Royal Liverpool and Broadgreen University Hospitals NHS Trust

Quality Report

Royal Liverpool University Hospital
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Date of publication: 02/07/2014
Date of inspection visit: 28-29 November and 11 December 20

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

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Overall summary

The Royal Liverpool and Broadgreen University Hospitals NHS Trust is one of the largest hospital trusts in the north of England serving more than 465,000 people in Liverpool. The trust currently delivers acute services from two sites: Royal Liverpool University Hospital and Broadgreen Hospital. It also includes the Liverpool University Dental Hospital at a third site. There is a new hospital project underway which is due for completion in 2017. As well as providing general services to local communities, the trust provides regional and national specialist services and is considered to be one of the UK's leading cancer centres. The trust is closely linked with the University of Liverpool and John Moores University for teaching and research.

The Royal Liverpool University Hospital is the largest hospital in Merseyside. It has over 40 wards, more than 750 beds (excluding day case and dialysis beds). It has the main accident and emergency department for the city of Liverpool capable of dealing with major trauma and life threatening illness. Broadgreen Hospital is the main location for the trust's elective general, urological and orthopaedic surgery, diagnosis and treatment, along with specialist rehabilitation. It has 3 medical wards, 2 surgical wards, a theatre suite and a Postoperative Extended Care unit (PAECU).

We inspected this trust as part of our new in-depth hospital inspection programme. It was being tested at 18 NHS trusts across England, chosen to represent the variation in hospital care across England. Before the inspection, our 'Intelligent Monitoring' system indicated that the Royal Liverpool and Broadgreen University Hospitals NHS Trust was considered to be a low-risk provider. CQC had inspected across both of the acute sites four times in total since it was registered in April 2010. It had always been assessed as meeting the standards set out in legislation.

Before the visit our analysis of data from our 'Intelligent Monitoring' system indicated that the hospital was operating safely and effectively across all key services. The trust's mortality rates in cardiology, other injuries and conditions due to external causes and miscellaneous were worse or much worse than expected although in infectious diseases they were much better than expected. The trust had been identified as a mortality outlier for patients admitted as an emergency case with an acute myocardial infarction. Investigation by the trust concluded that this was due to miscoding and action plans were put in place which will be monitored by the CQC local compliance team. We also reviewed information that we had asked the trust to provide and received valuable information from local bodies such as the clinical commissioning groups, Healthwatch, Health Education England and the Medical and Nursing Royal Colleges.

We also met with a group of local people representing people who can be more difficult to reach for their views before the inspection. We listened to people's experiences of the trust and during the inspection we held a public listening event in Liverpool and heard directly from 30 people about their experiences of care. We spoke with more than 100[GB1] patients throughout the inspection.

At this inspection our team included CQC inspectors and analysts, doctors, nurses, experts by experience and senior NHS managers. The team spent two days visiting the two acute hospitals, conducted a further unannounced visit a week later, and returned to Broadgreen for a follow up visit in January. Between the hospitals we held focus groups with different staff members from all areas of both hospitals and spoke to 100 members of staff. We looked at patient records of personal care or treatment, observed how staff were providing care, and talked to patients, carers, family members and staff.

Overall we found the trust provided excellent care in some areas including the end of life care service which was of a high standard and provided care seven days a week. In critical care, there was a formal critical network in place with other local trusts which ensured the needs of patients were met effectively. There was also an effective Critical Care Outreach Team (CCOT) and an Acute Response Team who support patients who had received care within the Intensive Care Unit. Medical and surgical care at the Royal Liverpool was being delivered well under difficult staffing circumstances and the staff should be praised for their commitment and hard work to

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maintain safe practice. The emergency department should also be commended for the hard work they put in to caring for the large numbers of people who attend the department.

The team were impressed with the surgical services provided at Broadgreen, seeing many examples of very good responsive care and received consistently complementary feedback regarding medical and surgical care. Wards and departments were well staffed and there was evidence of innovative practice within the surgical department and the postoperative extended recovery unit provided good care.

On both sites we met staff who were hardworking, caring and compassionate and who were proud to work for the trust. We found an open culture where staff could raise their concerns and felt supported in their roles. The trust was clean and there was hand hygiene gel available in all areas.

However, we also found there were some areas of concern which the trust must address.

Staffing was found to be adequate at the time of the inspection, but this was being supported by overtime, bank and agency work, particularly at the Royal Liverpool. The recruitment of substantive staff was being significantly delayed and this was impacting on staff morale. The excessive workload of junior doctors in vascular and colorectal surgery needs to be addressed to maintain safe and effective care delivery.

