Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Bolton NHS Foundation Trust - HQ

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Bolton NHS Foundation Trust
Overview of the service	Bolton NHS Foundation Trust serves the population of Bolton, which is approximately 264,000 and from neighbouring towns.The Royal Bolton Hospital provides a range of clinical services including in patient and out patient care and is a centre of excellence for maternity, neonatal and children's care. It is easily accessible via public transport and from the close motorway network.
Type of services	Acute services with overnight beds Community based services for people with mental health needs
Regulated activities	Diagnostic and screening procedures Maternity and midwifery services Nursing care Personal care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Bolton NHS Foundation Trust - HQ had taken action to meet the following essential standards:

- Cleanliness and infection control
- Staffing
- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 9 September 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by local groups of people in the community or voluntary sector and talked with other regulators or the Department of Health. We talked with other authorities and talked with local groups of people in the community or voluntary sector.

What people told us and what we found

During the inspection we visited C2, C3, D2, F3, Maternity Theatre and the Clinical Decisions Unit (CDU). We spoke with a total of 15 staff, including medical, nursing and support staff, 10 patients and four visitors.

We observed the general environment on the wards and departments visited was clean and well organised. Public corridor areas were free from clutter and were clean. Infection control links from ward and department staff had been identified and when we spoke with them we were told: "I take this very seriously and the rest of the staff do as well" and "I think the whole hospital is tackling this problem much better, we can get guidance from the infection control team but then it's about making sure that guidance if put into practice".

We spoke with patients who said: "I think this ward is very clean, you see staff washing their hands, even the doctors use that spray", "The ward is clean, I have been here for three days and the ward is cleaned every day", "The staff work hard to keep it clean" and "I am very happy with the standard of cleanliness, the whole place is much cleaner".

The trust had, since the last inspection, committed to invest in a significant increase in nursing and support staff, with a view to reducing the use of bank staff and was on track to fill vacant posts.

We found the trust had improved systems to identify, assess and manage the risks to the health and safety and welfare of the patients using the service.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

Following an inspection in April 2013 a compliance action was made.The Trust was to take action to comply with the required standard and regulation for cleanliness and infection control.The Trust submitted a robust action plan to the Care Quality Commission and this follow up visit was made to review progress.

We observed the general environment on the wards and departments visited was clean and well organised. Public corridor areas were free from clutter and were clean. At the last visit we found particular issues with one ward and so we spent time on this ward speaking with patients and staff. We saw equipment used on the ward was clean and free from dust. We examined all toilet and bathrooms and found these were clean and well maintained. Each was well stocked with soap, in wall mounted dispensers, and paper towels.

We spoke with patients who said: "I think this ward is very clean, you see staff washing their hands, even the doctors use that spray", "The ward is clean, I have been here for three days and the ward is cleaned daily", "The staff work hard to keep it clean" and "I am very happy with the standard of cleanliness, the whole place is much cleaner".

Visitors told us: "I was frightened to bring my X here after all you read about this place, but I have had no reason to complain about the cleanliness", "This ward is spotless; I haven't seen anything worry about", "I think the hospital is looking cleaner and better maintained right from the entrance", "I feel the staff here try their best to keep on top of things, patients and visitors have a responsibility as well".

A director of nursing had been recruited since the last inspection with the responsibility of lead director of infection prevention and control (DIPC). NHS trusts are required to appoint a senior manager to take the lead, under the Health and Social Care Act 2008, Code of

Practice on the prevention and control of infections.

We found the infection control committee was a more integrated committee, which included representation from the hospital and community health partners, including local authority representation from public health.Terms of reference and membership were updated. We reviewed minutes from the meetings and saw attendance had improved from all directorates. Leadership for infection control was improved with the appointment of two full time microbiologists.

We discussed the implementation of the C Difficle (C Diff) and infection control plan with one of the microbiologists and a consultant who was leading for infection control and prevention with medical staff. We were told all actions had been implemented. This included raising the awareness of all staff throughout the trust on infection control and prevention, strengthening the infection control committee, and implementing a more robust response to any infection outbreak.

