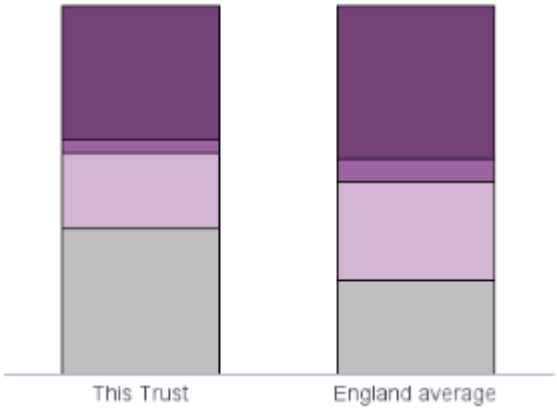
The senior clinical leadership team for the division identified consultant recruitment as a challenge and a concern for the future. This was particularly for the acute medicine and complex medicine consultants for which there was a national shortage. We saw that consultant staffing for haematology and dermatology had been identified on the trust risk register as high risk. The clinical leads told us they were working closely with the networks to develop job plans for the roles. The team planned to focus on upskilling the current workforce and were providing opportunities for more junior staff to develop their skills in preparation for more senior roles.

Staffing skill mix

As of July 2018, the proportion of consultant staff reported to be working in medical care at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 122 whole time equivalent staff working in medicine at Bolton NHS Foundation Trust

	This Trust	England average
Consultant	36%	42%
Middle career^	4%	6%
Registrar group~	20%	27%
Junior*	39%	25%



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/06/2018 - 30/06/2018))

The Senior leadership team had identified, due to national shortages in some specialist medical roles, that they needed to use the workforce and skill mix differently. As part of the next five-year strategy the division planned to focus on developing advanced nurse practitioner roles in acute medicine and frailty and the introduction of physician associate roles.

In the medicine division there was on site consultant cover Monday to Friday 9.00am until 10.00pm and Saturday and Sunday 9.00am until 4.00pm. Outside of these hours there was an on-call consultant. Consultant ward rounds were undertaken twice daily on the acute medical wards. The coronary care unit had a daily consultant ward round seven days a week and a dedicated consultant on call out of hours. The trusts divisional risk register showed a risk to patients due to a lack of cardiology consultant of the week and no consultant ward round on a Wednesday. At the time of our inspection we saw that there were no gaps in consultant cover that week.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient records were a mixture of paper and electronic records. Patient observations were recorded on electronic hand-held devices. Staff told us they had received training on the use of the electronic devices and felt they were easy to use.

Staff from the rapid assessment interface discharge team (RAID), had access to the electronic record keeping system for Greater Manchester Mental Health trust. This meant that they were informed of any care a patient was receiving in the community and could update the community mental health team that the person was in hospital

Admission documentation, prescription charts, care plans and medical notes were recorded on paper documentation. Paper records were stored in trolleys on ward corridors outside of the appropriate bedded area. Record trolleys were accessed by Digi lock entry which only authorised staff had the code for. We observed that the majority of recorded trolleys were locked during our inspection. We saw two trolleys on D2 and one trolley on D1 which were not locked, however staff took immediate action to secure the notes. This was an improvement from the last inspection.

Patient admission records provided a holistic assessment of patients' needs a took account of physical health, mental health and social needs and cultural preferences. We reviewed 15 patient

records and we saw that documentation was legible, dated and complete and we saw evidence that care plans were documented, reviewed and updated. There was evidence of multidisciplinary input into patient records and care including dieticians, speech and language therapy, physiotherapy, nursing staff and doctors.
The service monitored the quality of records on a regular basis. There were monthly audits that were reported and recorded as part of the ward performance heat map under the key performance indicator audit which sampled the documentation of 10 sets of notes on each ward and through the venous thromboembolism assessment compliance.

We reviewed the results of the audits in October and November 2018 for wards B1, B3, C3, D1, D2 and H3. We saw that key performance indicator compliance had an amber rating overall for all wards, the average compliance rate across the wards for October was 91.7% and November was 90.1%. The trust provided further audit results which showed overall average compliance rates for the last three months. In September compliance was 96%, October was 93% and November 94%.

We observed that compliance with venous thromboembolism assessments was in the main above the trusts target of 95%. However, ward B1 which was the frailty unit achieved 50% in October and 0% in November which indicated a red result.

We saw that action plans, which were developed monthly in response to the audit, identified improvements to be made for each ward area. Improvements were communicated to staff through safety huddles, multidisciplinary board rounds and team meetings. The divisional governance committee had oversight of ward performance.

Whilst we saw good documentation of care plans and patient assessments we found some inconsistencies in documentation. Three of the 15 records we reviewed did not have patient details documented on each history continuation page.

Medicines

The service followed best practice when prescribing, giving and recording medicines. Patients received the right medication at the right dose at the right time. However, there was an inconsistent approach to monitoring the storage temperatures of medication.

There was a dedicated pharmacy team for the service and the pharmacy ward based service was Monday to Friday 9.00am to 5.00pm. Out of hours and at weekends the service had access to an on-call pharmacist. There was no dedicated ward pharmacy service during the weekends; the pharmacy dispensary was open Saturday and Sunday 9.00 am until 4.00pm, and nursing staff could order urgent medication.

The pharmacy team undertook a range of duties which included medicines reconciliation, clinical medication reviews, medication advice, antimicrobial stewardship and audit. We saw that on the wards we visited the clean utility rooms had a dedicated area for the pharmacy teams to produce labels and dispense medication for patients on the ward.

Prescription charts were paper based documents and were stored at patient's bedsides. We reviewed 12 prescription charts across the wards we visited. We found that pharmacist prescription reviews and medication histories had been completed. Writing was legible and all medications prescribed had been signed for. We found that all patients allergy status had been documented and antibiotics had been prescribed as per the guidelines. However, we saw that on three prescription charts antibiotic reviews had not been completed in the review section, this was a required section on the prescription chart.

Antimicrobial audits were undertaken on a quarterly basis and looked at the five standards outlined in the Department of Health Best Practice Guidance on Antimicrobial Stewardship in Hospitals. We reviewed the audit results for April to June 2018 and we saw that the medicine

division had achieved an average of 87% compliance across the five standards. The trust had set a target of 90% compliance across all five standards.

Medication which had not been administered was clearly documented on the prescription charts and a code was used to indicate the reason for not administering a medication. On one of the prescription charts we reviewed we saw that a medication had not been given on six occasions the reason had been documented as no drug available. The medication was an antibiotic and so it was important the patient received this, we brought this to the attention of the ward manager who informed us that there had been a supply issue with the medication. Doctors had been made aware of the issue and extended the medication course accordingly.

Medication was stored securely on all the wards we visited. Medication rooms were accessed by keypad or swipe card entry and medication storage cupboards were locked by keys. On the majority of the wards we saw that medication trolleys were in use and we saw that all trolleys were locked and securely tethered to the walls. Named medication for patients were stored in locked cabinets at the patient's bedside, during our observations we saw that patients own medications were stored securely. Keys were held by the nurse in charge in all areas these included the controlled drug keys. We saw that medication stocks were within manufactures expiry dates and intact.

Oxygen was stored in locked medication rooms. We saw that there were oxygen storage containers in use on the wards we visited, these were specially designed boxes which separated the cylinders and provided storage raised from the floor. We found one oxygen cylinder which was not stored in line with health and safety guidance, however staff took immediate action to rectify this. This was an improvement since the last inspection.

We found that controlled drugs and registers were stored securely and the units undertook daily balance checks of stock held. We saw that these checks had been consistently completed and countersigned by a witness as per policy. Staff were aware of the process for escalating discrepancies in the controlled drug stock. The pharmacy team carried out a quarterly audit of the controlled drugs and disposed of any patients own controlled drugs that were no longer required.

The medication storage rooms we visited contained pharmacy returns bins. The bins were locked and secured to the walls of the storage rooms. We were told nursing staff put medications that were no longer required into the bins and pharmacy staff took them to the pharmacy department for disposal. The ward staff did not hold keys for the returns bins, these were held in the pharmacy department.

The temperature for the storage of medication was recorded and monitored. The units monitored the room temperature and fridge temperatures and were recorded on monitoring sheets kept in the medication storage rooms. The record sheets required staff to document where within the temperature range boxes the minimum, maximum and actual temperatures were. The boxes were colour coded green, orange and red to provide staff with a visual aid of what the temperature meant.

However, we saw that there was an inconsistent approach to the completion of temperature monitoring. We found gaps in the daily monitoring of the room and fridge temperatures. Wards D1 and C3 had the highest number of missed recordings. We observed that the discharge lounge was recording the temperature however not in the correct temperature range box on the sheet which meant that temperature deviations were not obvious to staff. We saw that the room temperature had been above 25 degrees for 16 days prior to staff escalating to the pharmacy team.

Incidents

The service managed patient safety incidents well. Staff recognised incidents 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.

Incidents were reported using an electronic system which was accessible through the trusts intranet. The trust used an electronic risk register which was linked to the incident reporting system and so incidents could be linked to the risk register. Senior nursing staff were responsible for investigating incidents for their ward area. The severity of the incident determined the level of senior nurse that was responsible for the investigation, for example matrons were responsible for investigating incidents which were classified as serious incidents under the Serious Incident Framework 2015.

Incidents were monitored and reviewed as part of the monthly divisional governance meetings. Learning from incidents was shared with staff through the daily safety huddles and staff team meetings. We observed that incidents and the learning from these were displayed in staff areas on the governance notice boards on the wards we visited. The governance notice boards also provided details of the risks for the area which were recorded on the risk register.

Staff could describe the process for reporting incidents and provided examples of incidents they had recently reported. Staff were positive about the incident reporting culture and described how they received feedback from incidents they had reported which included verbal and email responses. Staff were aware of incidents reported in the areas they worked and felt that learning from incidents was communicated well.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2017 to October 2018, the trust reported no incidents classified as never events in medical care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SI) in medical care which met the reporting criteria set by NHS England from November 2017 to October 2018.

The breakdown by incident type was as follows:

- Slips/trips/falls meeting SI criteria: eight
- Pressure ulcer: five
- Sub-optimal care of the deteriorating patient: three
- Medication incident: two
- Diagnostic incident including delay (including failure to act on test results): one
- Treatment delay: one

Most of these SI’s were reported to STEIS within 14 days of occurrence. However, in some cases it took the trust considerably longer to report:

- 0 - 14 days: 13

- 15 - 30 days: three
- 31 - 60 days: two
- Over 90 days: two

(Source: Strategic Executive Information System (STEIS))

We requested a copy of the serious incident investigations for four of the serious incidents reported above. So far, the trust has provided two of the root cause analysis investigations both of which do not relate to the medical wards. However, we reviewed a serious incident investigation relating to an incident which occurred on the endoscopy unit. We saw evidence of a comprehensive investigation report. Which included reporting to the appropriate agency, identified good practice, learning and contained an action plan for improvement to prevent similar incidents.

The service was aware of the roles and responsibilities under duty of candour which is being open and honest with people when things go wrong. Matrons told us that the electronic incident reporting system provided and automatic reminder for incidents identified as moderate harm or above. Staff were aware of duty of candour and could and describe the process and provided examples of when duty of candour had been undertaken. We saw that duty of candour was a section on the root cause analysis investigation paperwork for serious incidents.

Safety Thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service. The safety performance was reported on a monthly basis.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

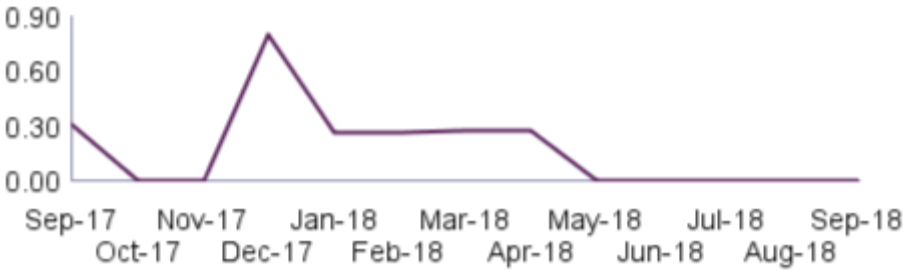
Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 34 new pressure ulcers, 23 falls with harm and eight urinary tract infections in patients with a catheter in medical care from September 2017 to September 2018.

Prevalence rate (number of patients per 100 surveyed) of patient harms at Bolton NHS Foundation Trust

Total Falls (23)

Total CUTIs[3] (8)



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter

(Source: NHS Digital)

Safety performance for each ward was displayed in public areas and so visible to staff and patients and visitors. Wards monitored and reviewed safety performance on a monthly basis through the monthly divisional performance meetings and the governance heat maps. The divisional meetings compared performance on a monthly basis and looked at the performance trend for a 12-month period. Safety performance was discussed with staff as part of daily safety huddles and monthly team meetings.

We reviewed the safety performance reported for the division for the last 12 months as part of the safety performance scorecard. We saw that in the main safety performance over the last 12 months had improved. However, the service had identified that performance for falls, acquired grade two pressure damage and blood culture contaminants were not in line with the aspirational standards.

The service had a focus on falls prevention and senior nursing staff were proud of the improvements made as a result. Falls were discussed as part of the standardised daily hand overs and safety huddles. The service had introduced a number of initiatives for patients who had been identified as at risk of falls. Examples of the initiatives in place were the use of electronic falls matts, bay tagging, non-slip socks, promotion of wearing shoes and decorated Zimmer frames which helped patients identify their mobility aid. Staff described a multidisciplinary approach to falls prevention and the falls prevention campaign encouraged all staff to take responsibility.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The service adapted guidance on quality standards for medical conditions such as acute coronary syndromes, acute upper gastrointestinal bleeding, headaches and sepsis. The service was working towards adapting National Institute for Health and Care Excellence (NICE) guidance on screening for tuberculosis.

We saw evidence that patients had comprehensive assessments of their needs, which included consideration of clinical needs, pain relief, mental health, physical health and wellbeing and nutrition and hydration needs. The service used nationally recognised assessments to assess patient care needs such as the Malnutrition Universal Screening Tool (MUST) to assess patient's nutritional needs and The Waterlow Scale to estimate risk of developing a pressure sore.

The expected outcomes were identified and care and treatment was regularly reviewed and updated, and appropriate referral pathways were in place to make sure needs were addressed. However, mental capacity assessments were not consistently reviewed.

Nutrition and hydration

Staff gave patients 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 patients' religious, cultural and other preferences. One patient we spoke with had been able to order halal food. Patients we spoke to said they always had a choice of food and that the food 'was smashing'.

The service had protected meal times throughout the wards we visited, on B1 a bell was rung to signal to staff to stop what they were doing and to help give out meals to the patients and assist those who needed additional support with eating. During our observations we saw staff assisting patients to eat. Additionally, the I-care project encouraged patient's carers and relatives to attend the ward during mealtimes and assist with eating.

On B1 patients were identified with 'Think First' on their bed board when they needed additional support with eating or needed their food intake monitored.

On the wards we visited, staff completed fluid risk assessments and put fluid balance charts in place when appropriate.

The service used guidance from the Food First Project to introduce snack pots, milkshakes at meal times and biscuits with tea to improve nutritional care. The diet chef also provided bespoke meals for patients with additional nutritional needs.

In the discharge lounge patients were offered a hot drink on arrival and food and drink throughout the day.

The service had a red jug and red plate initiative in place to indicate patients who required additional support with eating and drinking. A picture of a red jug and a red plate with a knife and fork was displayed above patient's beds to indicate to staff that additional support would be required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Patients we spoke to said they were offered pain relief and staff checked that it had worked.

There was a visual behavioural pain scale used in the enhanced care booklet for patients who may not be able to communicate their pain. The pain scale had faces showing smiles and sad

faces for pain. The chart was also coloured white, green, amber and red for severity of pain. We did not see this used whilst on inspection.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The service had a clinical audit plan for 2018-2019. The plan detailed the internal and external audits which the service planned to contribute to in that time period and specified when the audits were due to be undertaken. We saw that the document was used as a working document to monitor progress and identify areas for improvement. The audits were in place to monitor patient outcomes and benchmark against other trusts.

Service leads told us that the society for acute medicine benchmarking audit (SAMBA) published in December 2017 showed a higher than average discharge rate, an improvement in use of ambulatory care pathway, high intravenous antibiotics within 12 hours and primary carcinoma within four hours. The 2018 results showed a year on year improvement. We reviewed the society of acute medicine benchmarking audit and found that 95% patients were given an early warning score within 30 minutes, 100% patients had a tier one review within four hours and 100% of patients were reviewed by a consultant within 12 hours. The audit also showed the trust had a 22% readmission rate. These results showed that the trust was performing better than other trusts in England.

We requested the Myocardial Ischaemia National Audit Project (MINAP) which showed the trust was compliant with all six standards. A target improvement identified from the audit results, was to ensure that patients who have had a heart attack are moved to a cardiology ward within 24 hours of admission.

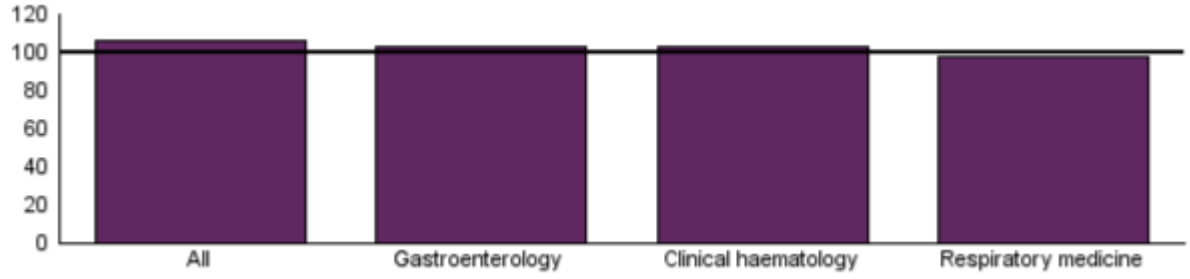
Relative risk of readmission

Royal Bolton Hospital – elective admissions

From June 2017 to May 2018, patients at Royal Bolton Hospital had a higher than expected risk of readmission for elective medical admissions compared to the England average.