In critical care the roles of the Acute Response Team and the Coronary Care Outreach Team must be clearly defined to ensure the appropriate specialist skills are employed to deliver care to the vulnerable patients these teams care for. The response to patients whose condition is deteriorating should be improved by the support of training for ward staff in how to respond to the needs of these patients in order to ensure specialist intervention in a timely manner to promote the best outcomes. Training for ward based staff regarding the care of patients with tracheostomy will relieve the pressure on critical care beds once they can be cared for on the wards. The Postoperative critical care unit (POCCU) at the Royal Liverpool must ensure that the staff working there are appropriately trained and registered post-anaesthesia care unit practitioners. In addition, the trust must address the inappropriate use of the theatre recovery area at the Royal Liverpool as overnight accommodation for which it is not designed.

In the emergency department, the use of an observation room as overnight accommodation for which it is not designed must also be addressed. The limited allocated space between beds in the Heart and Emergency Centre is unsafe and must be addressed as it currently poses a risk to effective care if patients need emergency equipment by the bed. There were also concerns raised regarding the adherence to infection control policies in the emergency department, especially at times of high demand. Some equipment used at these times was not clean and should not have been used.

Medicines were administered and stored safely throughout the hospitals. However, at the Royal Liverpool hospital some patients informed us that they had been without at least one item of medication for more than a day during their stay and staff told us the system for obtaining medication for patients to take home once they had been discharged did not work efficiently, particularly at weekends. We noted that there was not a pharmacy service after 12 mid-day on a Saturday until 9am on Monday. This is currently having a detrimental effect on patients who are not receiving all their medication from admission and delaying discharges which is compounding the pressure for beds when the hospital is constantly functioning at high levels of bed occupancy.

There was also no electronic drug dispensing system in use in the emergency department at the Royal Liverpool. The staff told us that the pharmacy was not always open and accessible. Staff told us they did not stock all necessary drugs in A&E so they often ended up running to other wards. The emergency department was not set up for ward type drug rounds when people were accommodated for longer periods than usual meaning that the dispensing of drugs was often not safe, there was an additional drain on staff resources and records were not always kept for auditing purposes.

At Broadgreen it appeared that up until recently, transfers to the Royal Liverpool site were not being audited. This meant that staff were not able to tell us exactly how many patients had needed to be transferred between the sites and how often this occurred. Although the postoperative

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extended care unit and recovery area appeared to have very good consultant support, it was not clear to our inspection team whether this was the same on the general medical and surgical wards.

From a trust wide perspective, the excessive delays in the recruitment of substantive staff needs to be resolved to reduce the use of temporary staff therefore providing a consistent staff base on which to deliver best quality care. Improvement is required in the care received by patients not cared for on wards of the relevant speciality (known as outliers), it is essential these patients are monitored and managed robustly to ensure they receive the same level of care as patients cared for on relevant wards.

The trust is also required to improve the failings of the risk management processes for the analysis and reporting of potential risks. The evidence has shown that not all significant areas of risk are being escalated appropriately to ensure the senior management and the board are fully informed. If the risks are not fully known they cannot be fully addressed and mitigated. The risk management processes also need to interact with the information from complaints to ensure holistic learning is made and the quality of care assured. We noted that the trust reported a significantly lower number of incidents in comparison to trusts of similar size. This can mean that not all incidents are reported and therefore appropriate lessons are not being learned.

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The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

Are services safe?

We saw lots of evidence of safe care at the trust. There was good assessment of patients' needs and care was being provided appropriately to meet those needs. There were procedures in place to keep people safe and records were maintained to a good standard in most areas.

Although staffing was generally found to be adequate, we were aware that extra shifts were being covered by regular staff and that there were a number of vacancies throughout the trust. Recruitment was ongoing, but we were made aware of delays caused by the external recruitment process. On the Royal Liverpool site we had concerns around the medical staffing levels on some of the surgical wards.

The wards were clean and patients told us that they saw staff washing their hands. We found that some areas of the A&E department at the Royal Liverpool were dusty, but that their infection levels are within expected levels for a trust of that size.

Escalation procedures were in place, and staff were aware what they should do in the case of a deteriorating patient. At Broadgreen site we were concerned that potential lessons were not always being identified following situations where patients were required to be transferred to the Royal Liverpool.

Are services effective?

Patients were receiving effective care and treatment; we saw examples of good and excellent work. We found staff were following best practice guidelines when treating and caring for patients. There was clear evidence of local and national audit practice and the national stroke audit placed the Royal Liverpool third in the country for their stroke service. The Liverpool Care Pathway was no longer in use but the trust had guidance in place for people receiving care at the end of their life.

At Broadgreen, we saw examples of innovative practice within the surgical department.

Are services caring?