Policies were being updated with the assistance of some junior doctors who had particularly expressed a wish to be involved in infection control in their specialities. Comments included: "We are slowly changing the attitude to infection control on all the wards not just the problem areas", "We have found staff are very committed" and "We have a cohesive team now who have a focus and aim to tackle infection control within the trust".

We reviewed the latest infection control data and although the trust were still at a high level for C Diff infections against its annual target, length of days between each case was increasing and the number of cases were slowly beginning to reduce.The trust had no cases of methicillin- resistant staphylococcus aureus (MRSA) at the time of the inspection.

We noted the trust had progressed well with a programme of deep cleaning, fogging and remedial work for each ward. Fogging machines had been purchased by the trust, with responses to any cases of c diff much quicker.

Wards were being transferred in turn as part of the "decanting" programme. This allowed deep cleaning and remedial repair work to the fabric of each ward so future infection control procedures were not compromised. We saw hand wash basins were now being placed at the entrance to wards where possible to ensure staff and visitors carried out hand washing before entering. Where sinks were not at the entrance, hand gel was available, along with notices instructing staff and visitors to ensure they washed their hands at the nearest sink as soon as possible.

When we spoke with staff it was clear that infection control and prevention was high on everyone's agenda. Awareness had been raised and when we spoke with staff we were told: "Infection Control is everyone's responsibility"," I have no problem asking visitors to wash their hands", "I think we are all putting infection control first now in everything we do, it's important for everyone that we are seen to be doing everything possible to stop infections spreading".

Cleaning schedules and infection control procedures had been reviewed. Audits of mattresses and pillows were undertaken each month, with a weekly check being undertaken by each ward and department. Hand washing audits demonstrated a more realistic outcome, with staff promoting hand washing amongst anyone entering the clinical areas.

Infection control links from ward and department staff were identified and those we spoke with explained: "We have had additional training to be able to carry out this properly, we get the time of the wards to attend meetings and then to ensure we have the opportunity to feed back to staff on the ward".

We found appropriate isolation facilities on wards and departments, with work undertaken to close open bays to contain and control any outbreaks more effectively, when side rooms were not available.

We observed good hand washing techniques and frequent hand washing and we observed one doctor using hand gel before moving to a different patient and then when returning to the nursing station to write notes.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

At the last inspection we were aware of a review of the staffing establishment across the trust and the lengthy consultation the trust had undertaken with staff and the staff side unions.The trust had, since the last inspection, committed to invest in a significant increase in nursing and support staff, with a view to reducing the use of bank staff.

The director of nursing explained recruitment events were still on-going and had been well attended.The process was slow but the trust wanted to retain the highest standard of staff as possible.The trust was supporting the continued use of bank staff until vacant posts had been appropriately recruited to.

We found the trust had implemented a system to report any staffing issues on a daily basis, supported by a procedure for staff to escalate to senior managers, any staffing concerns.

When we spoke with staff on the wards we visited we were told: "I think staffing levels are slowly improving", "We know we are getting to the right levels" and "Staffing levels are ok at the moment but can always be better".

Ward managers told us: "Recruiting staff is a long process but with the assessment centres, at least we know when staff start on the wards, it's the right speciality for them, we don't have staff leaving after a few weeks because it's not for them" and "Staffing levels are getting better, there is less use of bank staff, although when needed you know you are supported in finding staff as quickly as possible".

We found the majority of wards and departments had implemented a two shift pattern of working, with other wards visited ready to commence the system from the end of the month. Staff we spoke with expressed support for the shift patterns, explaining that there was no hand over period and the time was now better spent with patients.

It was clear the trust had supported other staff members who did not want to move over to this system. One staff member said: "I don't work the long days but I don't think that puts me at any disadvantage, I still feel part of the team and it fits in with the duty rota. I am happy to work anything extra as needed".