Patients in gastroenterology, clinical haematology and respiratory medicine had similar to expected risks of readmission for elective admissions

Elective Admissions - *Royal Bolton Hospital*



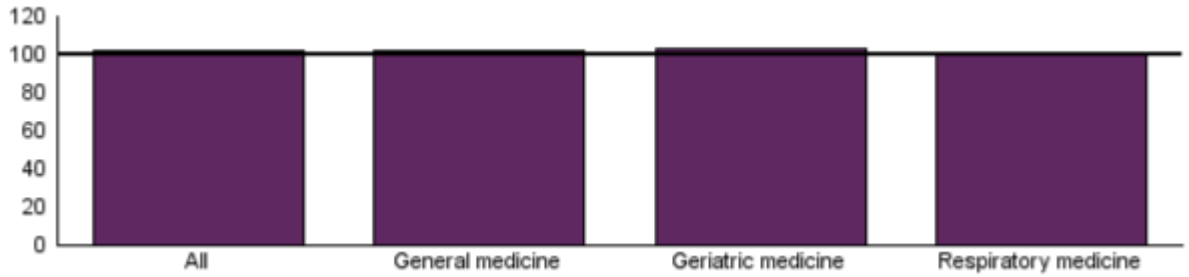
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Royal Bolton Hospital – non-elective admissions

From June 2017 to May 2018, patients at Royal Bolton Hospital had a similar to expected risk of readmission for non-elective medical admissions compared to the England average.

Patients in general medicine, geriatric medicine and respiratory medicine had similar to expected risks of readmission for non-elective admissions

Non-Elective Admissions - *Royal Bolton Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Sentinel Stroke National Audit Programme (SSNAP)

Royal Bolton Hospital takes part in the Sentinel Stroke National Audit programme.

The hospital's performance is shown in the tables below.

Overall Scores	Dec 16 - Mar 17	Apr 17 -Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
SSNAP level	C	B	B	B
Case ascertainment band	A	A	A	A
Audit compliance band	A	B	A	A
Combined total key indicator level	C	B	B	B

On a scale of A-E, where A is best, the hospital's overall SSNAP level improved from grade C for the audit period from December 2016 to March 2017 to grade B for the next audit period from April to July 2017. The hospital's performance for this indicator then remained at grade B over the subsequent two audit periods, through to March 2018.

Patient centred performance	Dec 16 -Mar 17	Apr 17 -Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
Domain 1: Scanning	B	B	C	A
Domain 2: Stroke unit	E	C	C	C
Domain 3: Thrombolysis	C	B	C	D
Domain 4: Specialist assessments	C	B	C	B
Domain 5: Occupational therapy	B	A	A	A
Domain 6: Physiotherapy	B	B	B	B
Domain 7: Speech and language therapy	D	D	D	D
Domain 8: Multi-disciplinary team working	C	C	C	B
Domain 9: Standards by discharge	B	A	A	A
Domain 10: Discharge processes	A	A	A	A
Patient-centred total key indicator level	C	B	B	B

The hospital's patient-centred stroke unit indicator improved from grade E for the audit period from December 2016 to March 2017 to grade C for the next audit period from April to July 2017. The hospital's performance for this indicator then remained at grade C over the subsequent two audit periods, through to March 2018.

The hospital's patient-centred total key indicator level improved from grade C for the audit period from December 2016 to March 2017 to grade B for the next audit period from April to July 2017. The hospital's performance for this indicator then remained at grade B over the subsequent two audit periods, through to March 2018.

Team centred performance	Dec 16 - Mar 17	Apr 17 -Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18
Domain 1: Scanning	N/A	N/A	N/A	N/A
Domain 2: Stroke unit	C	B	B	B
Domain 3: Thrombolysis	N/A	N/A	N/A	N/A
Domain 4: Specialist assessments	N/A	N/A	N/A	N/A
Domain 5: Occupational therapy	B	A	A	A
Domain 6: Physiotherapy	B	C	B	B
Domain 7: Speech and language therapy	E	E	E	E
Domain 8: Multi-disciplinary team working	N/A	N/A	N/A	N/A
Domain 9: Standards by discharge	B	A	B	A
Domain 10: Discharge processes	A	A	A	A
Team-centred total key indicator level	B	B	B	B

The hospital's performance for team-centred stroke unit indicator improved from grade C for the audit period from December 2016 to March 2017 to grade B for the next audit period from April to July 2017. The hospital's performance for this indicator then remained at grade B over the subsequent two audit periods, through to March 2018.

The hospital's team-centred total key indicator level was grade B for all four audit periods from December 2016 to March 2017 through to December 2017 to March 2018.

(Source: Royal College of Physicians London, SSNAP audit)

We spoke to clinical leads about Domain 7: Speech and language therapy and how they planned to improve their outcomes. The service had started a program with the Speech and Language Therapy team that trained nurses on the stroke ward to do basic swallowing assessments whilst a business case was being developed to expand the Speech and Language Therapy workforce to ensure high quality, timely care.

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit.

The crude proportion of patients seen by a cancer nurse specialist was 47.7%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 45.8%.

The case-mix adjusted proportion of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 18.6%. This was within the expected range compared to other trusts. In 2016 the trust's performance for this metric was not significantly different from the national level.

The proportion of fit patients with advanced NSCLC receiving systemic anti-cancer treatment was 55.3%. This was within the expected range compared to other trusts. The trust's performance in the equivalent measure from the 2016 audit was significantly worse than the national level.

The proportion of patients with Small Cell Lung Cancer receiving chemotherapy was 62.1%. This was within the expected range compared to other trusts. In 2016 the trust's performance for this metric was not significantly different from the national level.

The case-mix adjusted one year relative survival rate for the trust in 2017 was 34.1%. This was within the expected range compared to other trusts. In 2016 the trust's performance for this metric was significantly worse than the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

At Royal Bolton Hospital the crude proportion of patients who had a vision assessment (if applicable) was 33.3%. This did not meet the national aspirational standard of 100%. Results of less than 50% for this metric are rated as poor.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 25.8%. This did not meet the national aspirational standard of 100%. Results of less than 50% for this metric are rated as poor.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 30.0%. This did not meet the national aspirational standard of 100%. Results of less than 50% for this metric are rated as poor.

The crude proportion of patients with a call bell in reach (if applicable) was 61.3%. This did not meet the national aspirational standard of 100%. Results of between 50% and 79% for this metric are rated as fair.

(Source: Royal College of Physicians)

The national audit of inpatient falls fell below the national aspirational standard. The trust had acknowledged this and had a number of strategies in place to prevent inpatient falls such as electronic falls matts, non-slip socks, promotion of wearing shoes and own clothes and bay tagging. Competent staff

Competent staff

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

The learning needs of staff were identified and training was put in place to meet those needs. Staff were supported to maintain and further develop their professional skills and experience. For example, nurses were encouraged to become link nurses for a topic they were interested in such as safeguarding or dementia.

The service had developed a Masters level course in acute medicine accredited by Bolton University for band six and seven nurses to attend.

The service was introducing a process for monitoring competencies in endoscopy. The band seven nurse responsible was creating a matrix of skills possessed by staff. This matrix would enable staff to quickly identify which staff members were competent in each skill and identify who had capacity to take on additional competencies.

Staff were aware of training sessions offered by the rapid assessment interface discharge team (RAID). Link nurses shared updated knowledge. The Safeguarding adults lead, RAID team and learning disabilities specialist nurse ran bespoke, targeted training sessions when learning needs were identified on specific wards.

Doctors within the trust had received a training session earlier in the year on the health inequalities experienced by individuals with learning disabilities.

Staff we spoke with on inspection said they had had their appraisals and that they found them useful. The average appraisal rate with the division was 84% as of July 2018 compared to a trust target of 85%. The appraisal target was not met for six staffing groups.

Appraisal rates

From August 2017 to July 2018, 84.0% of staff in medical care at the trust received an appraisal, less than the trust target of 85%. However, information requested at the inspection showed that over-all medical compliance was 93.79% at the time of visit.

The 85% target was met for three staff groups. However, it was not met for six staffing groups including both qualified nursing staff, and medical staff.

Staff group	Staff who received an appraisal	Number required	Completion rate	Target	Met Yes / No
Other qualified scientific, therapeutic & technical staff	2	2	100.0%	85%	Yes
Support to other qualified scientific, therapeutic & technical staff	47	54	87.0%	85%	Yes
Support to doctors and nursing staff	373	432	86.3%	85%	Yes
Qualified allied health professionals	170	203	83.7%	85%	No
NHS infrastructure support	5	6	83.3%	85%	No
Qualified nursing staff	271	326	83.1%	85%	No
Medical staff	49	66	74.2%	85%	No
Qualified healthcare scientists	5	8	62.5%	85%	No
Public health & community health services	0	1	0.0%	85%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

We asked clinical leads about lower appraisal rates for medical staff. They challenged the data and stated that measures had been put in place to ensure doctors had their appraisal. The clinical leads told us that staff had been informed that they could not access study leave without

completing mandatory training or attending an appraisal. The trust provided data for consultant appraisal rates which demonstrated an appraisal completion rate of 81% as of December 2018.

Multidisciplinary working

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

We observed three multidisciplinary team meetings which were patient centred and social workers attended. Staff discussed the patient holistically including behaviour, emotional, mental and physical health. Discharge plans were a focus during these meetings. Patients were named and staff demonstrated good knowledge of the patient. Staff challenged each other and asked questions of specialities.

Nursing and medical staff on D1 and D2 said the introduction of the Home first team which included occupational therapists and physiotherapists contributed to the discharge process. The team would assess a patient's home situation to see if it was appropriate to discharge them rather than admit them. They would aim to put equipment or care in place to avoid admitting the patient, which would save an acute bed. To do this, the team was in contact with other organisations to acquire the care and equipment needed to safely discharge the patient.

We were told by staff on D1 that they would not discharge patients after 9pm unless the patient had their own transport and wanted to leave.

Staff on D1 told us they had appropriate access and referral to mental health support. The mental health team could be accessed by phone or bleep 24 hours a day seven-days a week for advice and referrals. Staff told us there was a six-hour response time to review a patient and that this could be manipulated to meet the needs of patients. Staff also said they had access to the Rapid Assessment, Interface and Discharge (RAID) team for support and that medical doctors would prescribe medicines if required. The RAID and mental health team were staffed by another trust.

Ward H3 received an award from the trust for multidisciplinary team working in June 2018.

Seven-day services

The service audited the impact of the seven-day consultant led service. The audit showed a decrease in mortality, length of stay and increase in discharge rates.

The wards we visited had access to consultants seven days a week. Doctors could be reached out of hours by using patient track to assign tasks such as patient reviews based on concerns documented in patient track.

Staff on D1 told us they had access to scans for emergencies at the weekends.

There was physiotherapist and occupational therapist cover at the weekend to consult if a patient was being discharged or in an emergency.

The service had an integrated discharge team available seven-days a week. This enabled the service to discharge patients safely any day of the week and weekend.

Junior doctors worked a dedicated rota to process unplanned discharges at the weekend.

The service had pharmacy support seven days a week. Staff told us they could order prescriptions up to 8pm for the last submission. Outside of these hours the Medical Assessment Unit and D1 had discharge lockers for dispensing prescriptions.

The service included round the clock access to mental health liaison covering all ages if staff

were concerned about risks associated with a patient's mental health. There was good access to psychiatric input from the rapid assessment interface discharge team which was provided by Greater Manchester Mental Health trust. The team were based within Royal Bolton Hospital and provided cover 24 hours a day and staff reported they were accessible, supportive and responsive when they had concerns. Specialist input was also provided by a learning disability specialist nurse and a dementia specialist nurse.

Health Promotion

Staff identified patients who may need extra support such as those in the last 12 months of their lives, those at risk of developing a long-term condition and carers. Staff told us about their 'I-Care Project' to enable carers of patients with dementia to stay at the hospital. The carer was given a room to stay in, a badge to identify them and basics like toiletries that had been donated by the local community.

The service had established a support group for patients with airway diseases that met monthly. The group planned to plant oak trees to promote health living. The trust was in the beginning stages of setting up another support group for patients with Interstitial Lung Disease (ILD).

Throughout the wards we visited during our inspection we saw 'Stop don't fall' signs encouraging patients to call for assistance when mobilising. Staff also encouraged family of patients to bring in anti-slip socks, shoes and clothing to encourage safe moving around the hospital.

In addition, we saw nutritional information on display in the wards we visited giving dietary advice, eat well guidance, and hydration matters promotion posters.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not consistently understand how and when to assess whether a patient had the capacity to make decisions about their care. They did not always follow the trust policy and procedures when a patient could not give consent.

Whilst staff received training, not all staff we spoke to understood their roles and responsibilities in regards to the Mental Capacity Act 2005.

However, staff knew how to support patients experiencing mental ill health to make decisions about their care. Staff showed us a flowchart with who to contact for patients detained under the Mental Health Act 1983.

The trust had a Mental Capacity Act policy that was in date and detailed the processes to be followed when assessing patient's capacity. This included a form to record formal capacity assessments. During the inspection we reviewed records relating to capacity assessments and applications for Deprivation of Liberty Safeguards. Formal capacity assessments were detailed and completed fully. Application for Deprivation of Liberty Safeguards were completed when necessary and the Safeguarding adults lead chased these up on a weekly basis with local authorities. Staff continued to treat patients in their best interests when authorisations had lapsed due to a delay in assessments outside of the trust's control.

Staff sometimes recorded lack of capacity as the reason for not discussing do not resuscitate decisions with the patient. In these cases, staff did not always document a formal capacity assessment. In addition, capacity assessments were not consistently reviewed and patient records did not record the details of the discussion when capacity assessments were reviewed.

Mental Capacity Act and Deprivation of Liberty training completion

Training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards is covered within the trust's safeguarding adults level 2 training module. As of July 2018 this module had been completed by 74.9% of staff within medical care, including 89.1% of qualified nursing staff and 65.1% of medical staff. Therefore the 95% target was not met overall, or for either of these two staff groups.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Qualified nursing staff	304	341	89.1%	95%	No
Medical staff	54	83	65.1%	95%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

The culture within the service supported and encouraged staff to provide the best care for patients. Staff had a strong patient centred approach to patients and cared for them with compassion. Feedback from patients and those close to them was continually positive.

We spoke with 13 patients and patients' relatives, the feedback about the care and treatment received was continually positive. Patients told us that staff treated them with respect and felt that their privacy and dignity was maintained.

Examples of feedback received were "couldn't have received better treatment from all staff", "I stayed in this hospital a few years ago it was a good experience then but it is even better now, staff are more friendly and I have been kept more up to date this time" a patient's relative told us "I like the care and attention my mum receives".

All staff were patient focussed and motivated to provide patient centred care. Patient admission documentation took account of patient's holistic needs including, social, activity, likes and dislikes, cultural and religious needs and preferences.

Relationships between staff and patients were caring, respectful and supportive. We observed interactions between patients and staff and saw that staff knew their patients as individuals and had built good relationships with them. We observed staff and patients singing together and staff assisting patients to eat their meals. We observed ward handovers and saw that the whole team knew their patients as individuals, staff discussed patients care and took into consideration their preferences.

Staff provided examples of how they had gone the extra mile for patients during their stay. We were told that there had been a long-term patient on one of the wards who was missing their dogs, staff on the ward made arrangements to bring the patients dogs into the hospital to visit them. We were told about an elderly couple who had both been admitted to the hospital, staff recognised that they were missing each other and one of the couple had been identified as being at the end of their life. Staff made arrangements for the couple to be accommodated in a large side room together so they could spend the last few days of their lives with each other. Staff made arrangements for a patient who was awaiting major cardiac surgery to attend their son's wedding.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. Staff were enthusiastic to ensure that patients with additional needs were supported, and staff at all levels spoke about how they could enhance the patient journey. Staff encouraged patients to bring in comfort objects from home, and used 'about me forms' to understand the needs of the patients they cared for.

There was an enhanced care team who provided activities and stimulation for patients. On ward B1 and the complex care wards we saw that there were activity sessions for each day of the week which patients could get involved in, these were led by different staff groups including nursing, therapy and the enhanced care team. Activities for patients included music and exercise, sensory, arts and crafts and games. During our observations on the frailty unit we saw staff assisting patients to decorate card cut outs of their hands we were told this was for a Christmas display on the ward.

Friends and Family test performance

From September 2017 to August 2018 the Friends and Family Test (FFT) response rate for medical care at Royal Bolton Hospital was 38.5%. This was based on 3,503 responses. This was better than the England average of 25%.

A breakdown of FFT performance by ward for medical wards at this hospital over the same period is shown below.

The worst annual score was for ward B3 (complex care): 86%. This was the only ward to report an annual score of less than 90%.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	
Ward D3	665	66%	100%	98%	98%	100%	94%	94%	86%	98%	97%	96%	95%	94%	96%
Ward D4	479	51%	88%	85%	95%	97%	94%	89%	94%	76%	91%	91%	100%	94%	91%
Coronary care unit	367	47%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	99%
Ward C3	328	32%	100%	94%	97%	100%	90%	96%	97%	94%	94%	95%	95%	94%	95%
Ward C1	309	35%	100%	92%	100%	92%	96%	100%		98%	98%	93%	100%	92%	96%
Ward C2	289	39%	100%	86%	80%	100%	100%	86%	96%	100%	97%	96%	95%	94%	92%
Ward C4	255	37%	97%	100%	96%	100%	100%	91%	100%	95%	96%	100%	92%	100%	97%
Ward A4	245	38%	93%	85%	90%	92%	82%	95%	89%	100%	87%	96%	100%	94%	93%
Ward H3	165	42%	95%	100%	100%	85%	100%	100%	94%			100%	100%	90%	95%
Ward B3	156	45%	100%	100%	100%	100%	60%	80%	100%	88%	100%	100%		85%	86%
Ward B1	135	32%	100%	100%		94%	100%			100%	100%	100%	100%	100%	99%

Highest score to lowest score

Key	100%	50%	0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Friends and family performance was monitored and reviewed as part of the wards monthly performance heatmap and we saw that the annual average recommendation rate for the service was 94.5%. Results of friends and family tests were displayed on wards in public areas, this included examples of feedback provided which was both positive and negative. The service had a

‘you said we did’ initiative in place and changes made to the service as a result of patient feedback were displayed alongside the friends and family test performance.