We found the services at the trust were delivered by a hardworking, caring and compassionate team of staff who were proud to work at the trust. All the people we spoke with were positive about their care and treatment at both hospitals. We observed staff treating people with dignity and respect and offering care to the best of their ability. We also saw examples of ways in which people were encouraged to share their thoughts of the trust.

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Are services responsive to people's needs?

We found the trust had many ways to respond to the varied needs of people who used the service. We found the palliative care responsiveness was excellent, operating seven days a week and seeing patients within 24 hours of receiving the initial referral. The accident and emergency service was responding to the varied needs of patients experiencing problems with alcohol and drugs, as well as a high number of patients who were homeless, through specific teams commissioned to expedite their safe discharge.

Broadgreen were able to give us many examples of how services had been developed in response to patient feedback, for example evening meetings for patients prior to their admission for surgery to discuss any concerns and answer questions. Supernumerary discharge planners were in place on the wards, and nurse-led discharges helped to ensure that patients were able to be discharged as soon as they were seen.

However, there were concerns at the Royal Liverpool regarding theatre recovery and the observation room CDU6 in A&E, which were being used as overnight facilities. We also noted that the Royal Liverpool site often had a significant number of patients not on the most appropriate ward. Lack of a robust bed management system meant that clinicians were not always aware of where their patients were currently situated within the hospital.

Are services well-led?

We found there was an open culture where staff could raise concerns. Doctors and nurses felt supported in their roles and training was available; they were very dedicated, compassionate and proud to work at the trust and we saw monitoring of the quality of the service was happening. Leadership at service level was apparent and at the Broadgreen site we were told repeatedly that the site team were very visible.

However, some staff said they felt that more senior staff within the organisation did not always listen to their views, despite attempts by the executive team to engage with the 'frontline' following feedback from the NHS staff survey. They felt the executive management team did not fully appreciate their workload or the effect that perceived low levels of staffing had on their morale. The risk management system failed to recognise some areas of concern despite them being recognised and reported by staff and these were not clearly acknowledged at either division or board level. The process for the analysis of incident and complaints information meant the trust was not making full use of the information, only being directed by strategic targets and serious incidents.

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What we found about each of the main services in the hospital

Accident and emergency

Overall, we found the emergency department at Royal Liverpool Hospital was generally safe and the service being provided was mostly effective. The emergency department was well-led at ward level and supported by caring staff who strived to look after all the patients. The department had many support services in place such as a liaison link for homeless people, an alcohol specialist nurse and teams to deal with patients with mental health issues. We saw these teams worked efficiently and cohesively to expedite patient discharges.

However, the physical environment in the emergency department was small and not always fit for purpose. Use of observation room CDU6 overnight was not appropriate and there were some concerns about staff not following infection control procedures.

Broadgreen does not have an accident and emergency department.

Medical care (including older people's care)

We were impressed by the medical unit at the Royal Liverpool, which showed close integration with the emergency department. Ward areas were clean, essential equipment was available on most wards and people had been provided with appropriate food and hot drinks. Most of the patients and relatives we talked to commented on the kindness, professionalism and patience of staff at all levels involved in their care. We observed the staff were hardworking and patient.

However, not all patients were being treated on the appropriate wards at the Royal Liverpool for their specific condition. This meant that some patients were being cared for by inappropriately skilled and experienced staff and there was a risk that some patients would be forgotten about due to the lack of robustness of the information held regarding the whereabouts of these patients. Review of this at the time of the unannounced inspection showed the trust did not have accurate information regarding all these patients and they did not receive the same level of medical review as those patients on the appropriate specialist ward.

There were concerns around the management of medicines as some patients had been without at least one item of medication for more than a day during their stay and the system for obtaining medication for patients to take home did not work efficiently, particularly at weekends. We were concerned to note that when patients left the ward, they are recorded as discharged on the hospital computer system, which meant that if an enquiry was made, inaccurate information could be given regarding the patient's whereabouts.

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Nursing staff shortages were noted on most wards, which were being supported by bank staff and permanent staff working overtime, although they were medically well staffed. In addition there was no system in place to establish the dependency levels of patients and amend the staffing rotas accordingly.

Surgery

Staffing levels both in theatres and on the wards were acceptable to be able to meet patients' needs in a timely manner although recruitment delays meant agency staff were being utilised for long periods. However, at Royal Liverpool the high number of vascular patients on other wards increased the workload of the junior doctors excessively. Shortages of medical staff on the some of the surgical wards (colo-rectal wards) had led to some patients not being reviewed by a senior doctor as often as necessary.