On the wards we visited we saw that staffing levels were consistent, with ward managers able to utilise bank staff as required for short term sickness and absence. Ward managers were now taking a "supervisory role". One manager told us this enabled her to take a step back and ensure that she provided a better leadership role and focus on quality and reducing risks within the clinical area.

We saw more robust scrutiny of staffing levels across all wards and departments with establishment levels, posts recruited to, forthcoming interviews and remaining vacancies being reviewed by senior managers and the director of nursing. It was clear the trust was on track to improve and maintain staffing levels.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We found the trust had improved systems to identify, assess and manage the risks to the health and safety and welfare of the patients using the service.

The integrated performance dashboard was more robust and gave a clearer picture of overall quality and risks. The latest dashboard demonstrated the trust was performing well in most key areas, with the exception of cases of C Difficile and pressure ulcers, however more robust action plans to address areas of concern were in place.

The trust was progressing well through the recovery plan agreed with Monitor and other external agencies.

We discussed how the trust board non-executive members were assisted in having an improved scrutiny of data presented at meetings. We were told that there was more challenge from board members and a more detailed explanation of data and responses, rather than just an acceptance of the data presented.

We were told members had a clearer picture of the impact of performance of the trust on patients. When required quality exception reports were also presented to the board. This gave a better understanding of what actions had been undertaken to address issues of concern.

Patients were now invited to board meetings to discuss their personal experiences of the service and the care they had received.

"Patient Stories" provided an opportunity for patients to highlight when they had experienced both positive care or care which they felt had fell short of expectations, or raised concern. It was clear from minutes of board meetings that learning for the trust was noted and action taken.

Daily incident reports continued to be reviewed by executive managers. Staff on the wards and departments told us visits were continued to be made to the ward by the executive

who was "buddy" for that area, to discuss any incident and establish action taken. Staff said they found this very useful and that they felt better supported by senior managers. Staff explained this had also enabled them to understand more about the executive team and the restraints in resources of the trust.

Staff said that senior managers were more visible on wards and departments. A programme of patient safety walk abouts had been implemented. Visits were undertaken by executive and non-executive board members, members of council of governors and the clinical commissioning group, responsible for monitoring the quality and performance of the trust.

We spoke with two governors during the inspection. They confirmed they had been invited to participate in patient safety walk abouts. One governor said that the trust had begun to "turn a corner" and felt that they received better information about the quality performance of the trust. Another said they felt able to challenge data presented and felt that senior managers were more open. We were told: "The trust now has a more stable board and senior clinical managers, progress is being made, even with the c diff issue, the trust is working through the agreed plan following the input from external expert".

Shared learning from serious untoward incidents had improved. Reports to the quality assurance committee were
summarised with clearer actions, accountability and responsibilities. One example was a lessons learnt newsletter.
This was produced by one of the Obstetrician's on the maternity unit, to highlight incidents and the subsequent actions taken.This was then disseminated across all other specialities across the trust to encourage shared learning and to help minimise risks.

The audit programme across the trust had been sustained. Risk management was further embedded in the culture of the organisation, with stronger leadership and emphasis on improving quality and reducing risks.

The trust had sought external advice and a Risk Management Improvement Programme Road Map was in place. A new board assurance framework was to be presented at the next board meeting. A redesign of the risk management system and escalation process was planned to provide a simplified risk management process across the trust.

Staff told us they felt the leadership in the trust had improved and that they had been given more opportunities to discuss issues. We were told: "I think things have got better recently, certainly I feel more valued", "We have more time to discuss issues and we can see that things are beginning to improve" and "This trust has taken a battering and a lot of staff felt let down, but most staff are working hard to improve care".

Patients told us:"The staff on the ward have been great, they work hard and really are caring", "I have had a problem with one member of staff and I spoke with the ward manager; it was sorted quickly", "I have no complaints at all, the staff have explained everything" and "Every one of the staff have been kind, nothing is too much trouble".

Visitors also said: "I am grateful for the care shown to my X, they are doing a great job" and "I know this hospital has had problems but I can't say anything negative" and "My X was very poorly and the care and dedication given was second to none".

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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