Emotional support

Staff provided emotional support to patients to minimise their distress and recognised that their emotional needs were as important as their physical needs.

Staff took account of patients’ emotional needs and we saw that this was discussed as part of the multidisciplinary ward rounds. Staff explained how they could refer patients to the rapid assessment, interface and discharge service for the hospital who provided psychological support to patients. The cardiac rehabilitation team included a clinical psychologist. Staff on the coronary care unit explained how they could access the service for patients on their wards.

The trust had a chaplaincy and spiritual care service which provided a multi faith service to patients and their families and was available 24 hours per day, seven days a week. Staff were aware of the service and could contact the service on behalf of patients. We saw that there were information leaflets available in ward areas about the service.

One member of nursing staff had recognised the benefit therapy animals could bring to patients. The staff member had worked with the trust to make arrangements for their own dog to become a pet as therapy dog for the trust. The dog visited wards on a weekly basis and staff identified patients who would benefit from spending time with the dog. Staff spoke highly of the effect it had on patients’ moods, we were told that patients who were agitated and withdrawn relaxed when they spent time with the dog.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment, and encouraged them to become active partners in their care. Staff were committed to working in partnership with patients and their families and carers.

Staff empowered patients to have a voice and to realise their potential. Patients felt that they were part of discussions about their care and that all staff took the time to explain and discuss their treatment. Patients spoke positively about how their families were included in discussions about their care and how people close to them were kept updated about their treatment.

Staff had access to communication aids to help patients with communication barriers, become partners in their care and treatment. Staff gave examples of when they had used aids to support communication including Makaton symbols and translation services.

Staff recognised that patients and their carers needed to have access to support networks within the community. The service had a number of support groups available to patients and their carers which were held on a regular basis. There were carer support groups, a memory group, Bolton respiratory support group and the interstitial lung disease support group had been newly formed. Staff encouraged patients to attend the support groups to manage their conditions. Therapy staff held breakfast and lunch clubs for patients.

The service had introduced a project call ‘I-Care’ which linked to a national campaign to involve carers in patients care during their hospital stay. The initiative enabled patient’s carers to have unlimited visiting and encouraged carers to assist with patient’s personal care and eating and drinking. Staff spoke highly of the positive impact it had on both patients and carers.

Carers were given a pack which included a name badge and lanyard so that they were part of the ward team. The service also provided accommodation on each ward we visited so that carers and relatives could stay over. We saw that relative’s rooms were decorated pleasantly and provided

refreshments and toiletries for their comfort. We spoke with a patient's relative who was assisting with their care, they spoke highly of being able to support their loved one with eating and drinking and described how they kept the patient calm during blood tests and diagnostic procedures.

Patients relatives and carers were encouraged to get involved with the activities on the wards. At the time of our inspection on the frailty ward we saw patients and their visitors enjoying afternoon tea in the reminiscence café.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

The service identified an aging population and high prevalence of patients living with dementia. The service had five complex care wards providing care to patients. In addition to this the trust had created an enhanced care team, the team provided care to patients with enhanced care needs across the hospital. On the complex care wards, we saw that there was a focus on patient activities which provided patients with complex needs distraction therapy and cognitive stimulation. The service also linked in with a well-known charity to provide support to elderly patients in their own home following discharge from hospital.

The service linked in with the trusts strategy to reduce avoidable hospital admissions. There was a home first team who was based in the emergency department and the medical assessment areas, which were wards D1, D2, clinical decisions unit and the ambulatory care unit. The service started in August 2017 and was led by therapy staff, wards D1 and D2 had recently been added to the team. The service was for patients who were medically fit but required cognitive and social input. The team undertook mobility assessments of patients using a national scoring tool which was sent to the patient's general practitioner for ongoing monitoring following discharge.

The team worked with patients and their families and carers along with community teams to set up reablement packages and packages of care so patients could return home and receive ongoing care and support in their own home.

The liver and alcohol service was developing services as part of the Bolton Integrated steering group. The group consisted of the acute specialist nurses, local commissioning services, community teams, general practitioners and Bolton neighbourhood teams. The group was working to streamline services and reduce length of stay in hospital for this patient group. The service had introduced a rapid access alcohol detoxification pathway.

The gastroenterology ward identified that in their patient group that there was a regular requirement to provide a dedicated sclerosis drainage service. The service had introduced a direct admission pathway which meant that patients requiring the procedure could phone the ward and book a bed to have the procedure. The service was led by the specialist nurse and was situated on ward C3. Service leads told us that this prevented patients moving through the emergency department and admissions wards and reported an improvement in patient experience and a decrease in length of stay for the patient group. It had been identified that the process was safer for the patients involved.

The service had arrangements, to meet patients' urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. The RAID team provided all age cover across 24 hours a day. All staff we spoke to were aware of how to contact the mental health

team in an emergency. The team manager for mental health liaison explained the team had a six-hour response time for medical assessment wards and 24 hours for all other wards.

Meeting people's individual needs

The service took account of patients' individual needs.

There was a focus on patients who had enhanced care needs this included patients who were living with dementia or those who had a learning disability. The service used enhanced care and 'getting to know me' booklets for patients with additional needs. These were completed with patients and their relatives and carers. The booklet took into account patients likes and dislikes, hobbies and interests, information about their lives, communication preferences, mobility, eating and drinking and personal care. This meant staff could tailor their care and approach to patient's individual needs.

Each ward had link nurses for learning disabilities, mental health, dementia and safeguarding. These link nurses attended regular meetings to develop their knowledge and skills. Wards had enhanced care trolleys which contained a variety of activities that could be used to either distract patients who were distressed or to engage them in reminiscence. For example, there were prompt cards to initiate conversations, information for carers and a range of activity resources. Staff reported good working relationships with the learning disabilities specialist nurse who supported any adults with learning disabilities within the hospital. The specialist nurse also led patient and carer groups for learning disabilities and dementia to develop the services to meet patient's individual needs.

There was an enhanced care team which was led by an occupational therapist. The team visited all medical wards to ensure that patients with enhanced care needs had received an appropriate risk assessment and had the appropriate support mechanisms in place to meet their needs. The enhanced care team provided support to staff looking after patients with additional needs and supported arrangements for additional supervision for patients if necessary. The team also provided distraction therapy and activities for patients to reduce distress and improve mobility and cognitive function.

The new endoscopy unit had been designed to provide a dementia friendly environment to patients. The service used green and grey flooring and furniture so that patients could identify different areas and objects. Arrangements were made for patients who had a learning difficulty to attend the endoscopy unit prior to a procedure. Patients were given a tour of the department, they were shown the equipment and given an explanation of the equipment and the procedure. This was an opportunity for the patient and carer to ask questions and meet the nurse and doctor who would be responsible for their care during the procedure.

The service had access to translation services, arrangements could be made for face to face translators and interpreters or in emergency situations there was a telephone service. Staff accessed the services via the trusts intranet pages. The endoscopy unit made arrangements for translation services for patients ahead of their procedures. Staff also explained that where possible and dependant on the patient's wishes they would use family members to interpret.

There were a variety of information leaflets available to patients on all of the wards we visited. The leaflets provided details of conditions and condition management, services provided by the hospital, falls prevention and how to raise concerns. We saw leaflets from disease charities and external agencies in use. All of the trust leaflets we saw in use were in printed English. We did see

that on the back of the trust leaflets there was information relating on how to request them in alternative formats which included audio, large print or other languages.

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 were in line with good practice.

The service had a focus on patient flow through the hospital. Discharge planning was initiated at the beginning of a patients stay. The service used a colour coding system to identify how patients were progressing towards discharge these were classified as red and green days. There was a culture in which all staff took responsibility for supporting patient flow.

We observed multidisciplinary ward rounds and daily board rounds and saw that discharge planning and progress was discussed for each patient. Whilst we saw that discharge planning was a priority for the teams we saw that staff were not prepared to prioritise a patient discharge over patient safety. We observed a multidisciplinary meeting in which nursing staff expressed concerns about a patient going home who they did not feel had adequate support in place. We observed a multiteam approach to planning for this patient.

The service had introduced the home first team and the integrated discharge team to assist with patient flow.

The home first team worked in assessment wards to prevent unnecessary hospital admissions. They provided mobility assessments for patients who were well enough to return home but required additional support. The team made arrangements for packages of care and reablement services to be set up. The team reported that of the patients seen 40% were sent home which equated to 9,822 bed days saved.

The integrated discharge team was split into three hubs across the hospital. The teams attended the daily multidisciplinary ward meetings. The team was integrated within a multi professional team including social workers, mental health, community assessment officers, district nurse liaison and housing officers. The team followed up on delays with packages of care and provided advice and support to staff in making appropriate social referrals. The team facilitated fast track discharges for patients who were at the end of their lives and involved the relevant support agencies. They were also involved in making arrangements to obtain and co-ordinate community healthcare funding and services for patients with complex health and social needs.

The service had different admission pathways to make sure that patients were assessed in the most appropriate place, this helped to aid flow and prevent avoidable inpatient admissions. There was a clinical decisions unit which took patients who had been referred from their general practitioners or from the emergency department, they were patients who were no acutely unwell. The criteria for patients was those requiring rapid review and diagnostic test. The unit provided a fourteen-bedded ward. Once patients had undergone the required diagnostic tests they were either discharged home, transferred to the appropriate ward or referred to the home first team for assessment prior to discharge.

The service had access to the trusts discharge lounge. The lounge provided a waiting area for patients who were being discharged that day and were awaiting finial discharge arrangements, such as medication or transport. This enabled the wards to release a bed ready for a new admission and aid patient flow. The discharge lounge reported an increased use in the last six

months. The team proactively followed up patients who had been identified as suitable to attend the discharge lounge at ward level and followed up discharge letters and medication. The health care assistants on the discharge lounge supported the ward staff by assisting to transfer patients to the lounge.

The trust had a dedicated flow team who monitored beds admissions and discharges through the hospital. The team provided a bed management role and monitored the review of patients who were outlying to a ward which was not the speciality ward for their treatment an example of this is a medical patient being treated on a surgical ward due to a lack of medical beds. The flow team held bed management meetings three times a day, these were attended by the matrons for the medical wards. The meetings discussed potential discharges, the number of admissions expected from the emergency department, available beds, staffing and outlying patients.

There was an outlier's policy which was being updated at the time of our inspection. Patients who had been outlying to different wards were displayed in the flow office on a computerised system. The flow administration team provided reports each morning to the medical team of where patients in their care were outlying. It was the medical teams' responsibility to review these patients by 12.00pm. Patients who had not received a review were identified at the 12.00pm bed meeting and escalated to the senior bed manager of the day to organise a review. At the time of our inspection there were no medical patients outlying to other wards. Medical staff we spoke with were aware of their responsibilities for outlying patients and could describe the policy.

Average length of stay

Royal Bolton Hospital

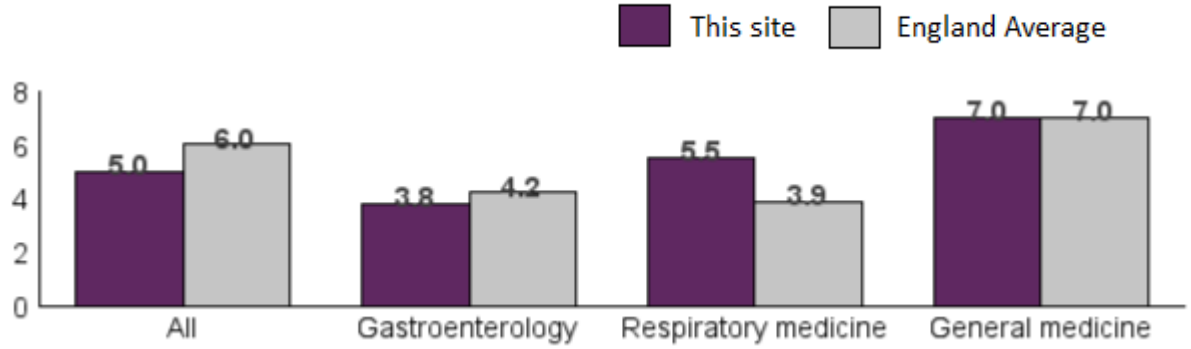
From July 2017 to June 2018 the average length of stay for medical elective patients at Royal Bolton Hospital was five days, which was shorter than the England average of six days.

Average lengths of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology was similar to the England average; while average length of stay for elective patients in general medicine was the same as the England average

- Average length of stay for elective patients in respiratory medicine was longer than the England average

Elective Average Length of Stay - Royal Bolton Hospital



Note: Top three specialties for specific site based on count of activity.

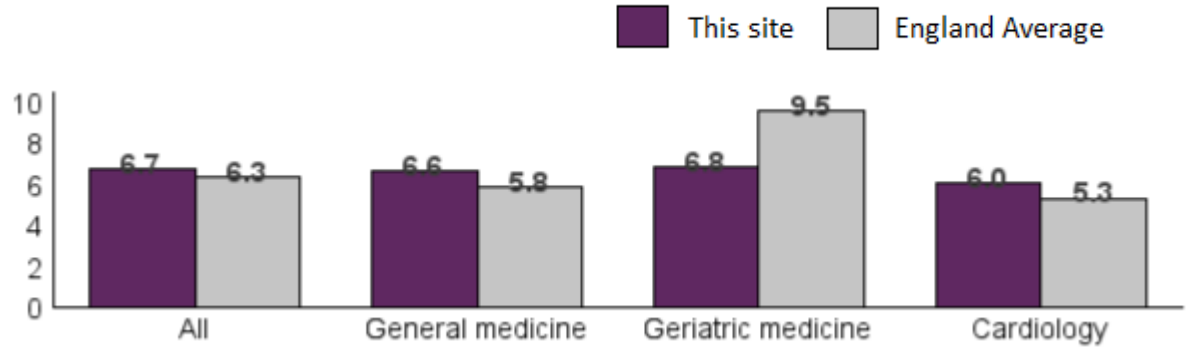
Over the same period, for medical non-elective patients, the average length of stay was 6.7 days, which was similar to the England average of 6.3 days.

Average lengths of stay for non-elective specialties:

- Average lengths of stay for non-elective patients in general medicine and cardiology were similar to the England averages

- Average length of stay for non-elective patients in geriatric medicine was shorter than the England average

Non-Elective Average Length of Stay - Royal Bolton Hospital



Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

The service had seen a decrease in length of stay for patients following the introduction of the home first team and the specialist nurse led sclerosis drainage on the gastroenterology ward.

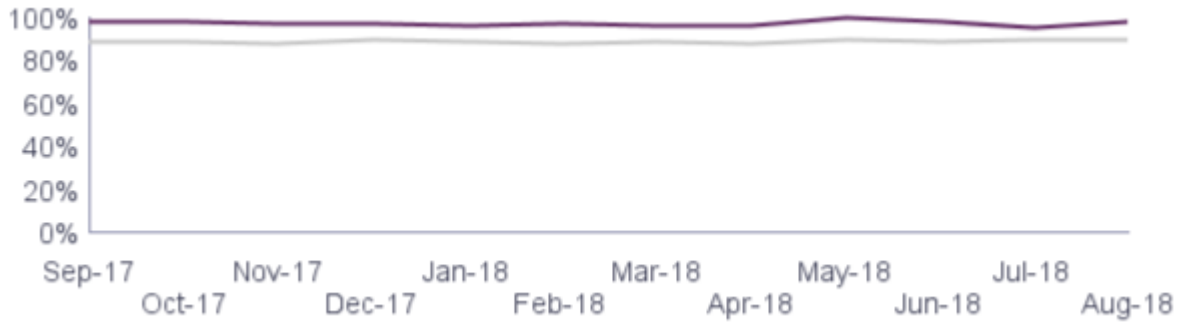
Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for medicine was consistently better than the England average.

The trust's performance over these 12 months never fell below 94.8%.

Month	Trust score	England average
September 2017	98.4%	89.1%
October 2017	98.3%	88.9%
November 2017	96.9%	88.2%
December 2017	97.4%	89.4%
January 2018	95.9%	88.3%
February 2018	97.1%	88.0%
March 2018	95.8%	88.9%
April 2018	96.3%	88.0%
May 2018	99.5%	89.3%
Jun 2018	97.7%	88.7%
July 2018	94.8%	89.2%
August 2018	97.6%	90.0%

This Trust — England Avg.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

All three medical specialties for which the trust had admitted referral to treatment data were above the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Geriatric medicine	100.0%	96.9%
Thoracic medicine	100.0%	93.4%
General medicine	97.1%	96.6%

(Source: NHS England)

However, the endoscopy unit was not compliant with NHS England's diagnostic waiting time of six weeks or with the endoscopic retrograde cholangiopancreatography waiting time of two weeks. We saw that this was recorded on the divisional risk register and displayed in staff areas. We were told that the delay was due to staffing capacity, the service had recently had a business case approved to increase staffing so that more lists could be added per week. Following the inspection, the service provided the below waiting times which demonstrated improvements in waiting times from September to November 2018.

Patients awaiting outpatient endoscopy following clinic attendance

	Sept 18		Oct 18		Nov 18	
	Average Wait	Median Wait	Average Wait	Median Wait	Average Wait	Median Wait
Colonoscopy	11.04	11.00	8.36	7.00	8.13	8.00
Flexi	11.00	13.00	11.89	8.50	9.47	10.00
Gastroscopy	10.27	9.00	8.92	8.00	7.27	7.00
Other	9.50	9.00	15.00	11.50	9.50	9.50

Waiting times in days

Patients awaiting outpatient endoscopy on a straight to test pathway

	Sept 18		Oct 18		Nov 18	
	Average Wait	Median Wait	Average Wait	Median Wait	Average Wait	Median Wait

Colonoscopy	16.67	10.50	8.00	10.00	7.50	7.50
Flexi	N/A	N/A	N/A	N/A	8.00	8.00
Gastroscopy	7.47	7.00	6.96	6.00	7.98	6.00
Other	N/A	N/A	N/A	N/A	N/A	N/A

Waiting times in days

(Source: Post inspection additional evidence request)

Patient moving wards per admission

The trust noted that they are unable to differentiate between ward moves for clinical and non-clinical reasons.