At the Royal Liverpool there was ineffective use of theatres, resulting in lists being regularly changed and operations cancelled. There were difficulties in finding patients as they were often not on the allocated wards. Surgeons had to stop operating as the recovery area was full. Since September 2013, the theatre records showed 11 patients had stayed in the recovery area overnight, three of them for two nights. When we visited for the unannounced inspection, we found that one person had stayed overnight. We were concerned about the quality of recovery including mobilisation and physiotherapy, access to medicines, personal care, and privacy and dignity of these patients. This was not the case at the Broadgreen site, where we were impressed by the care received by patients on the wards and in the theatre areas.

Theatres at both hospitals had systems in place to improve patients' safety, including team briefs and the World Health Organization (WHO) theatre checklist. We were told at Royal Liverpool that they had audited their completion rates the previous week, and were in the process of undertaking the same at Broadgreen. We were told that previous non-compliance within the department had been addressed.

Most of the staff we spoke with on the Royal Liverpool Hospital felt supported by their immediate line manager but felt that more senior staff did not listen to their views. Some staff were frustrated about the lack of their involvement in discussions about service developments, in particular the reconfiguration of the vascular service.

Intensive/critical care

At the Royal Liverpool site there are three critical care areas. There were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. However, we were concerned at the number of staff due to take maternity leave before the end of 2013 and how this would be covered with the ongoing issues with recruitment at the trust. Patients' care needs were assessed and plans were in place. There was a formal critical network in place with other local trusts to ensure that the needs of patients were met

effectively. We found the Post Operative Critical Care Unit (POCCU) functioned more like an Intensive Care Unit (ICU) with the range of care and treatment that was undertaken there. We found that the four beds within the POCCU were close together, which was a potential infection risk as well as a safety hazard.

The overall bed availability across the hospitals often resulted in people staying in the unit longer than planned or required. There were systems in place to ensure that patients were moved to the most appropriate areas of care, but it was a time consuming role to ensure patients were moved appropriately when there were no available beds. There was an effective Critical Care Outreach Team (CCOT). Staff from the CCOT followed up patients on the wards who had been cared for on ICU or High Dependency Unit (HDU) for more than four days. This gave patients the opportunity to discuss their experience of critical care and we were told that the patients appreciated this opportunity to discuss and understand the care that they had received. As well as the CCOT, there was an Acute Response Team, which responded to concerns from ward staff about individual patients. However, the roles of the teams lacked clarity and were sometimes used inappropriately due the wards staff poor understanding of the teams' different roles.

The Broadgreen site has a postoperative extended care unit not a critical care unit. This is discussed in greater detail in the Broadgreen report.

End of life care

The trust had a multi-professional approach to end of life care and worked in partnership with the Marie Curie Palliative Care Institute Liverpool (MCPCIL). This meant that good practice was shared across the trust and MCPCIL. The trust no longer used the Liverpool Care Pathway for people in the last few days of their lives. However, it had implemented a care of the dying pathway, which was seen to be working well at the time of our inspection.

The palliative care team focused on ensuring the provision of high-quality services that met the needs of the patients who used their service and their families. They underpinned their practices with the belief that care for the dying is part of the core business of their organisation. If care was necessary within the hospital environment, the palliative care team provided support and information to the patient, their families and the care team working on the ward.

People told us that they were satisfied with the care they received from the palliative care team. For patients who remained in hospital, plans were put in place to ensure that their wishes were respected. The evidence we found indicated that the care of the dying pathway was being followed from diagnosis until after death and that patients were receiving appropriate support and compassionate care.

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Outpatients

On the whole, patients received effective, safe and appropriate care. Patients told us that they were generally satisfied with the service they received. The outpatient areas were clean and well maintained but aspects of the physical environment were cramped and poorly laid out causing possible access problems for the physically disabled.

We found there were a number of issues around the patient experience within the outpatient services at both hospitals. Waiting times were still unacceptably long in some departments whereas others departments, for example x-ray, were seeing people quickly and efficiently. We found that some outpatient areas did not respect patients' privacy and dignity, in that people were seen in cubicles rather than rooms; this meant that consultations could be overheard. We also noted that if English was not a patient's first language an interpreter could be booked in advance of their appointment, but this service was "hit and miss."

Senior staff were aware of the issues with inconsistent service across the different specialities. We saw evidence of improvement in some areas, particularly around patients' appointment letters. However, it was acknowledged by the senior managers that there were still further improvements to be made. There were clear leadership structures in place and staff were aware of the issues around the outpatients department and were working pro-actively to address them.

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What people who use the trust's services say

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they needed similar care or treatment. The results have been used to formulate NHS Friends and Family Tests for A&E and inpatient admissions.

Royal Liverpool and Broadgreen University Hospitals NHS Trust achieved a score of 43 out of a possible 100 for the Accident and Emergency (A&E) Friends and Family Test – below the national average. The response rate was 9.4% for the department, which was also below the national average of 11.3%.

In August, 672 people completed the test, and 88.8% of inpatients asked were either "likely" or "extremely likely" to recommend the ward they stayed in to friends or family; for A&E, 561 people completed the test and 81.2% of patients asked were either "likely" or "extremely likely" to recommend the trust's A&E department to friends or family.

Analysis of data from CQC's Adult Inpatient Survey 2012 showed that overall, the trust scored within the expected range for all 10 areas of questioning. The trust scored better, on average, than other trusts in care and treatment. Particularly in questions around information and inclusion in discussions regarding treatment, privacy and confidence and trust in the doctors treating them.

The trust performed within the top 20% for 21 of the 64 questions in the 2012/13 Cancer Patient Experience Survey. There are four questions in the lowest 20% of trusts nationwide. These questions were around having seen a GP before being told to go to hospital, information about support groups and the impact of cancer, and privacy when examined or treated.

Areas for improvement

Action the trust MUST take to improve

- Resolve the staff recruitment issues so that staff can take up posts in a timely manner.
- Address the use of theatre recovery and the observation room CDU6 as overnight facilities.
- Improve the responsiveness of pharmacy for the provision of medicines on admission and discharge and ensure that the emergency department has access to required medication at all times.
- Address the excessive workloads of junior doctors, particularly on the vascular and colo-rectal wards.
- Address the failings of the risk management processes for the analysis and reporting of potential risks, to ensure they are appropriately reported at all levels.
- Prospectively audit the management of patients whose conditions deteriorate while they are an inpatient on the Broadgreen site, including those who are transferred to the Royal Liverpool.
- Support the training of ward staff in how to respond to the needs of deteriorating patients and those with a tracheostomy.
- Improve the process for learning from complaints.
- Improve the care received by patients not cared for on wards of the relevant speciality (outliers), including the ongoing monitoring of these patients.
- Ensure that staff on the Post Operative Critical Care Unit are appropriately skilled.
- Address the unsafe allocated space between beds in the Heart and Emergency Centre.
- Improve the infection control procedures within the emergency department.
- Ensure that there is regular auditing of the World Health Organisation surgical checklist at both sites.

Action the trust COULD take to improve

- Implementation of a patient acuity and dependency tool.
- Define the roles of the Acute Response Team and the Critical Care Outreach Team.
- Resolve the issue caused by two of the care of the elderly wards sharing a hoist, despite being located on different floors.

Summary of findings

- Information about patients' whereabouts needs to be more robust, to make sure patients can be located while they remain within the trust, particularly when they are moved to the discharge lounge.

Good practice

Our inspection team highlighted the following areas of good practice:

Royal Liverpool

- End of life care service and dedicated bereavement team.
- Effective Critical Care Outreach Team (CCOT).
- Cohesive A&E and Acute medical unit.
- Initiatives to improve the knowledge of all staff in the hospitals regarding the appropriate responses to support a person breathed via a tracheostomy ("neck breather").
- The stroke service, which was ranked third in the country by the Sentinel Stroke National Audit Programme (SSNAP).

Broadgreen

- Purpose-built urology department and improvements made in response to patient feedback.
- Nurse-led discharge on the surgical wards.
- Seven-day multidisciplinary meetings on the surgical wards.
- Evening educational meetings for patients due to be admitted for surgery to remove their prostate gland.
- Specially designed 'barn' theatre.

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Detailed findings

Hospitals we looked at:
Royal Liverpool Hospital; Broadgreen Hospital

Our inspection team

Our inspection team was led by:

Chair: Mike Bewick, Deputy Medical Director, NHS England.

Team Leader: Lorraine Bolam, Care Quality Commission

The team of 33 included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience and senior NHS managers.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. . Before the inspection, our 'Intelligent Monitoring' system indicated that the Royal Liverpool and Broadgreen University Hospitals trust was considered to be a low-risk service.

We held a focus group for people who found it more difficult to give their opinions and a listening event, during which we spoke to a wide range of people who shared their experience of the trust with us. Some of the issues they identified were that staff were caring despite being busy, information from the trust was not always in an acceptable format, interpreter services were inconsistent and the provision of reasonable adjustments for people with disabilities could be better. We used this information during our inspection.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

It should be noted there are no Maternity and family planning or Children's care services at either the Royal Liverpool or Broadgreen Hospital. The Broadgreen site does not have an accident and emergency department or a critical care unit. It performs elective surgery, after which some patients are looked after in their postoperative extended care unit (PAECU). It also offers inpatient dermatology, care of the elderly and rehabilitation services.

The announced inspection was carried out over two days on 28 and 29 November 2013. This was followed up with a one day unannounced inspection on 11 December 2013 and a further announced inspection of Broadgreen on 22 January 2014.