The trust supplied data for the two reporting units in medical care with the largest numbers of ward moves for the 12 months from September 2017 to August 2018. These were the two medical assessment wards: D1 and D2. Of the patients on these two wards, 35.7% did not move wards during their admission, and 64.3% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

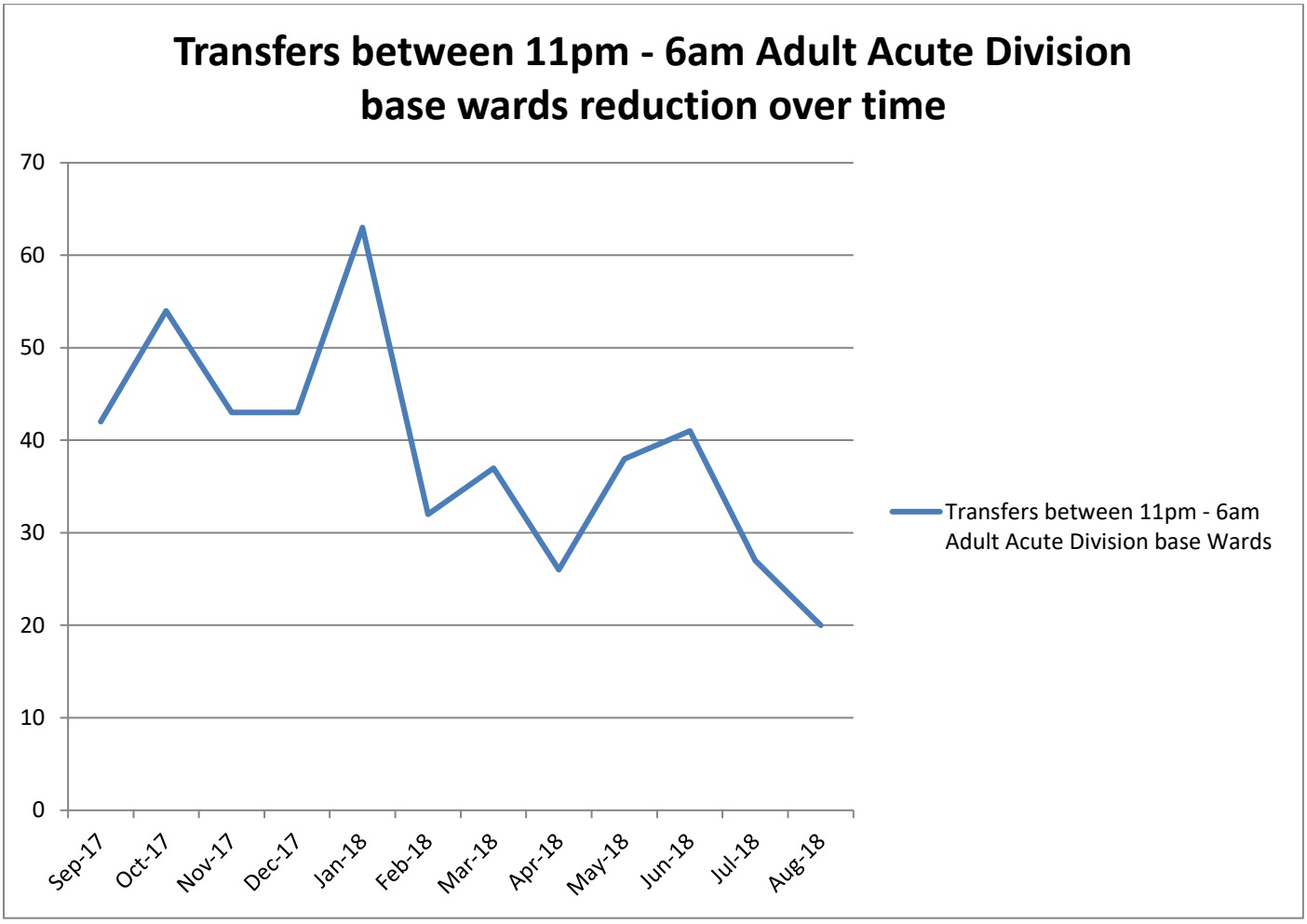
From September 2017 to August 2018, there were 2,754 patient moves at night on medical wards. The highest numbers of ward moves were reported in January 2018 (306), October 2017 (278) and December 2017 (272).

The highest numbers of ward moves at night over this period were reported for the two medical assessment wards, D1 (1,278) and D2 (1,009), and ward C1 (cardiology, 67).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

The number of reported ward moves at night was 2754. However, 2287 of these were from the medical assessment wards, this is where patients needs are assessed and they are transferred to an appropriate base ward. In the 12-month period September 2017 to August 2018 there were 467 bed moves at night from base wards across the service. Bed moves at night were recorded as a risk on the divisional risk register. Senior nursing staff explained that they tried not move patients after 11.00pm unless there was an urgent need to. Staff explained that if a bed needed to be made available they would identify the most suitable patients who had a lower acuity to be moved to another ward. We were told that they did not move elderly patients after this time.

The service monitored bed moves at night through the daily flow meetings and the risk management committee. We were informed that through monitoring it had been identified that a number of the moves were appropriate and due to clinical need. However, it had been identified that there were anomalies in the actual time a patient was transferred compared to the information recorded on the electronic patient record system. A task and finish group had been set up to make improvements and the group were working to address the data issues. Following our inspection, the trust provided additional information collected between September 2017 and August 2018. The data showed a reduction in the number of bed moves after 11.00pm, see the table below.



(Source: post inspection additional evidence request)

During the inspection staff on D1 told us that they did not discharge patients after 9.00pm unless the patient had suitable arrangements to get home safely and expressed a wish to return home.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Complaints were monitored as part of the ward performance heatmap and discussed as part of the divisional governance meetings. Learning from complaints was shared with staff and discussed at safety huddles and team meetings. We saw that in staff areas complaints and learning from this was on display for staff information. Staff could provide examples of complaints that had been made in their ward area and changes made as a result.

We saw that there were leaflets available in public areas on wards which detailed how to make a complaint, raise concerns or give a compliment. The patients we spoke with told us they were not aware of the formal procedure for raising complaints however they did express that they felt comfortable in raising concerns if they needed to.

Summary of complaints

From September 2017 to August 2018 the trust received 72 complaints about medical care. For the 69 complaints that had been closed at the time of data submission, the trust took an average

of 36.4 working days (mean) to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 35 working days.

The three complaints that had not yet been closed had been open for an average of 26.3 working days at the time of data submission. This was in line with the policy statement that complaints should be responded to within 35 working days.

The breakdown by subject can be seen in the table below.

Subject	**No. of complaints**
Clinical care	40
Communication	10
Delay in diagnosis/test results/treatment	8
Care package arrangements	3
Medication	3
Attitude of staff	2
Consent	2
End of life care	1
Cancellation	1
Appointments	1
Complaints handling	1
Total	**72**

The four wards and units with the largest numbers of complaints received over this period were wards D3 (nine), C2 (six), D4 (five), and B1 (five).

It should be noted that data for wards C4 and A4 only covered the period from January to August 2018.

(Source: Routine Provider Information Request (RPIR) – Complaints tab

We reviewed three complaint outcomes from the list above. We saw evidence that the service appropriately investigated and responded to complaints and apologised where necessary. We also saw evidence that the service had met with complainants to discuss the concerns and a written response was provided following the meeting which contained details of the discussions. We also saw that lessons had been learnt from complaint investigations and where this was appropriate there was an action plan attached for improvements.

Number of compliments made to the trust

From November 2017 to October 2018 the trust received 32 compliments about their endoscopy service. This was the only clinical area of medical care for which the trust was able to provide compliments data. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Patient feedback was continually sought and patients were encouraged to provide feedback about their care and treatment. We saw that shout out boards were in used for staff and patients to leave compliments about those involved in their care. We also saw thank you cards on display from patients and their relatives.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Nursing and clinical leaders were motivated and enthusiastic about providing patient centred care. Leadership teams were visible, approachable and staff spoke highly of the support they received. Leaders were clear about their roles and responsibilities and the reporting structure in place. Matrons and ward managers spoke of 'strong divisional support'.

The leadership team were aware of the challenges faced by the service and the delivery of sustainable and high-quality care. The senior clinical leadership team identified that succession planning was a challenge to the service for medical staff, particularly for acute medical consultants. There was a focus on upskilling staff to develop future consultants from within the service. Service leads described future plans to use staffing skill mix differently to deliver future services and the need to upskill multidisciplinary roles to undertake the traditional medical roles.

The trust had a focus on leadership development and staff could attend internal and external courses. One of the matrons we spoke with had received funding from the trust to undertake a chartered managers degree and was currently working through the two-year training programme.

Ward managers and matrons were keen to develop the staff in their teams, there were opportunities for staff who identified an interest in a leadership role. Staff were given opportunities to shadow matrons to gain an understanding of their roles and responsibilities. Ward managers involved staff in planning and creating ward rosters, attending divisional meetings in both a shadowing and deputising role. Band five and six nurses could attend the trusts human resource training and undertake appraisals for more junior members of staff. A band five nurse within the service was undertaking a first line management apprenticeship which was externally funded, the matron for the ward was providing support in a mentor role.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The current strategy in place outlined the divisional priorities for 2018/2019 it had been aligned to the trusts Better Care Together Our Quality Improvement Strategy 2017-2020. There were four main objectives these were quality of care, leadership and people, creating a continuous learning culture and enhancing patient and carer experience. Each aim had quality measures attached to it so that performance could be measured and monitored. Progress against the strategy was monitored at divisional level and then reported to the trust board.

Business and clinical leads were in the process of developing the strategy for the next five years and could articulate future plans for the service which included the expansion of frailty services and the movement of those services closer to the front door, a focus on decreasing length of stay on assessment wards, re-mapping patient pathways across acute and community services and a review of staffing skill mix to include an expansion of advanced nurse practitioner roles and the introduction of physician associates. We were told that the strategy was in the early development stages, and prior to finalisation there was planned engagement with the public and staff to include their views.

The trust had a set of values which the overall vision was based on these were ‘VOICE’ (vision, openness, integrity, compassion and excellence). The values were displayed on posters and stationary and formed part of the trusts branding.

Staff were aware of the direction for the service. The trust values formed the basis of the appraisal document and process. During our observations of patient care and feedback from patients and relatives we could see that staff demonstrated these values.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service supported and encouraged staff to provide the best care for patients. Staff described a positive culture and felt that leaders were supportive and encouraged development. Staff were proud to work for the organisation and the common reasons for being proud were excellent teamwork and patient focussed care.

Leaders were keen to celebrate the staff’s successes and had introduced recognition boards where other staff members and patients could recognise the good work staff have done, these were displayed in public areas. There were monthly staff awards which were called ‘ABC’ care awards. Staff were nominated on a monthly basis, staff who won the awards were given a badge to wear for recognition and their picture was put on the wall to celebrate their success.

Staff felt that the service was a safe place to speak up and share their concerns and ideas for improvement. We observed staff raising concerns about a patient during a multidisciplinary board round and other staff members demonstrated a supportive and constructive approach to their concerns.

The division had a freedom to speak up guardian who was an established senior nurse, who staff described as a ‘well-known familiar face’. The freedom to speak up guardian was in the process of appointing four speak up champions to support their role and provide a more diverse team.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Medical care was part of the acute adult care division. The division was split into specialties which included complex care, stroke, gastroenterology, cardiology, respiratory and acute medicine. Each speciality had a monthly speciality governance meeting which reviewed performance, risks, incidents, harm free care and complaints. Information from the speciality governance meetings fed up into the divisional governance board and then up into the divisional board.

Integrated performance meetings were held monthly, these fed into the finance meetings, which fed up into the senior management team meetings and then the divisional board.

Under the divisional and speciality meetings were senior nurse and clinical leads meetings and then below this ward team meetings and safety huddles. Safety huddles were held daily, risks incidents, complaints and performance were discussed during safety huddles. Information relating to risks performance and incidents were displayed in staff areas on governance notice boards for staff to refer to if they had missed the safety huddles.

We were told that ward team meetings were supposed to be held on a monthly basis, however for the majority of the wards these were not held regularly and in some areas, had been recently introduced. We were told that there were a number of reasons for this, examples were staffing and the logistics for getting all ward staff together at once. We received mixed feedback from staff about the effectiveness of communication.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The trust used an electronic risk register which was linked to the incident reporting system, this meant that incidents could be linked to risks on the register. Risks were reviewed as part of divisional governance meetings. Managers were aware of risks and could articulate the risks for their areas.

At the last inspection it was identified that risks on the risk register for the service had not been reviewed and actioned within the specified timescales. In the acute adult divisional integrated governance report for April- June 2018 we saw that speciality risk clinics had been introduced every six weeks, this meant that clinical teams had a focus on the review of risks and updated actions. The reported demonstrated that in July 2018 the number of action breaches had reduced from 121 to 83. The service provided data following the inspection which confirmed that the number of action breaches had reduced further to 11. In the divisional governance meeting minutes, we saw evidence that a monthly risk register update was a standard agenda item.

Performance was monitored and reported on a regular basis through the board assurance heatmaps and the integrated performance score card. Performance was fed up into the divisional board meetings and down to staff through safety huddles, team meetings and governance notice boards. The service bench marked monthly performance against the previous month and the performance for the 12-month period.

We reviewed the monthly divisional clinical governance board meeting minutes for October to December 2018. We saw evidence that heat map performance was discussed for each speciality within the division. Standard agenda items reviewed performance, risk, incidents and learning.

The strategy identified areas of performance and risk as future development and improvement. We could see from the October 2018 scorecard that in the main performance against the indicators had improved.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The majority of patient records were paper based and stored in Digi locked cabinets. Electronic systems were accessed via password entry or staff smart cards.

Appropriate information was recorded and available on patient records. The service could effectively extract data to monitor quality and performance. The service contributed to a number of internal and national audits to benchmark against similar trusts.

The service had recently introduced an electronic observation system to record early warning scores. Staff had access to hand held devices to document observations. During board rounds

staff could review patient's observation scores to identify high risk patients and monitor and prioritise care.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service encouraged patient feedback. Staff encouraged the completion of the friends and family surveys. Friends and family survey results and response rates were reported and monitored as part of the monthly governance heatmaps.

The service had a 'you said we did' initiative in place which demonstrated changes which had been made in response to patient feedback. This information was displayed in public areas on wards. We saw that call bell champions had been introduced on ward C3 following feedback about the delay in answering patient calls bells.

Public engagement formed part of the acute adult divisional integrated governance report as a standing agenda item. We reviewed the report for April- June 2018 and saw that in April 2018 the service had hosted a patient experience day to promote the core values for staff. The day had a focus on attitudes, behaviour, communication and dignity. As a result, the service had introduced leads for each speciality to work alongside the assistant divisional director of nursing and the matron for their area to improve patient engagement. Improvement work will be monitored by the divisional patient experience group.

The service engaged with staff through the safety huddles, team meetings and 'ABC care awards. The service had identified technology as forum to engage with staff. There was a closed social media group information to be shared with staff and for staff to celebrate their successes and share learning and good practice. Staff described a positive reaction to this form of engagement and senior nurses described that it had created a buzz between staff.

The services also engaged with the wider public and professional groups through celebrating their good work on public social media platforms and producing publications in professional journals.

The liver and alcohol service was developing services as part of the Bolton Integrated steering group which met on a three-monthly basis. The group consisted of local commissioning services, community teams, general practitioners and Bolton neighbourhood teams. The group was working to streamline services and reduce length of stay in hospital for this patient group.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The service promoted shared learning from complaints and incidents. Safety huddles had standard agenda items which meant that complaints and incidents were discussed. Governance boards displayed case studies containing incidents and complaints and the learning as a result.

The service promoted continual improvements to patient care and multidisciplinary working through the ward accreditation scheme known as 'BOSCA'. The accreditation process took into account a range of quality measures such as antibiotic compliance, confidentiality of medical notes, evidence of senior review and adherence to the uniform policy. The accreditation was on a six-monthly cycle. The wards would be accredited either white, bronze, silver, gold or platinum.

Action plans where developed to improve the ward and this was shared by ward managers in ward meetings and safety huddles. Ward A4 had improved from white to gold. Staff on the ward told us that they used to get lots of complaints but these have now reduced and they receive compliments and thank you cards from patients and families.

There was a focus on staff development and opportunities for staff to expand their knowledge and skills. The service's strategy supported and promoted the development of the workforce. Medical staff received weekly training sessions and structured competency files which they were supported to complete by the consultants. We were told that the training programme for junior doctors was good. Medical staff working on the acute wards were encouraged to complete the national acute care training programme.

All qualified nursing staff were encouraged to become mentors for student nurses. Nursing staff were supported to develop in the direction which they wanted for their career including undertaking advanced nurse practitioner qualifications. Nurses who had been in post for 12 months on the acute admissions units were encouraged to enrol and achieve the acute medicine qualification.

Research and innovation was encouraged and staff described how they felt empowered to be involved in change and drive improvement. The service contributed to a number of commercial and research clinical trials.

Examples of innovative work were the introduction of the enhanced care team lead by an occupational therapist and the introduction of daily activities and distraction therapy for patients. In conjunction with the enhanced care team the introduction of the 'pimp my zimmer' initiative to assist patients in identifying their walking aid for those who may have visual impairments or who were living with dementia.

Therapy teams had been involved in the initiation of the 'Food First' project which had a focus on encouraging patients to eat. This involved work with a diet chef and the availability of snacks on wards for patients who were reluctant to eat large meals.

Maternity

Facts and data about this service

Bolton NHS Foundation trust has 108 inpatient maternity beds across two sites.

Of these 104 are located within seven wards and units at Royal Bolton Hospital:

Ward/unit	Speciality or description	Inpatient beds/rooms
Antenatal day unit	Day assessment area providing foetal monitoring, blood pressure monitoring and assessment for high risk pregnancies	5 beds
Birth suite	Midwife-led birth suite with five rooms including a birthing pool offering supportive and safe low-risk pathway for women and families	5 rooms
Central delivery suite	Consultant-led unit providing care for high risk women with complex pregnancy needs	15 beds
Maternity triage	Assessment area for women presenting in labour or with obstetric problems	3 beds
Ward M2	High risk antenatal inpatients and induction of labour	22 beds
Wards M4 and M5	Postnatal women and babies	44 beds
Ward M6 (early pregnancy unit)	Emergency assessment of early pregnancy and gynaecology, and day case management of hyperemesis. Includes facilities for scanning and manual vacuum aspiration (MVA) procedures.	6 side rooms

The hospital also has 10 consultant rooms providing bookings and antenatal care for high-risk patients.