We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We conducted interviews with members of the trust's executive team and interviews with senior staff as required. Focus groups were held with a range of staff in the hospital, nurses, doctors, physiotherapists and occupational therapists. We talked with patients and staff from all areas of both hospitals including the wards, theatre, outpatient departments, mortuary, chaplaincy and the A&E departments.

We placed comment boxes around the trust and held-drop in sessions to receive comments from people who used the service and staff.

We held a listening event on the evening of 28 November 2013. People were able to talk to us about their experiences and share feedback on how they thought the trust needed to improve.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

We saw lots of evidence of safe care at the trust. There was good assessment of patients' needs and care was being provided appropriately to meet those needs. There were procedures in place to keep people safeand records were maintained to a good standard in most areas.

Although staffing was generally found to be adequate, we were aware that extra shifts were being covered by regular staff and that there were a number of vacancies throughout the trust. Recruitment was ongoing, but we were made aware of delays caused by the external recruitment process. On the Royal Liverpool site we had concerns around the medical staffing levels on some of the surgical wards.

The wards were clean and patients told us that they saw staff washing their hands. We found that some areas of the A&E department at the Royal Liverpool were dusty, but that their infection levels are within expected levels for a trust of that size.

Escalation procedures were in place, and staff were aware what they should do in the case of a deteriorating patient. At Broadgreen site we were concerned that potential lessons were not always being identified following situations where patients were required to be transferred to the Royal Liverpool.

Our findings

Staffing

Staffing throughout the trust was found to be adequate to meet the needs of the people using the service in the majority of cases. At the Royal Liverpool there were some staff shortages within A&E and on the wards, but overall we saw there were sufficient numbers of staff on duty at any one time. However regular staff were working extra shifts to ensure consistency of care for patients. Staff told us that these staffing levels were being maintained through the goodwill of staff and is not sustainable and staff shortages were having a detrimental effect on sickness levels, which for nursing staff, were at 6.3% at the trust against a national average of 4.4%; levels were 6.1% for other staff against a national average of 4.2%, although medical staff sickness was very low at 0.3% against a national average of 1.2%.

In the majority of cases recruitment was being considerably delayed by the process for recruiting through an external source. The staff told us there were delays that had caused some people to look elsewhere for employment. Ward managers told us it was common to wait six months from the date of interview to the staff member joining the trust. The executive team were aware of this and had taken steps to address the issue but the problem had not been resolved. This was impacting on the consistency and quality of care as well as the morale of staff.

At the Royal Liverpool we found the junior doctor levels in the vascular speciality were low in comparison to the demand on the service, which had increased since a recent remodelling of the service. Patients were receiving the care they required and we saw patients were safe, but the doctors could not always attend to patients' needs in a timely manner. On one day during our inspection there were 30 vascular patients on other wards because all of the beds on the vascular unit were full. This increased the workload of the junior doctors and it meant that they were consistently working around four hours extra each day.

We found good levels of staffing at the Broadgreen site. Where appropriate (for example, the acute response team and staff on the postoperative extended care unit) staff rotated constantly with the Royal Liverpool site to ensure their skills were up to date.

The analysis of diagnostic tests and assessments were undertaken by qualified staff in outpatients and advice was sought from other healthcare professionals, where necessary. However, the X-ray department had several job vacancies and required more staff.

Escalation policies

Staff were aware that the greatest challenge faced by the Royal Liverpool site was the pressure of the demand for beds. Staff were aware of the escalation procedure when the A&E department was busy, and the systems in place to find beds for people who were to be admitted. The trust's full-capacity protocol was part of the major incident plan. This meant that the patient flow management team followed the consultants to see which patients could be

placed in the discharge lounge and who could be discharged home. We did however find patients not on the appropriate ward for their condition and that at times this led to them not having the relevant speciality review.

Patients who required more intensive intervention after their operation were transferred from the Broadgreen site (which does not have an intensive care unit) to the Royal Liverpool site. There was appropriate involvement from senior members of the medical team (consultant anaesthetist) in these circumstances. We were concerned that on the medical and surgical wards, there would not always be the same consultant involvement.

Equipment and environment

Staff had access to the equipment they required. Essential equipment, such as commodes and hoists, was available on all wards and was clean and well maintained. We did note that at the Royal Liverpool site two of the medical wards caring for frail elderly people had to share a hoist which meant patients had to wait inappropriately. This had been exacerbated by the temporary move of one of the wards to the seventh floor.

Again at the Royal Liverpool site some of the resuscitation equipment in the outpatients clinics had not been regularly checked to see if it was in good working order. Some equipment was stored in poorly accessible areas which meant that it would not be readily available in an emergency.