In addition, the trust operates the Ingleside Birth and Community Centre in Salford, a free-standing maternity unit for low risk pregnancies with four en suite pool rooms. The centre also carries out antenatal checks.

The trust provides 11 community antenatal clinics:

Clinic location name	Address
Blackrod Health Centre	68 Church Street, BL6 5EQ
Bolton One	Moor Lane, BL3 5BN
Ellenbrook Medical Centre	14 Morston Close, M28 1PV
Horwich Clinic	Jones Street, BL6 5PY
Horwich Kildonan GP Practice	Ramsbottom Road, BL6 5NW
Little Hulton Childrens Centre	Longshaw Drive, M28 0BD
Sides Medical Centre	Moorside Road, M27 4EW
Swinton Gateway	Crompton House, M27 6BP0
The Gill Medical Centre	5 Harriet Street, M28 3DR
Walkden Medical Centre	2 Hodge Road, M28 3AT
Walkden Gateway	2 Smith Street, M28 3EZ

The trust provides 10 combined antenatal and postnatal clinics:

Clinic location name	Address
Alexander Children's Centre	Blackledge Street, BL3 4BQ
Coronation Road Children's Centre	1 Westminster Avenue, M26 3WD
Great Lever Children's Centre	Leonard Street, BL3 3AP
Harvey Children's Centre	Shaw Street, BL3 6HU
Oldhams Children's Centre	Forfar Street, BL1 6RN
Oxford Road Children's Centre	Oxford Grove, BL1 3BH
Tonge Children's Centre	Starkey Road, BL2 2ED
Tottington Health Centre	16 Market Street, BL8 4AD
Winifred Kettle	Washacre Barn, Greenhalgh Lane, BL5 2NE
Woodbank Children's Centre	Elton Library, Brandllesholme Road, BL8 1AX

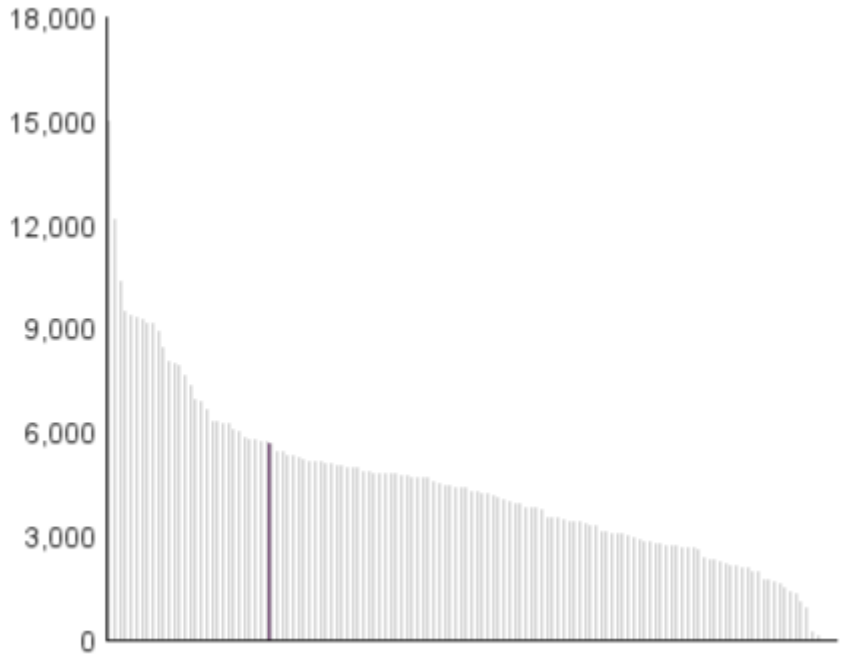
The trust's five community midwifery teams provide a 24-hour service covering Bolton, Salford and Bury. The teams provide care at all stages of pregnancy.

(Source: Trust Provider Information Request – Acute sites)

From April 2017 to March 2018 there were 5,636 deliveries at the trust.

A comparison of the number of deliveries at the trust to the national totals during this period is shown below.

Number of babies delivered at Bolton NHS Foundation Trust – comparison with other trusts in England



A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

Profile of all deliveries (April 2017 to March 2018)			
	Bolton NHS Foundation Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	5,474	98.5%	98.6%
Multiple	81	1.5%	1.4%
Mother's age			
Under 20	220	4.0%	3.1%
20-34	4,387	79.0%	74.9%
35-39	791	14.2%	18.1%
40+	157	2.8%	4.0%
Total number of deliveries			
Total	5,555		596,828

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods (April 2017 to March 2018)			
	Bolton NHS Foundation Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Gestation period			
Under 24 weeks	*	*	0.1%
Pre-term 24-36 weeks	362	6.7%	7.8%
Term 37-42 weeks	5,059	93.2%	91.9%
Post Term >42 weeks	*	*	0.2%
Total number of deliveries with a valid gestation period recorded			
Total	5,431		498,704

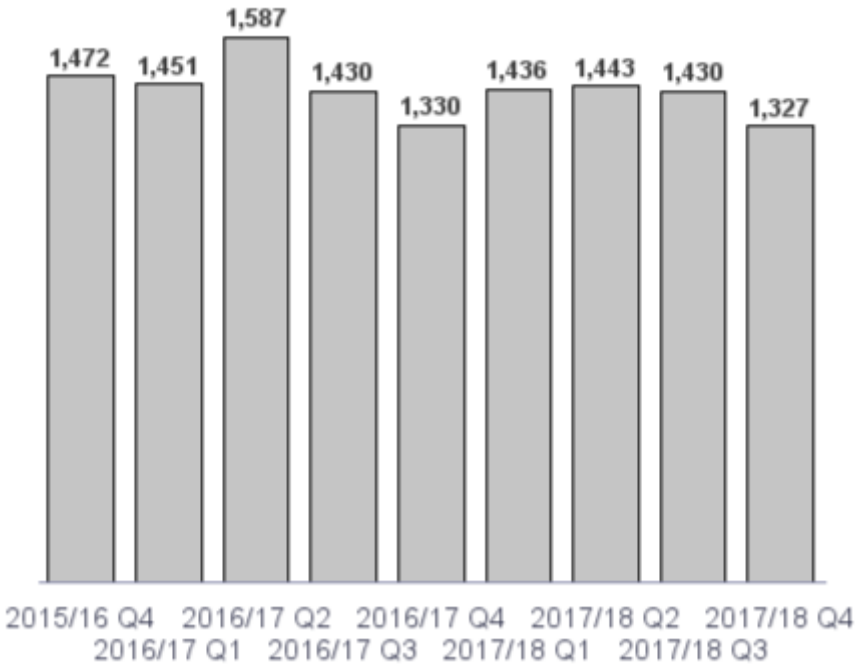
Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

To protect patient confidentiality, figures between one and five have been suppressed and replaced with "" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.*

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Bolton NHS Foundation Trust by quarter



There were fewer deliveries at the trust in quarter 2 of 2017/18 (1,443) compared to quarter 2 of 2016/17 (1,587, a reduction of 9.1%). The numbers of deliveries in the other three quarters of 2017/18 closely mirrored the equivalent quarters of 2016/17. There was a fall in deliveries in the fourth quarter of both years.

SOURCE: Hospital Episode Statistics (HES) - Deliveries (April 2017 - March 2018)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of basic life support, conflict resolution, information governance and medicine management training. The trust set a target of 95% for completion of all other mandatory training modules.

A breakdown of compliance for mandatory training courses from as of July 2018 for midwives and qualified nursing staff working in maternity is shown below:

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Equality and diversity	230	238	96.6%	95%	Yes
Blood transfusion	218	238	91.6%	95%	No
Fire safety 2 years	214	238	89.9%	95%	No
Medicine management training	223	249	89.6%	85%	Yes
Basic life support	213	238	89.5%	85%	Yes
Information governance	208	238	87.4%	85%	Yes
Infection prevention (level 2)	206	249	82.7%	95%	No
Conflict resolution	185	237	78.1%	85%	No

The trust had an overall training compliance rate of 88.2% for midwives and qualified nursing staff working in maternity. Training targets were met for four of the eight mandatory training modules for which these staff were eligible.

A breakdown of compliance for mandatory training courses as of July 2018 for medical staff in maternity is shown below:

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Conflict resolution	19	19	100.0%	85%	Yes
Equality and diversity	20	20	100.0%	95%	Yes
Blood transfusion	19	20	95.0%	95%	Yes
Information governance	17	20	85.0%	85%	Yes
Basic life support	17	20	85.0%	85%	Yes
Medicine management training	19	24	79.2%	85%	No
Fire safety	15	20	75.0%	95%	No
Infection prevention (level 2)	17	24	70.8%	95%	No

In maternity the trust had an overall training compliance rate of 85.6% for medical staff. Training targets were met for five of the eight mandatory training modules for which medical staff were eligible. The lowest completion rates were for fire safety (75.0%) and infection prevention level 2 (70.8%).

The trust found data quality issues with their training completion data for moving and handling (inanimate loads); this module is therefore excluded from the analysis above.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During inspection we reviewed local records of mandatory training and saw that staff had completed this although overall rates were below trust targets.

Core mandatory training compliance for all staff was 81%; this was below the trust target of 85%. Compliance for completion of statutory training was 93%, just below the trust target of 95%. For band 5 midwifery staff there was 100% compliance with mandatory training.

Staff were also aware of training sessions offered by the rapid assessment interface discharge team (RAID) to support women with a mental health need, autism or a learning disability. The lead midwife for perinatal mental health provided a session in mandatory training for rmidwives.

Safeguarding

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of July 2018 for midwives and qualified nursing staff working in maternity in maternity is shown below.

The completion rates of zero for safeguarding adults level 1 and safeguarding children level 1 may be the result of errors in the data and should be queried with the trust.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Safeguarding children (level 2)	236	249	94.8%	95%	No
Safeguarding adults (level 2)	219	249	88.0%	95%	No
Safeguarding adults (level 1)	0	249	0.0%	95%	No
Safeguarding children (level 1)	0	217	0.0%	95%	No

The trust had an overall safeguarding training compliance rate of 47.2% for midwives and qualified nursing staff working in maternity. The 95% target was not met for any of the four safeguarding training modules for which these staff were eligible. Safeguarding adults level 1 or safeguarding children level 1 was covered as part of the level 2 training.

During the inspection we reviewed local records for completion of safeguarding training. Midwifery staff were 98% compliant with level three children's safeguarding training.

A breakdown of compliance for safeguarding training courses as of July 2018 for medical staff in maternity is shown below.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Safeguarding adults (level 2)	20	24	83.3%	95%	No
Safeguarding children (level 2)	19	23	82.6%	95%	No
Safeguarding adults (level 1)	0	24	0.0%	95%	No

In maternity the trust had an overall safeguarding training compliance rate of 54.2% for medical staff. The 95% target was not met for any of the three safeguarding training modules for which medical staff were eligible. None of the required staff had completed safeguarding adults level 1. However, the trust informed us that all medical staff had completed level 3 safeguarding children training as of July 2018.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff were aware of the types of safeguarding concerns which could arise in maternity services and followed trust procedures when these occurred. Staff we spoke with could explain the safeguarding process to us and were confident in using this.

Safeguarding resources were available in all clinical areas, with relevant documentation and guidance for staff to follow for any safeguarding concern. Maternity records included a form to alert staff where any safeguarding concerns were identified.

We reviewed maternity records during inspection which showed safeguarding was raised and followed up appropriately. A discreet flag was used on the electronic patient record to indicate where any safeguarding had been identified. This alert system also indicated when a woman had additional mental health needs or a learning disability.

The service had a safeguarding lead midwife who provided additional support for staff where this was needed. The lead midwife worked closely between the adult safeguarding team and other lead midwives in the maternity service, including the lead midwife for teenage pregnancy and the lead midwife for perinatal mental health. During inspection we observed the lead midwife was in frequent communication with staff in wards and services, to share new referrals and safeguarding information. The safeguarding lead midwife also shared communications with safeguarding specialist midwives in other trusts and external agencies when required. A file was held on the labour ward containing details of local and national out of area referrals. Staff also had access to the trust's adult safeguarding team and safeguarding champions if required.

The safeguarding lead midwife also provided safeguarding supervision for midwives in community outreach teams and offered support and a debrief for staff in the event of a safeguarding incident.

Maternity staff completed mandatory safeguarding training, including training for female genital mutilation and domestic abuse.

We observed babies on the maternity unit were fitted with an electronic baby identification tag for security monitoring.

Cleanliness, infection control and hygiene

The service controlled infection risk well and had low rates of infection**.** Staff implemented control measures to prevent the spread of infection and to keep themselves, equipment and the premises clean. The wards and clinical areas we visited were visibly clean and orderly.

Staff were aware of the trust's infection control policy and followed current infection prevention and control guidelines. We saw staff in clinical areas were 'bare below the elbows' when providing treatment and care.

Handwashing facilities, hand gel and protective personal equipment, such as aprons and gloves, were available in all the wards and departments we visited. Wall-mounted hand gel dispensers were placed at ward entrances, with notices displayed to prompt visitors to clean their hands before entering the ward.

We saw “I am clean” stickers on different equipment and all equipment was visibly clean.
The service carried out monthly hand hygiene audits. Divisional hand hygiene audits for April to June 2018 showed 100 % compliance for antenatal, birth suite and postnatal wards. Central delivery suite showed 95% compliance, with actions identified to support improvement.

Housekeepers maintained cleaning schedules to ensure the environment was clean. A low score in June 2018 for environmental audit on the postnatal ward had improved following identified action.

We saw that the treatment room on the early pregnancy unit did not have a sink in the clinical room, this was outside the treatment room. Staff told us this had been identified on the risk register.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Directions to the units were clear and areas were accessible for those with mobility needs. During inspection we observed the atmosphere in the early pregnancy unit, delivery unit and birth suite was settled and calm. We also saw the antenatal day unit and clinic areas were busy and there was more congestion here,with these waiting areas often full.

Access at ward entrances was limited by keypad control and monitored with security cameras. Reception and ward staff could observe who was seeking access to the ward before granting entrance to individuals.

The maternity department had a dedicated antenatal clinic, a maternity day unit and obstetric scanning facilities.

The maternity unit had a triage area next to the central delivery suite. The triage area had three cubicles and was open 24 hours per day. The central delivery suite and birth suite had spacious rooms providing different equipment for assisting women in labour. Rooms were decorated in soft colours, with adjustable lighting to provide a relaxing environment. Each room also had an ensuite shower or bath and a toilet.

Specialist equipment was available for monitoring maternal and fetal wellbeing, including cardiotocograph machines and blood pressure machines. Records confirmed this equipment was checked and maintained within manufacturer’s servicing dates.

The delivery suite had a bereavement room with suitable facilities for parents who had lost a baby. This was situated in a quieter part of the unit to allow for some privacy.
The midwife led birth centre at the maternity unit had five birthing rooms Women were actively encouraged to stay in these rooms and that their partners could stay with them throughout their labour.

There were three obstetric theatres next to central delivery suite; one was for elective surgical procedures and two were for emergency obstetric procedures. At the time of inspection theatre two was out of use due to a broken tap, however this did not have an immediate impact for obstetric cases. Women remained in theatre recovery area immediately following their surgery, before transferring to the post-natal ward. If they required a more intense level of care they returned to delivery suite. The high dependency unit was situated above theatres in case women needed this input after surgery. An anaesthetist was based in theatre, with consultant obstetrician on call. If a second obstetric emergency arose whilst theatre one was in use, a suitably trained midwife would scrub to support theatre staff.

Emergency equipment to be used in the event of a neonatal or obstetric emergency was available in all relevant areas and we saw that daily checks were recorded for this equipment. Arrangements for managing specimens kept people safe. Clinical staff tested urine samples using designated equipment.

The postnatal ward had 44 beds, with four sidewards, including two enhanced recovery bays for women following caesarean section. Fridges for storage of breast milk were available and records of temperature checks completed correctly.

Staff on the postnatal ward told us of plans for bedside sterilising equipment, although this was dependent on overall arrangements for refurbishment.

The division had opened a community midwife-led birth unit providing maternity care for women with low risk pregnancies. The Ingleside centre had four birth suites, each incorporating audio-visual facilities and decorated with calming décor. Every room had ensuite disabled accessible facilities and one of the rooms had access to a small garden area, with outdoor furniture.

Assessing and responding to patient risk

Staff completed and updated risk assessments to mitigate potential risks to women and staff.

Risk assessments were completed at the time of booking, to assess the level of risk for the woman during the pregnancy. These considered factors including previous history; risk of venous thromboembolism; and growth plan as part of ‘gap and grow’. The level of risk identified determined any needs for referral to an obstetrician.

A gynaecology registrar was available to support ante-natal day unit and to refer women needing escalation.

The service used a modified early obstetric warning score (MEOWS) to monitor vital signs and any changes in women’s condition. Midwives used MEOWS to identify any possible underlying infection or need for escalation to higher risk obstetric care. We saw that MEOWS had been completed correctly in the patient records we reviewed.

A sepsis pathway was in place and included part of the guideline “maternity early warning score, the unwell pregnant woman including the diagnosis and management of sepsis in the antenatal, intrapartum and postnatal period.”

Staff in the service followed the practice of ‘fresh eyes’ for managing women in labour, as recommended by the Royal College of Midwives. This practice was used when a woman in labour was having continuous electronic fetal monitoring. A midwife or obstetrician would regularly reviewed the fetal heart trace with a colleague to reduce the chances of misinterpreting fetal heart

trace results. Staff informed us that the practice of closer fetal monitoring in ante natal care had resulted in higer rates of induction of labour.

Midwives supported women throughout labour with one to one care, with 99% of women receiving one to one care.

Midwives and support staff completed basic life support training for adults and children. In hospital maternity services, 93% of midwives had completed intermediate life support skills training and there was always at least one midwife with newborn life support skills available on shifts. All community midwives had completed newborn life support skils training, with plans for 14 further midwife staff to complete this in early 2018. The service completed 'skills and drills' training one to two times per month. This training ensured clinical staff maintained their skills for managing a range of obstetric emergencies, including shoulder dystocia, postpartum haemorrhage and cord prolapse.

Ninety six per cent of midwives had completed practical obstetric multi-professional training (PROMPT).

All wards held safety huddles twice a day to share important safety information and any updates about women receiving care in the area.

The rapid assessment interface discharge team provided all age cover across the service for women experiencing mental ill health, 24 hours a day. All staff we spoke to were aware of how to contact the mental health team in an emergency.

A midwife was not identified as part of the trust's routine on call arrangements, however divisional leaders were fully assured in there being two midwife co-ordinators on call to provide cover.

The service used the World Health Organisations (WHO) Five Steps to Safer Surgery for all women having babies by caesarean section. During our inspection we observed theatre procedures where staff followed the WHO checklist. This included the team brief and introductions immediately prior to the commencement of the procedure. In theatre, the operating department practitioner remained in the department until the woman's care was handed over to ward staff.

Community midwives completed environmental risk assessments to ensure the safety of the midwives as well as the woman and baby. Risk assessments were completed for midwives carrying entonox for home deliveries in the community.

The Ingleside community midwife birth centre followed the inclusion criteria as applicable for home birth, for women with low risk pregnancies. The service also had an escalation criteria for women in labour needing transfer to Royal Bolton Hospital. Since the centre opened in April 2018, there had been 24 transfers out of a total 61 births, six of these transfers were for postnatal care. Staff told us there had been an average transfer rate of six women a month for medical reasons, mainly for induction of labour for reduced fetal movements.

Women requiring induction of labour were usually cared for and treated in the delivery suite where they could be closely monitored.

Diabetes was monitored at the trust throughout the pregnancy and post-natally. Diabetic specialist midwives and the trust endocrinologist supported specialist antenatal clinics.

Nursing and Midwife staffing

The trust reported their staffing numbers for midwives and qualified nursing staff working in maternity as below as of March and July 2018.

Site	March 2018			July 2018		
	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate
Midwives and qualified nursing staff working in maternity	220.6	230.6	95.6%	217.8	232.6	93.6%

The trust's data group most of these staff under the reporting unit "obstetrics". As of July 2018, 215.8 of the 217.8 WTE's in post were grouped under this unit. The remaining two WTE's were shown under Ingleside Birth Centre. However as of March 2018, all 220.6 WTE's in post were grouped under "obstetrics".

As no staff were shown as allocated to any of the trust's other maternity services, it is clear from the data that the staff grouped under "obstetrics" work across all the reporting units in maternity.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 4.8% for midwives and qualified nursing staff working in maternity. This was lower than the trust target of 6.0%.

The trust's vacancy data group most midwives and qualified nursing staff working in maternity under "obstetrics". It is therefore not possible to examine these data at the level of individual wards and units.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 8.3% for midwives and qualified nursing staff working in maternity. This was lower than the trust target of 10.0%.

Unlike the vacancy data, the trust's turnover and sickness data split this staff group between two reporting units: specialist midwives and all other midwives. The turnover rate was lower for specialist midwives (2.6%) than for all other midwives (8.7%).

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 6.1% for midwives and qualified nursing staff working in maternity. This was higher than the trust's target of 4.2%.

The sickness rate was much lower for specialist midwives (3.3%) than for all other midwives and qualified nursing staff working in maternity (6.4%).

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The trust bank staff should be noted are from their own substantive staff and therefore the risk

of using bank staff is reduced.

The trust provided bank and agency staff usage data for qualified midwifery staff and unqualified nursing and midwifery staff in maternity, broken down between two reporting units at Royal Bolton Hospital: ward M2 (high risk antenatal inpatients and induction of labour) and the postnatal wards (M4 and M5).

From August 2017 to July 2018, the trust reported that 7.0% of qualified midwife hours across these reporting units were filled by bank staff, while no qualified midwife hours were filled by agency staff. In addition, 2.7% of qualified midwife hours were not filled by bank or agency staff to cover staff absence.

Over the same period, the trust reported that 14.5% of unqualified nursing and midwifery staff hours across these reporting units were filled by bank staff, while no hours for this staff group were filled by agency staff. In addition, 3.1% of hours for this staff group were not filled by either bank or agency staff to cover staff absence.

Staff group	Bank		Unfilled		Total hours available
	Hours	%	Hours	%	
Qualified midwives and qualified nursing staff	5,497	7.0%	2,101	2.7%	78,598
Unqualified nursing and midwifery staff	6,840	14.5%	1,447	3.1%	47,203
Total	**12,336**	**9.8%**	**3,548**	**2.8%**	**125,801**

From August 2017 to July 2018, bank midwifery staff usage was much higher on the two postnatal wards, M4 and M5, than on ward M2.

The proportion of hours left unfilled was also higher for unqualified midwifery staff on the postnatal wards, than on ward M2.

However, the proportion of hours left unfilled for qualified nursing and midwifery staff was higher on ward M2 than on the postnatal wards.

Bank usage on the two postnatal wards, M4 and M5, combined:

Staff group	Bank		Unfilled		Total hours available
	Hours	%	Hours	%	
Qualified midwives and qualified nursing staff	3,499	8.5%	899	2.2%	41,119
Unqualified nursing and midwifery staff	5,384	18.0%	987	3.3%	29,833
Total	**8,883**	**12.5%**	**1,886**	**2.7%**	**70,951**

Bank usage on ward M2 (high-risk antenatal inpatients and induction of labour):

Staff group	Bank		Unfilled		Total hours available
	Hours	%	Hours	%	

Qualified midwives and qualified nursing staff	1,998	5.3%	1,202	3.2%	37,479
Unqualified nursing and midwifery staff	1,456	8.4%	460	2.6%	17,371
Total	**3,454**	**6.3%**	**1,662**	**3.0%**	**54,850**

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Midwife to birth ratio

From April 2017 to March 2018 the trust had a ratio of one midwife to every 22.4 births. This was higher than the England average of one midwife to every 25.7 births.

(Source: Electronic Staff Records – EST Data Warehouse)

The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, divisional managers had identified this from a staffing review and were actively recruiting to the service at the time of inspection.
There were processes in place to ensure sufficient numbers of trained midwifery and support staff in different ward areas and theatres to provide safe care and treatment. Staff worked together effectively to ensure women received safe care.

Divisional leaders had invested in a new acuity tool to further assist in management of safe staffing and were anticipating this imminently.

The division had also introduced a 'helicopter bleep' system, in which a senior midwife was rostered onto the bleep rota. The midwife visited ward and department areas three times a day to monitor safe staffing levels, allowing ward managers to continue with operational duties and care of women. The helicopter bleep holder provided an electronic written handover to the head of midwifery and matrons three times a day, highlighting any issues or maternity red flags breached. The red flag system was in accordance with the National Institute for Health and Care Excellence (NICE) guideline NG4: *Safe midwifery staffing for maternity settings*.

Where any shortfall of staff was identified, staff were moved between areas in response to areas of higher demand. This had particular impact when staff were moved from the midwife-led birth suite, leaving this area short of staff. We saw as a result of staffing moves, the birth suite had to close on 50 out of 123 days between July to October 2018.

The head of midwifery had completed a staffing review in July 2018, identifying and recruiting 14 new midwife posts following this. All the midwives we spoke with said there had been staffing difficulties on the unit although this was recently starting to improve, with recruitment and the helicopter bleep system.

We saw noticeboards in each area during inspection, displaying the expected and actual numbers of midwifery and nursing staffing levels for the maternity unit. These confirmed staffing levels were fulfilled at the time of our inspection.

Community midwives were allocated women as their named midwives. A buddy system was used to promote continuity for women in line with the *Better Births: Improving outcomes of maternity services in England* recommendations. This meant that either the named midwife or buddy should be in contact with women both antenatally and postnatally.

Midwives we spoke with said continuity in care was a priority for midwives supporting women in labour and this was managed. As soon as babies were delivered however, staff said they felt the pressure of workload to complete the necessary paperwork for transfer to postnatal wards.

Medical staffing

The trust reported their medical staff numbers as below as of March and July 2018.

Site	March 2018			July 2018		
	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate	Actual staff (WTEs)	Planned staff (WTEs)	Fill rate
Medical staff	42.9	45.8	93.7%	45.7	45.8	99.8%

(Source: Routine Provider Information Request (RPIR) –Vacancy tab)

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 3.6% for medical staff in maternity. This was lower than the trust target of 6.0%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 16.8% for medical staff in maternity. This was higher than the trust target of 10.0%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 5.5% for medical staff in maternity. This was higher than the trust's target of 4.2%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Medical staffing was recruited to full establishment of staffing at the time of inspection

Bank and locum staff usage

The trust were unable to provide the total number of hours worked by all medical staff in maternity at the trust from August 2017 to July 2018. The trust were also unable to report the number of hours left unfilled by bank or locum staff to cover staff absence. This is because medical staff at the trust were not on a central roster over this period. The trust report that they have a plan in place to move their medical staff onto roster to enable reporting on hours worked and fill information.

Therefore, it was not possible to calculate the percentages of medical staff hours worked by bank and locum medical staff. Instead only the raw numbers are available.

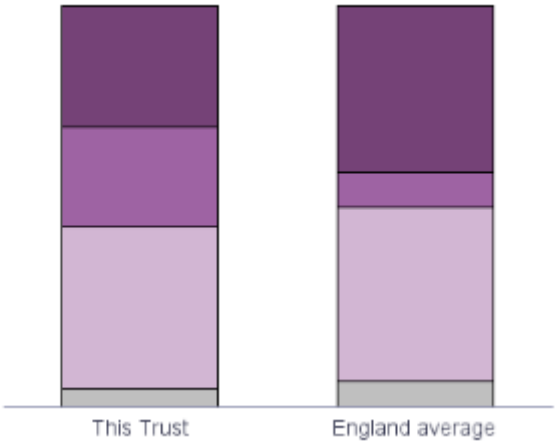
From August 2017 to July 2018, the trust reported that no medical staff hours in medical care at Royal Bolton Hospital were filled by bank staff, while 1,023 medical staff hours were filled by locum staff.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Staffing skill mix

As of July 2018, the proportion of consultant staff reported to be working in maternity at the trust was lower than the England average, while the proportion of junior (foundation year 1-2) staff was similar than the England average.

Staffing skill mix for the 42.8 whole time equivalent staff working in maternity at Bolton NHS Foundation Trust.



	This Trust	England average
Consultant	30%	41%
Middle career^	25%	9%
Registrar group~	40%	43%
Junior*	5%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/06/2018 - 30/06/2018))

There had been recruitment of medical staffing further to a staffing review, with increased establishment of junior doctors in August 2018. At the time of inspection there was a full complement of medical staff for the service and leaders were considering plans, including for physician's associates, for the future. Consultants said they worked well together as a consultant body and stood in for any cover if this was needed. From January 2019 two additional consultants would be available to cover obstetrics and gynaecological services. The service was also looking towards developing the assistant physician role for the future.

Records

Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
Midwifery care records were a combination of electronic and paper records. Medical staff recorded care in paper clinical records.
Paper clinical records were stored securely either in lockable trolleys or areas only accessed by authorised staff. We looked at the care records for three women and found these were clear and completed to a good standard.

The electronic record system had a flag to indicate where a woman had a particular need, including safeguarding concern or learning disability.
Midwives documented risk assessments for women at all stages of their maternity care. We saw these were documented appropriately.
Standardised documentation was kept at the end of patient beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.
Midwives completed discharge checklists which were shared with parents, GPs and health visitors. Parents were provided with their baby's developmental and health record book, for health visitors to continue with monitoring.
Community midwives had a base in the community birth centre and at local community clinics where they liaised with other staff directly or via communication books.
Management plans for postnatal women were located in record folders at the end of their bed and updated daily.

Medicines

The service prescribed, gave, recorded and stored medicines well.
All medicines we checked in different areas of the maternity unit and birth centre were within manufacturers' expiry dates and stored securely in a locked cabinet, in accordance with national guidance.
Controlled drugs were stored separately with stock checks correctly recorded, in accordance with trust policy. Registers for controlled drugs had been signed by two staff members when these medications had been dispensed.
Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges. This ensured medicines were safe and effective to be administered to women. We checked and saw records were complete and up to date for daily fridge temperature checks.
We reviewed 15 medicine prescription charts for women and found that medicines were administered as prescribed and that prescriptions were legible and signed for. Allergies were clearly documented in all of the medicines prescription records we checked.
A stock of take home medicines were stored on the ward to give to patients discharged outside of the pharmacy's opening hours. Processes were in place to ensure the safe issue of medicines at the point of a patients discharge.
Medicines were kept in digitally locked boxes at women's' bedsides on the postnatal ward.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2017 to October 2018, the trust reported no incidents classified as never events in maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SI's) in maternity which met the reporting criteria set by NHS England from November 2017 to October 2018.

The breakdown by incident type was as follows:

- Maternity/obstetric incident: mother and baby (this includes foetus, neonate and infant): three
- Medical equipment/devices/disposables incident: two
- Maternity/obstetric incident: mother only: one

Four of these six SI's were reported to STEIS within 14 days of occurrence. Of the other two SI's, one took 33 days to report and the other took 51 days to report.

(Source: Strategic Executive Information System (STEIS))

Staff were aware of the types of incident which could occur in the service and reported these using the trust's electronic incident reporting system. Staff completed details of incidents fully, together with any initial follow up actions. Midwives described how they would also discuss any incidents with the nurse in charge as soon as possible following the incident, so that they could take any other immediate action that was needed. Staff confidently said they would write incident reports and receive feedback on the incident reported, this was also fed back to the ward manager. Ward managers supported members of staff with individual feedback where any immediate learning had been identified and staff could also access further support from practice midwifery advocates.

Important information and learning relating to incidents was shared with staff at daily safety huddles, team meetings, maternity spotlight bulletins and trust email circulations.
Staff reported shortage of staffing as an incident when this occurred. Frequently reported incidents related to transfer of women who were in labour.

We heard from several midwives who felt the systems for sharing learning from incidents could be improved. One member of staff told us they had had not been well supported following a serious incident and that they still had anxiety following their experience. They had good peer support however and opportunity for seeking further advice for their concern.

The service investigated serious incidents using a root cause analysis approach. We reviewed completed investigation reports and saw these identified appropriate actions and included any lessons learned.

Staff we spoke with understood the term duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw from review of serious incidents that the duty of candour process had been followed. Staff followed the principles of duty of candour in their day to day approach and were clear in describing how they might explain any errors that may occur when providing care to women.

The service reviewed cases of mortality at trust mortality review group meetings, attended by senior divisional leaders. Cases were discussed with any lessons learned or actions included, with this information shared across the service. The governance and senior clinical lead arranged to

meet with families following any serious incident, to share discussions and review of the case.

Safety Thermometer

The service used safety monitoring results well. Staff collected safety monitoring information and shared it with staff, patients and visitors. The service used information to improve the service.

The safety thermometer monitors pressure ulcers, falls and urinary tract infections. It is used to record the prevalence of patient harms and to provide information and analysis for frontline teams to monitor their performance in delivering harm free care.

The service reported one incident of a patient fall, with no harm, between April to June 2018.

Is the service effective?

Evidence-based care and treatment

Care and treatment was based on national guidelines including National Institute for Health and Care Excellence (NICE) guidelines. This included guidance from the National Institute for Health and Care Excellence, Royal College of Obstetricians and Gynaecologists and Mothers and Babies Reducing Risks Through Audits and Confidential Enquiries (MBBRACE-UK).

Guidelines, policies and standard operating procedures were reviewed and discussed during governance meetings. Staff also shared any updates and NICE guidance bulletins in daily safety huddles.

Policies and procedures were available on the trust intranet page for all staff, making them easily accessible. Policies appropriately referenced current good practice and national guidelines and documents contained clear guidance, referral flow charts, escalation pathways and other information. We noted during inspection that some guidelines and policies were past their review date. These included the policy for management of ante-natal and postnatal mental health disorders. We raised this to the trust at the time of inspection.

The service participated in the trust's audit programme, with audits compared to recognised standards and guidelines both internally and nationally.

We checked resource folders containing different documents available for staff reference in the birth suite. These included guidelines for severe pre-eclampsia; eclampsia; antepartum and postpartum haemorrhage; shoulder dystocia; umbilical cord prolapse; uterine inversion; anaphylaxis and local anaesthetic toxicity.

The service had also developed a local integrated care pathway for the management of stillbirth in second trimester and from 24 weeks' gestation.

Nutrition and hydration

Women in labour were supported to eat light food and drink fluids according to their choice. Midwives monitored women's fluid intake following caesarean section and jugs of water were provided.

Women were provided with hot meals during their inpatient stay. Menu choices were available to meet cultural and religious preferences.

A specialist midwife and support workers assisted women with infant feeding. They supported women with breast and bottle feeding, both on the ward and in the community either face-to-face or by phone. There was a breast-feeding room on the maternity ward with comfortable chairs

and access to breast pumps if required.

The service achieved level three accreditation for UNICEF's Baby Friendly Initiative. The Baby Friendly Initiative is a nationally recognised accreditation programme that trains health professionals to support mothers to breastfeed and help parents to build a close and loving relationship with their baby, irrespective of feeding method.

Tea and coffee facilities were easily accessible 24 hours per day for women and their partners in the inpatient areas.

Pain relief

Staff provided pain relief for women when they needed this.

Midwives could routinely administer simple analgesia such as paracetamol or ibuprofen, unless this was not indicated. Women had access to a variety of pain relief when in labour including Entonox, dihydrocodeine and epidural.

Midwives offered alternative forms of pain relief to women, including the use birthing pools and aromatherapy in both the labour ward and birth centres.

Women we spoke with on the postnatal ward said they had been well supported with pain relief and were comfortable. Midwives frequently checked women's comfort and asked if they needed any pain relief; they also responded promptly when women asked for any pain relief.

Patient outcomes

National Neonatal Audit Programme

In the 2017 National Neonatal Audit the trust's performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 185 eligible cases identified for inclusion. Of these, 85.1% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate, where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit's recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

There were 61 eligible cases identified for inclusion. Of these, 36.1% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was lower than the national aggregate of 43.5%, and put the hospital in the middle 50% of all units.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

This was noted to have improved at the time of the visit in December 2018, Magnesium Sulphate compliance for eligible women was 100% in the month.