Medicines management

In general, medicines were managed safely throughout the trust. However, nursing staff and patients informed us that at the Royal Liverpool site some patients had been without at least one item of medication for more than a day during their stay and the system for obtaining medication for patients to take home once they had been discharged did not work efficiently, particularly at weekends. This resulted in patients missing doses of their regular medication on admission and waiting for long periods on the wards or in the discharge lounge awaiting their discharge medication.

There was no electronic drug dispensing system in use in the emergency department at the Royal Liverpool. The staff told us that the pharmacy was not always open and accessible. Staff told us they did not stock all necessary drugs in A&E and they often ended up running to other wards. The emergency department was not set up for ward type drug rounds when people were accommodated for longer periods than usual. This meant that the dispensing of drugs was often not safe, there was an additional drain on staff resources and records were not always kept for auditing purposes.

Cleanliness

Overall, we observed that the trust was clean and infection prevention and control procedures within the hospitals were being used in most cases. However, in the Accident and Emergency department at the Royal Liverpool we found trolleys and mattresses were not always cleaned appropriately and staff hand hygiene was not consistent. We observed thick levels of dust at high levels such as the curtain tracks and on ledges, and the clinical areas were not consistently cleaned between patients. A nurse told us it was often the case that there was not sufficient time in between patients for staff to clean the area and to decontaminate the equipment. There was a checking process in place but this did not demonstrate decontamination was being carried out effectively. This meant patients were at risk of hospital acquired infections.

Information regarding infection control at the trust showed infection rates for C. Difficile and MRSA were the same as for other trusts of a similar size. However, the 2012 Department of Health NHS staff survey showed only 62% of staff reported that hand washing materials were always available.

Learning from incidents

Before we inspected the Royal Liverpool and Broadgreen University Hospital NHS Trust, we reviewed the large amount of information we held or the trust had sent to us. This information highlighted that the trust was a low reporter of incidents including serious incidents. . This can indicate a lack of identification and internal reporting of incidents. We noted the reports made did not demonstrate regular reporting of near misses, which can inform improvements in safety without harm to patients.

We found that the trust had taken action in response to some of the information, for example, footwear with anti-slip soles had been introduced throughout the trust to reduce the number of falls in response to the incidence of falls with harm.

Staff we spoke with at all levels and within all disciplines were familiar with the incident reporting system and told us they were encouraged to report incidents. However, there was no clear analysis and action of some areas of concern

Are services safe?

reported by staff, at either division or board level. It was felt the trust was being directed by strategic targets and serious incidents but was using information, for example, on the analysis of incident and complaints and. This meant they were responding to known risks but failing to identify potential risks and acting before the risk presents as an incident.

Safeguarding

He trust had safeguarding training in place and attendance was good. We saw staff were aware of the Mental Capacity Act and it's implication for patients in their care. One example was on one ward at the Royal Liverpool site, where we saw that the correct procedures had been followed for a patient who was not able to consent to the treatment themself. A "best interest" meeting had also been held and appropriate staff had been involved. This meant that the rights of person who could not make some of their own decisions had been protected.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients were receiving effective care and treatment; we saw examples of good and excellent work. We found staff were following best practice guidelines when treating and caring for patients. There was clear evidence of local and national audit practice and the national stroke audit placed the Royal Liverpool third in the country for their stroke service. The Liverpool Care Pathway was no longer in use but the trust had guidance in place for people in end of life care.

At Broadgreen we saw examples of innovative practice within the surgical department.

Our findings

Intelligent Monitoring

Prior to our inspection we reviewed the data we had about the effectiveness of the care provided at the Royal Liverpool Hospital. All of the effective indicators were within expected range, indicating that the care provided was mostly effective.

The trust had one mortality outlier for patients diagnosed with an acute myocardial infarction (heart attack). This was discussed with the trust who had investigated this internally. Their review had concluded that the issue was one of miscoding, in that patients were attributed to have died from an acute myocardial infarction (MI), when in fact this was the terminal event caused by their co-morbidities or illness. The trust did discover that their management of patients with a non-ST elevation myocardial infarction (NSTEMI) could be improved and as a result had put in place an action plan.

Working with others

We saw many examples of good and excellent work including an effective critical care outreach team and high-quality provision of care through an excellent multi-professional approach to end of life care, which was supported by the work with the Marie Curie Palliative Care Institute Liverpool.

We saw several examples of good co-operation with other providers, which included the prompt acquisition of a breast pump for a nursing mother on one ward and an efficient transfer of care for one patient from another hospital. There was a consultant-led GP advice line which was provided by the cardiology department each lunchtime. However, we were informed by the consultants that, due to a recent restructuring of the administrative staff, letters to GPs and patients following out patients appointments were subject to delays of up to four weeks. This meant that there was a significant delay in information which may have an effect on the way in which a patient's care is managed from returning to their GP.