Standardised Caesarean section rates and modes of delivery

From April 2017 to March 2018 caesarean section rates were similar to expected for both elective and emergency caesareans.

Standardised caesarean section rate (April 2017 to March 2018)					
Type of caesarean	**England**	**Bolton NHS Foundation Trust**			
	Caesarean rate	**Caesareans (n)**	**Caesarean rate**	**Standardised ratio**	**RAG**
Elective caesareans	12.4%	606	10.9%	92.8 (z = -0.7)	Similar to expected
Emergency caesareans	15.9%	996	17.9%	112.8 (z = 1.0)	Similar to expected
Total caesareans	**28.3%**	**1,602**	**28.8%**	**104.3 (z = 0.6)**	**Similar to expected**

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery, the table below shows the proportions of deliveries recorded by method in comparison to the England average from April 2017 to March 2018:

Proportions of deliveries by recorded delivery method (April 2017 to March 2018)			
Delivery method	**Bolton NHS Foundation Trust**		**England**
	Deliveries (n)	**Deliveries (%)**	**Deliveries (%)**
Total caesarean sections[1]	1,602	28.8%	28.3%
Instrumental deliveries[2]	701	12.6%	12.4%
Non-interventional deliveries[3]	3,252	58.5%	59.3%
Total deliveries	**5,555**	**100%**	**100% (n=596,828)**

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

1. Includes elective and emergency caesareans
2. Includes forceps and ventouse (vacuum) deliveries
3. Includes breech and vaginal (non-assisted) deliveries

Over these 12 months the trust's normal (non-assisted) delivery rate was similar to the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of 5 November 2018 the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.23 which was worse than expected.

This was up to 10% higher than the average rate for the comparator group of 6.20.

This equated to 1 extra stillbirth per 33,333 births higher than peer and so the trust were at an expected standard for a maternity unit of our size and type.

(Source: MBRRACE UK)

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff in the service participated in the regional strategic network to share best practice and participated in different audits related to obstetric care.

In the Saving Babies Lives Quality Improvement Programme, the division showed an improvement in rates of still birth. Over a 12 month period, the stillbirth rate at Bolton Hospital was reduced to 3.4/1000 births meeting the national safety ambition for 20% reduction in stillbirths by 2020 two years ahead of schedule.

The trust had an accreditation scheme for services to use in identifying their improvements. Ward M2 antenatal achieved a gold rating in this scheme, with all other areas of hospital maternity services achieving silver rating.

Quarterly audits on the use of the Mental Health Act considered both the legality of the detention process and the quality of the assessments and medical recommendations. These were reported to the safeguarding committee and escalated to the quality assurance board. The Mental Health Act administration was located within the Royal Bolton Hospital and the RAID team supported staff with the scrutiny of Mental Health Act documentation.

Competent staff

Appraisal rates

From August 2017 to July 2018, 77.5% of staff in maternity at the trust received an appraisal. This was less than the trust target of 85%.

The 85% target was met for qualified healthcare scientists, staff in the staffing group support to other qualified scientific, therapeutic and technical staff and staff in the group support to doctors and nursing staff.

However, the target was not met for medical staff or midwives and qualified nursing staff.

Staff group	Staff who received an appraisal	Number required	Completion rate	Target	Met Yes / No

Qualified healthcare scientists	3	3	100.0%	85%	Yes
Support to other qualified scientific, therapeutic & technical staff	7	7	100.0%	85%	Yes
Support to doctors and nursing staff	104	119	87.4%	85%	Yes
Medical staff	20	25	80.0%	85%	No
Midwives and qualified nursing staff	272	370	73.5%	85%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers completed staff appraisals and local records we reviewed during inspection showed these had been completed and were up to date for all staff. Completion of appraisals in the family division was 90.7% in December 2018.

The national 'advocating for education and quality improvement '(A-EQUIP) model had been introduced to replace midwifery supervision. This model supported staff with personal and professional resilience, in preparing for their appraisal and professional revalidation.

The maternity service had link nurses for learning disabilities, mental health, and safeguarding, in addition to a mental health midwife. These link nurses attended regular meetings to develop their knowledge and skills to be able to support other staff locally. Link nurses shared subject updates and contact information for relevant services; this included the rapid assessment interface discharge team.

Senior midwives supported newly qualified staff through a period of preceptorship. Junior midwives we spoke with described having good support, with this lasting for 18 months. A preceptorship file included details of local induction checklist and a departmental rotation plan. Competency booklets were kept in departments for staff to complete, with designated mentors in each area to support this process. Subjects included breastfeeding support; diabetes; bereavement; infant feeding policy and medications management. Each midwife had an individual training passport linked to the trust's electronic learning management system. Staff received prompts when training was due.

A team of five advanced midwifery practitioners worked across the service to support staff with expertise in specialist areas of obstetric care. Each practitioner had a lead area of clinical focus, including: the maternity and neonatal safety collaborative; cardiotography (CTG) monitoring; human factors; preventing cerebral palsy in preterm labour (PRECEPT); and guideline group. The overall service focus had been for cardiotography monitoring, with 93% of midwives in antenatal services and 100% of midwives on central delivery suite completing this training. The service also had a competency framework for midwifery support staff to complete.

Multidisciplinary working

Staff worked well together with in the multidisciplinary team and care was co-ordinated to provide the right support for women in pregnancy and following delivery. There was good communication

between staff both within the service and externally; staff in all parts of the service engaged with both clinical and non-clinical staff in the course of their everyday activity.

Midwifery handovers took place on the maternity ward when staff began a shift. These included clear verbal and written information about women. Handovers also included sharing of information such as changes in policies.

We observed collaborative working of all relevant health professionals providing surgical care, including midwives, obstetricians, anaesthetists, operating department practitioners and theatre nurses.

There was effective team working and communications with external agencies, including other maternity providers, social work departments and the local NHS ambulance service.

A perinatal mental health team provided support for women with a mental health need, when this was required. The perinatal mental health lead midwife worked closely with the consultant perinatal psychiatrist and community perinatal psychiatric service.

There was effective external team working. Specialist safeguarding midwives liaised with social workers when necessary. Records reviewed showed that information was shared appropriately with GPs, and health visitors as well as midwives in the community.

Seven-day services

Maternity services were available seven days a week. Medical and anaesthetic cover was provided outside of normal working hours and midwifery staff told us that they felt well supported during these periods.

Laboratory, imaging and pharmacy services could be accessed through an on-call system at weekends.

Bereavement midwives were not available at weekends to provide specialist support if this was needed. The perinatal mental health team was also not available at weekends; community link midwives provided some cover and the trust's RAID team was available seven days a week, 24 hours a day.

Midwife sonographers provided a six day service for early pregnancy assessment. Outside of this, referrals would be made to the hospital's main ultrasound department.

Health Promotion

A lead midwife for smoking cessation was available to promote the 'baby clear' initiative. Midwives checked whether women smoked during antenatal booking appointments, providing information and support to help them stop smoking. Improved outcomes in smoking cessation at delivery.

Newborn screening tests were completed with follow up referral and support for any identified needs. An antenatal clinic for BCG vaccinations was held on a weekly basis.

A weekly frenulotomy clinic had been introduced to treat babies with tongue tie. This allowed babies to have corrective treatment within approximately two weeks following discharge. This corrective procedure helped babies to establish breastfeeding more easily.

Clear advice on safe sleeping for babies was provided to mothers before they left the labour ward.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards is covered within the trust's safeguarding adults level 2 training module. As of July 2018 this module had been completed by 77.7% of staff within maternity, including 88.0% of midwives and qualified nursing staff working in maternity and 83.3% of medical staff. Therefore the 95% target was not met overall, or for either of these two staff groups.

Training module	Number trained	Number eligible	Completion rate	Target	Met (Yes/No)
Midwives and qualified nursing staff	219	249	88.0%	95%	No
Medical & Dental staff - Hospital	20	24	83.3%	95%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust had a Mental Capacity Act policy that was in date and detailed the processes to be followed when assessing patient's capacity. This included a form to record formal capacity assessments.

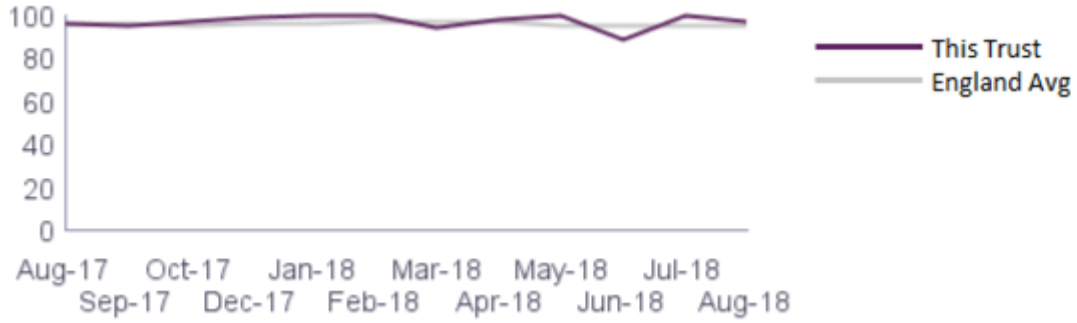
Is the service caring?

Compassionate care

Friends and family test performance

Please note that no data for the four maternity Friends and Family Tests were published by NHS England for November 2017 due to data quality concerns. Therefore, in the charts below, data for August 2017 to August 2018, excluding November 2018, have been included in order to provide 12 months of data.

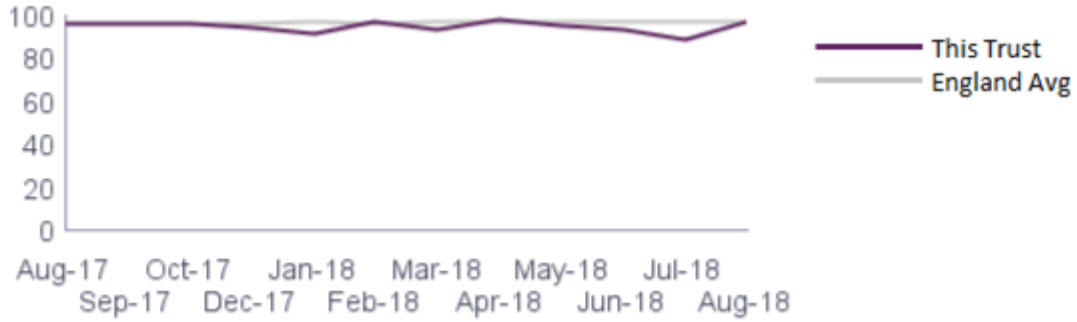
Friends and family test performance (antenatal), Bolton NHS Foundation Trust



From August 2017 to August 2018, excluding November 2017, the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was mostly quite consistent.

The trust's worst performance was in June 2018, when it scored 89% compared to the England average of 96%. Otherwise the trust's performance never fell below 95%, and was consistently quite similar to the England average.

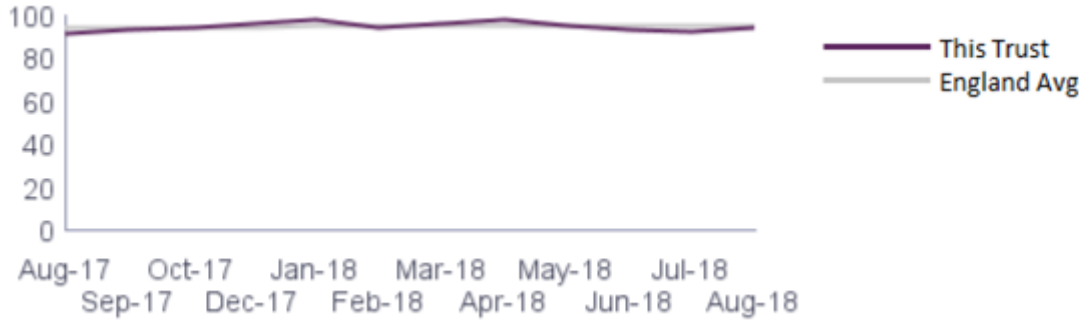
Friends and family test performance (birth), Bolton NHS Foundation Trust



From August 2017 to August 2018, excluding November 2017, the trust's maternity Friends and Family Test (birth) performance (% recommended) was mostly consistent.

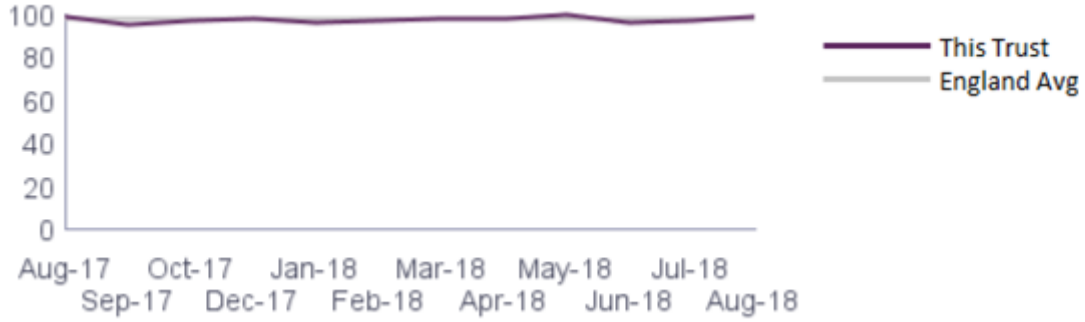
The trust's worst performance was in July 2018, when it scored 88% compared to the England average of 97%. Otherwise the trust's performance never fell below 92%, and was consistently similar to the England average.

Friends and family test performance (postnatal ward), Bolton NHS Foundation Trust



From August 2017 to August 2018, excluding November 2017, the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was consistent. The trust's performance never fell below 92%, and was consistently similar to the England average.

Friends and family test performance (postnatal community), Bolton NHS Foundation Trust



From August 2017 to August 2018, excluding November 2017, the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was consistent. The trust's performance never fell below 95%, and was consistently similar to the England average.

(Source: NHS England Friends and Family Test)

CQC Survey of women's experiences of maternity services 2017

The trust performed similarly to other trusts for all 19 questions in the CQC maternity survey 2017

Area	Question	Score	RAG

Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.7	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	8.3	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.2	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	8.8	About the same
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	9.3	About the same
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	7.8	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	7.9	About the same
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.4	About the same
	If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time	9	About the same
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.6	About the same
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.4	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.3	About the same
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	7.8	About the same
	Looking back, was there a delay in being discharged from hospital?	6.1	About the same
	Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?	8	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8	About the same
	Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?	5	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	9.1	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.6	About the same

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Midwives introduced themselves and communicated well to ensure women's understanding. There was a caring culture fully embedded across the service. Throughout our inspection we saw exemplary patient-centred care being given, and this was confirmed in patient feedback.

Time spent with women was not rushed, and care was delivered with kindness, compassion and understanding, which extended to the whole family.
Staff were enthusiastic to ensure that women with additional needs were supported, and staff at all levels spoke about how they could enhance the patient journey.

Women we spoke with said staff respected their privacy and dignity at all times and always asked if they would like curtains closed while breastfeeding.

Emotional support

Staff provided emotional support to women to minimise their distress.

Staff were aware of the changing emotional states women experienced antenatally, perinatally and postnatally. They adapted their communication in response to different behaviours and were professional and encouraging when providing care. Staff supported women if they became distressed in an open environment and assisted them to maintain their privacy and dignity.

Staff supported women experiencing disorders of mental health, including anxiety and depression, throughout their maternity care. The trust were recruiting for a new perinatal mental health team and this service was currently provided by the RAID team.

We saw that staff respected women's privacy and dignity while they were undergoing surgical procedures.

Staff were sensitive and supportive to parents after the loss of their baby, providing direction for bereavement care. Midwives on the early pregnancy unit felt there could be more support offered to women after miscarriage. They were keen to improve links with the bereavement service and had arranged for additional training to improve this aspect of provision.

Understanding and involvement of patients and those close to them

Staff supported women to be actively involved in decisions about their care.

Staff spoke to women and their families sensitively and appropriately, dependent upon individual need. Partners were encouraged to attend and support women during their care. Staff respected women's choices and provided a personalised approach wherever possible.

Women and their families told us that they received relevant information in a manner which they understood. We spoke with women and their partners who told us there was a right balance of allowing parents independent choice and 'leaving mum to cope', whilst checking in to provide further information and assistance when this was needed. Parents were positive about the continuity of care available and said staff were 'great at keeping them updated'.

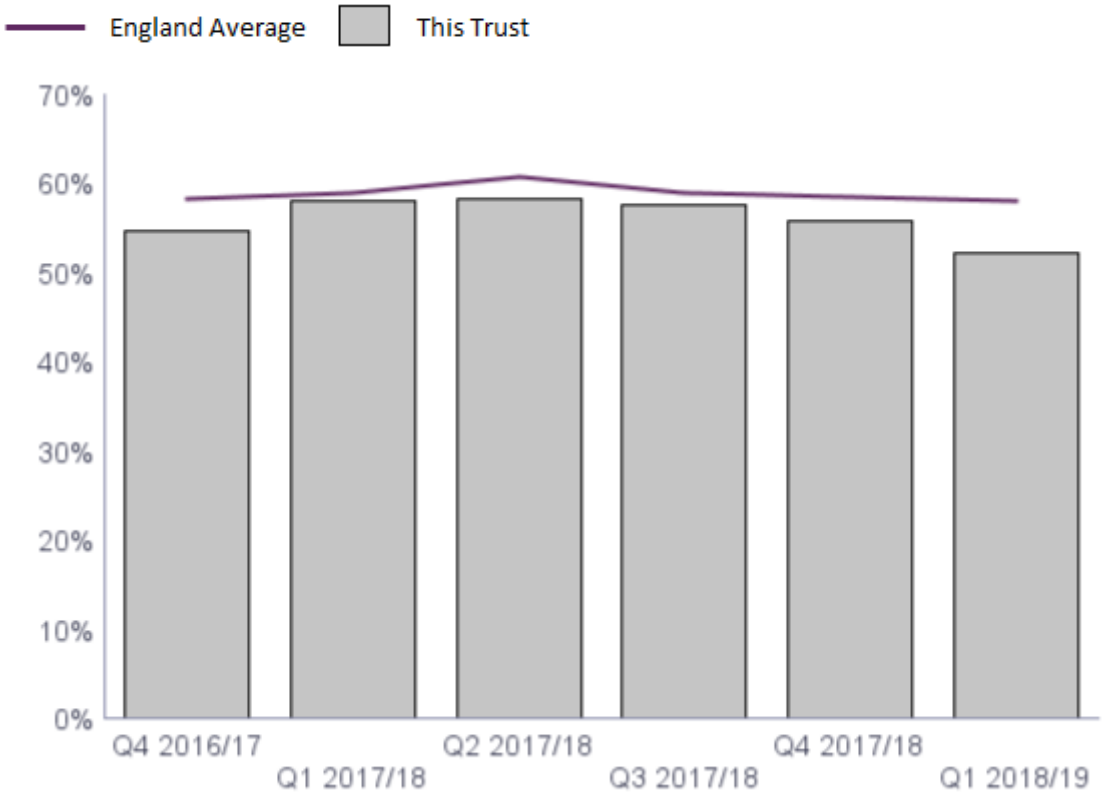
Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy

From Q4 2016/17 to Q1 2018/19 the bed occupancy levels for maternity at the trust were consistently lower than the England average. In Q1 2018/19 the trust reported occupancy of 52.1% compared to the England average of 58.1%.

The chart below shows the trust's bed occupancy levels compared to the England average over the period.



(Source: NHS England)

The service planned and provided services to meet the needs and wishes of its service users.

Women were offered choice of maternity care and as far as possible, depending on the level of risk, the service aimed to accommodate women's preferences in this. Community midwives provided antenatal care in local clinics as an alternative to hospital attendance. Community midwives also supported women giving birth at home and at the community birth centre.

Services were provided to meet the needs of the local population including special clinics and lead midwives for particular support, such as diabetes. The Ingleside midwife-led birth centre had been established to provide a community hub for the local area and had received positive feedback. From January 2019 this service would be extended to include a scan clinic two days per week.

The early pregnancy assessment unit was located as part of a gynaecology ward. Five midwife sonographers were available to provide diagnostic and growth scans for ante-natal women. There was no fetal medicine unit at the trust however obstetricians were available to advise and provide onward referral where indicated. We were informed there was limited availability for surgical evacuation after miscarriage, with two sessions per week provided for this procedure. We did not

hear of any direct impact on women or complaint regarding this issue, although some staff felt this perhaps limited women's choices.

Leaflets providing different information were available in antenatal areas wards and the community birth suite.

Maternity services provided by Bolton Foundation Trust contributed to the North West Sector Maternity Pioneer. This national programme, commissioned by NHS England, aimed to promote choice and personalisation in care; the trust was selected as one of only seven sites to offer this.

Meeting people's individual needs

The service took account of people's individual needs.

Bolton Hospital offered a VBAC service to meet the needs of women who wished to attempt a vaginal birth after caesarean section. This service was recognised as an exemplar service and as such Greater Manchester LMS had adopted Bolton's clinical guideline on this to be adopted regionally.

Information boards in ward areas displayed pictures of midwives and leaders of the service. Resources, including visual aids, were provided to support women who had a learning disability in pregnancy and labour, also for parenting education. Staff gave examples of when they had used aids to support communication including using a telephone translation service.

The lead midwife for perinatal mental health had recently started in post and was developing the service. The focus had been to update guidelines and identify systems for identifying women with mental health needs who were receiving care.

There was also good access to psychiatric input from the rapid assessment interface discharge team which was provided by Greater Manchester Mental Health trust. The team were based within Royal Bolton Hospital and provided cover 24 hours a day. Staff reported these teams were accessible, supportive and responsive when they had concerns.

Staff reported good working relationships with the learning disabilities specialist nurse who supported any adults with learning disabilities within the hospital. For women identified as having additional support needs, a care plan was developed antenatally and included identified supports, for example the allocation of a side room, a longer stay if they wished, and a named visitor being able to stay with them.

Midwives and maternity support workers provided advice and guidance to support women with breastfeeding. Women we spoke with described this as 'brilliant' and staff were 'amazingly patient'.

The service supported women with physical disabilities in different ways. Staff described how they assessed individual needs on a case by case basis. Equipment was sourced where needed, including specialist beds and steps.

On the postnatal ward, women whose babies were receiving care on the neonatal unit were accommodated in one bay where possible.

The service had two bereavement midwives to provide support for parents following the loss of their baby following a scan or during delivery. If the pregnancy was lost under 16 weeks, care was managed through the early pregnancy unit; if over 16 weeks care was managed in the central delivery suite. Bereavement midwives had prepared grab bags for midwives to use in supporting bereaved parents. These contained different information, including a hospital chaplaincy leaflet;

parking permit for bereaved parents; and care pathways for under and over 24 weeks gestation. Bereavement midwives said they responded to individual needs and took direction from parents accordingly, allowing time for parents to absorb information and reach any decisions they needed to make. A bereavement suite was available on central delivery suite for parents' use, offering parents private facilities and time for recovery in the days following their bereavement. The suite had a double bed and a sitting area, with tea and coffee making facilities. The service had developed a comprehensive support package for bereaved parents, including memory books and keepsake boxes for personalisation. These contained packets of seeds for sowing in the chapel gardens and at home if parents wished. A multi-faith chaplaincy service was also available for families who wanted this support.

Access and flow

People could access the service when they needed it. However we saw antenatal services were very busy with long waiting times.

The helicopter bleep system helped with staffing and managing patient flow through different service areas.

The early pregnancy unit was available between 8am and 6pm. Outside of this, women were directed to the gynaecology ward and followed up as required.

Midwives in ante-natal clinics monitored appointment attendance and followed these up where women had failed to attend. Midwives would check electronic patient records for any admission and the patient booking system for any change of address. They would follow up with direct phone contact and text messaging, raising any safeguarding concerns where needed. Midwives told us there was a 9% 'did not attend rate' for booking in appointments.

We saw during inspection the antenatal day unit was very busy. The waiting area for this unit had eleven women waiting to be seen, with others also waiting in the main ante natal waiting area. Two more women were also waiting at the antenatal day unit reception area. Medical and midwifery staff said this was 'becoming the norm', due to the need for daily CTG monitoring, in accordance with new guidelines for reduced fetal movements. The clinic was running three hours behind and there was no communication of waiting times to women in waiting areas.

Women were supported with enhanced recovery on postnatal wards following Caesarean section; improved pain management allowed women to be discharged the day following surgery. Women told us they felt comfortable with discharge arrangements and that even when this was planned, they did not feel pressured to leave if they were uncertain and did not feel ready to go home.

Staff worked actively with other agencies to ensure appropriate discharge arrangements for people with complex health and social care needs. Outreach midwives supported women following discharge from the postnatal ward. Staff said there had been an improvement in this service, with the identification of an outreach midwife on call to receive referrals. The learning disability specialist nurse also provided support to coordinate with community services.

Learning from complaints and concerns

Summary of complaints

From September 2017 to August 2018 the trust received 38 complaints about maternity. For the 34 complaints that had been closed at the time of data submission, the trust took an average of 39.5 working days (mean) to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 35 working days.

The four complaints that had not yet been closed had been open for an average of 20.0 working days at the time of data submission. This was in line with the policy statement that complaints should be responded to within 35 working days.

The breakdown by subject can be seen in the table below.

Subject	No. of complaints
Clinical care	25
Delay in diagnosis/test results/treatment	4
Communication	4
Appointments	2
Attitude of staff	1
Medication	1
Consent	1
Total	**38**

The majority of these complaints concerned five reporting units:

- Post-natal wards (M4 and M5): nine
- Birth suite (midwife-led): seven
- Ward M2 (high risk antenatal inpatients and induction of labour): five
- Antenatal clinics: four
- Ward M6 (early pregnancy unit): four

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From October 2017 to September 2018 the trust received 12,292 compliments about maternity. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Learning from complaints was presented at quality forums and divisional board to ensure continued improvements in reponse to women's experiences.

Is the service well-led?

Leadership

Managers at all levels had the right skills and abilities to run the service and provide high quality sustainable care.

Leadership of the division was strong and arrangements for oversight of services were clear. Whilst the service had been in a period of change until early 2018, we saw there was effective and knowledgeable teamworking between senior divisional leaders, with evidence of progress gained over a short time. Leaders shared a deep understanding of the service context, both internally within the trust and externally, within the wider local health economy.

Senior leaders had reviewed the divisional leadership structure to provide a comprehensive management system across the service, with implementation from January 2019. Staff in senior positions were currently working towards this new structure, whereby the consultant midwife,

governance lead and deputy head of midwifery all reported directly to the head of midwifery for day-to-day operational and strategic service management.

All staff we spoke with in leadership positions were enthusiastic and worked well together, with a central focus on the needs of women and their babies. We saw there was a positive approach to development of the maternity services, which was both ambitious and realistic. Leaders were aware of the different challenges within services and action plans identified targeted improvements for responding to these challenges.

The divisional directors reported to the trust's executive leadership and service progress was routinely monitored at strategic and operational levels. Communications with executive leaders were described as 'constant', with regular contact between the deputy director of nursing and the head of midwifery; we were told there was a strong strategic focus on maternity services.

We also saw there was established and clear leadership at local level in all areas of the service we visited. Matrons, ward managers and staff were clear about their responsibilities and communications were good. Staff felt supported their work and all said they had access to guidance from leaders when they needed this, although we did hear isolated comments from a few staff members in contrast with this view. All staff we spoke with told us their managers were visible and encouraging and that they had regular meetings together, although again there were exceptions to this.

Overall, staff particularly acknowledged the head of midwifery for the improvements and leadership of the service since coming into post during 2018. We heard some matrons described as 'amazing' and showing 'outstanding leadership'. Staff described communications with leaders as open door access and "an equal, two-way process".

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The maternity service strategy was identified in the overall family care divisional strategy. The strategy was based on key national programmes and initiatives in maternity services, including saving babies' lives; spotlight on maternity; better births; and spotlight on maternity. The main focus of the maternity strategy was to ensure robust plans were in place for the delivery of both the local and national initiatives. The identified strategic aims were to continue with the maternity quality improvement programme; to promote Ingleside and monitor the effectiveness of care; to implement a perinatal mental health pathway; to implement an improved pathway for diabetes in pregnancy; to develop advanced midwifery practitioner role; to improve the maternity voice partnership role; and to further develop new roles. The maternity strategy was reflected as part of the trust's overall strategic direction.

The trust had a set of values which were promoted in communications to the public and members of staff across the trust. Staff we spoke with could readily identify the trust values said these were meaningful and relevant to the work of the service. The values themes of vision, openness, integrity, compassion and excellence were used by staff to focus discussions during their appraisals. We saw during inspection that staff routinely demonstrated behaviours which were in accordance with the trust values.

Progress in delivery of the strategy was monitored at divisional and trust board level. Staff we spoke with said they were aware of the future direction and general plans for the service; there had been opportunities to contribute their views towards this planning and there was good communication from the division and trust.

The service had a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually. This was reviewed every two months at the safeguarding committee and annually by the board.

Culture

Managers promoted a positive culture that supported and valued staff, and created a sense of common purpose based on shared values.

There was an open and transparent culture in the service and all staff we spoke with were passionate about the services they worked in and the achievements they had made. Staff of different grades reflected that following a number of changes in the leadership of the service during the past year there was now a feeling of greater confidence within the service. Staff were clear about their roles and felt they had good support from managers and were valued by the trust for their work. Morale was high and staff were enthusiastic; they felt involved in the future development of maternity services.

Staff automatically supported each other in different ways; there was a strong sense of teamworking which was focussed on providing the best care for women. We saw each member of staff had a commitment to the service and there was a high level of mutual respect and appreciation between all members of the team. The service encouraged openness and honesty at all levels and we saw there was a positive attitude to sharing and learning from incidents.

We spoke with staff who said they felt able to raise issues of concern to managers, without fear of retribution, although we did not hear of any examples of when they had done this. Staff were aware of the trust's Freedom to Speak Up Guardian and the purpose of this role. Since 2016, all NHS trusts are required to have a Freedom to Speak Up Guardian to support staff and promote a culture of speaking up, in situations where they may have identified concerns.

Staff followed trust procedures and were aware of how to seek direction when this was needed. Many midwives told us they appreciated the independence they had an opportunity to lead different service developments, whilst still having 'open door' access to senior leaders when required.

Managers and senior leaders promoted a holistic approach in delivery of the maternity service, in which all members of the team were aware of and contributed in the different parts of the service. Midwives could work flexibly between different areas of the maternity service when this was needed and had a comprehensive understanding of the maternity service. Both the maternity community teams and hospital services communicated well together to provide seamless care for women before, during and after the birth of their baby.

Governance

The service used a systematic approach to continually improve service quality and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

There was an established trust committee structure for monitoring clinical quality and patient safety, with monthly governance meetings attended by divisional service leaders. Divisional leaders had undertaken different reviews to benchmark performance and improve outcomes in maternity services. These reflected national initiatives, such as the Royal College of Obstetrics and Gynaecology's 'each baby counts' programme, with results used to monitor continuing progress. The service had continuing action plans for all areas of the programme, including reducing smoking, reduced fetal movement, and growth restriction; although there was a particular focus on the fetal monitoring element of the programme.

Senior leaders had previously identified a need to strengthen the governance arrangements within the division and told us they now had greater assurance regarding these. A full review of governance processes had been completed, with establishment of a lead midwife role for quality improvement and service development. In addition, a quality improvement midwife educator and a clinical audit standards midwife supported staff at ward level. The midwife educator visited different areas of the service, promoting information updates and resources to assist staff awareness of safety and quality in maternity care. We saw quality was a central focus of the service and staff were fully engaged with this learning.

The service had implemented extensive learning arising from serious incidents, with resulting changes in practice following this. All staff received regular feedback from lessons learned and could access further guidance through the trust's intranet. Departmental meetings were also held each month for staff to share any updates.

The service had adopted the 'advocating for education and quality improvement' (A-EQUIP) model to replace midwifery supervision. This model supported the continuous improvement process through enhancing quality of care. Leaders identified a local A-EQUIP plan, linked to the regional strategic clinical networks. Seven local midwives had completed training for this, with a further two due to complete and a rolling two year programme to support continuing future development.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with the expected and unexpected.

The service had a risk register which identified key risks and progress in actions to mitigate these. Divisional leaders and managers had good awareness of service risks and could provide current updates of the actions to reduce these. Risk registers were reviewed at monthly quality and safety meetings, with escalation of any risks to the corporate risk register where this was indicated. Senior staff including governance leads, consultants, matrons and ward managers attended these meetings, to review relevant issues, regarding the risk register, safety incidents and performance.

The service achieved compliance with the 10 safety criteria for the NHS maternity safety strategy clinical negligence scheme and was allocated a rebate on the basis of this.

At the time of inspection, leaders identified the management of diabetes in obstetric care as the highest risk within the service.

The head of midwifery held a monthly 'directorate surgery' for staff to discuss risks and raise any issues of concern. We heard positive comments from different members of staff about the value of the directorate surgery as a mechanism for sharing information. Risk meetings were held weekly on delivery suite, open for all staff to attend.

The director of nursing had lead responsibility for mental health within the trust. There were clear reporting and escalation procedures.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Senior staff had access to the information they needed to monitor performance and to ensure there was sustained or improved standards of care. Clinical staff had access to patients' investigation results and there were no concerns regarding any delays in receiving these.

Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues. Staff could access relevant information, such as policies and other guidance, via the trust's intranet.

The service used different IT systems for certain activities. The electronic patient record was accessible to all midwives, providing details of the woman's pregnancy and history. A separate electronic system was used for monitoring women in labour and delivery. Some staff said it would help if these electronic systems could communicate with each other.

Engagement

The service engaged well with patients, staff and the public to plan and manage appropriate services and collaborate with partner organisations effectively.

Services were delivered as part of a local maternity system partnership across the region, in engagement with the Greater Manchester and Eastern Cheshire Local Maternity System. Local maternity system network meetings and monthly divisional board meetings were held at Ingleside birth unit. Staff of different levels participated in different clinical and non-clinical network meetings across the region.

Bolton Hospital have an active MVP (Maternity Voices Partnership) chaired by a service user. The service users participate in key events such as appointment of key roles in the maternity service.

The safeguarding named midwife had organised a multi-agency study day on female genital mutilation. Professionals from different organisations and services participated in this, including general practitioners, police, maternity, sexual health and gynaecological services.

Midwives and neonatal services were working together in a project to develop transitional care pathways. This work was focussed on supporting babies born pre-term, from 33 weeks gestation and above. Staff described this as an 'exciting project', involving partnership working across the regional maternity network.

A baby memorial service was held once a year for parents and families. The local university had designed a sculpture for the hospital gardens as a memorial; this was in the form of a tree with hands representing parents and families. The hospital also participated in the 'wave of light' global commemoration for families to light a candle in the baby garden. Local supermarkets provided refreshments for the occasion.

Junior doctors were well supported with listening lunches events for responding to feedback.

Staff received trust and department communications regularly. The service had an employee of the month scheme, with staff rewards.

The Ingleside community midwife led birth centre had undertaken comprehensive engagement activity during the planning and establishment of the centre and this was a continuing and central element of the service. Representatives from key services and community groups, including the maternity voice partnership and local authority, had participated in this engagement. Sexual health clinics and citizens advice services were available as part of the community hub provision. A local artist had designed and produced cards titled 'a baby born in Salford' to be given to the first 1000 babies born at Ingleside. The service had a Facebook page with 2000 followers and had developed a promotional video, including women sharing their experiences of the birth centre. The centre had held a celebration event to mark the international day of the midwife, attended by the heed of the Royal College of Midwives, the local mayor, choir and symphony orchestra.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There was a proactive approach to innovation in the service, with a strong focus on a culture of safe care. All staff completed human factors training as part of mandatory training and had awareness of learning from situations and incidents when they occurred.

Consultant obstetricians held special interest group meetings every three months with clinical staff in the service.

One midwife had completed a postgraduate qualification for examination of the new-born and was able to use this knowledge in their role.

Advanced midwifery practitioners provided teaching sessions in local universities for midwifery students.

The specialist midwife for perinatal mental health had completed a training course with the NHS advancing quality alliance programme; this was focussed on continuity of care.