We also saw examples of co-operation with other hospitals resulting in efficient transfers. We also saw an example of a memory café session initiative for people suffering with memory problems which had been organised between a number of agencies.

Clinical audit

Clinical audit sits within the trust's Governance and Quality directorate. An annual report of audit activity is compiled and presented to the Clinical Governance committee. Medical and surgical divisions hold quarterly meetings with the clinical audit leads.

The trust contributed to 90% of National clinical audits and departments were able to demonstrate that they regularly compared themselves with national benchmarks and comparable providers.

On the vascular wards we saw that a nursing quality audit had been completed and an action plan was in progress to address the concerns that had been raised. Within theatres we saw that an audit had recently been completed on compliance with the WHO checklist. The staff within theatres at the Royal Liverpool Hospital had regular meetings that included the quality of care.

The critical care units submitted the required data to the Intensive Care National Audit and Research Centre (ICNARC), which aims to foster improvements in the organisation and practice of critical care (intensive and high dependency care) in the UK. The data from this was on display on the units and it was clear that staff members were fully aware of their results in comparison to other ICUs and HDUs around the UK. However it was not clear how much of this information was sent to the Board for review. The review of the data is important to monitor the effectiveness of the unit and allow comparison with other

Are services effective?

(for example, treatment is effective)

intensive care units nationally. The Broadgreen PAECU did not appear to have real time data on display, and staff could not tell us how they benchmarked themselves with other units.

The palliative care team monitored ward referrals and all end of life care concerns and complaints. A coding system of red green and amber was in place to prioritise urgent cases and trigger additional reviews. A regular sample audit was carried out around deaths within the hospitals and the information gathered was used to direct which wards required additional support or extra training. The trust also participated in the National Care for the Dying Audit, which looks at appropriate and compassionate care for patients who are dying. We found that end of life care data was recorded monthly as part of the trust's quality performance report and was therefore included in the trust's mainstream reporting and mitigating action planning process. This demonstrated that the trust had systems in place to ensure the end of life care pathway was effective.

In the most recently published Sentinel Stroke National Audit Programme (SSNAP) the Royal Liverpool had the third highest overall SSNAP performance scores in the country and the highest score outside of London. The audit rates each trust's performance from 'A' to 'E'. The trust was one of only three trusts outside London to be awarded an overall level of 'B'. To date, no trust has been awarded an overall level of 'A'.

Surgical services at Broadgreen

Broadgreen has one of only few 'barn' style theatres nationwide. This style of theatre improves productivity as a senior surgeon can supervise several operations at the same time. It also encourages sharing of good practice and increased collaborative working between theatre staff. They have reduced their length of stay for patients undergoing prostatic surgery from 3.7 days to one day following the introduction of robotic technology. The department has been invited to mentor other trusts as they set up similar units. The urology department is hosted in a purpose built area, with lithotripsy (a procedure that breaks up kidney stones) and cystoscopy (where a camera can look inside a patient's bladder) in one place. This means that patients who are originally referred for one problem but are found to have another, can usually have the problem investigated at the same time without the need for a second appointment.

Are services caring?

Summary of findings

We found the services at the trust were delivered by a hardworking, caring and compassionate team of staff who were proud to work at the trust. All the people we spoke with were positive about their care and treatment at both hospitals. We observed staff treating people with dignity and respect and offering care to the best of their ability. We also saw examples of ways in which people were encouraged to share their thoughts of the trust.

Our findings

Patient experience

The majority of patients we spoke with were positive about their care and treatment. They could not speak highly enough about the caring and professional attitude of the staff. Patients told us, "Our experience has been wonderful, the staff were courteous" and "We have nothing but praise for the staff". One person told us "The service is smashing, just perfect! The sister came with me when I got transferred to Broadgreen Hospital and helped me settle in."

We spoke with outpatients both at the Royal Liverpool Hospital and the Broadgreen Hospital. They told us that overall they were satisfied with the service they received though they often experienced long waits. We noted that there was some confusion around appointment times in some outpatient departments. One patient arrived to be told that their appointment had been cancelled. They were then told that they had not contacted the department to 'opt in' to their appointment. However, on examination of these patients appointments letter it was not clear that the patient had to 'opt in' to their appointment.

Patient-centred care

Patients felt involved in their care and well looked after. Patients we talked with told us they were involved in their care knew what was happening and that staff listened to them and explained their care. Patients commented, "Care staff explain what they are doing" and "the consultant has explained everything and I understand and I am happy with that". However, during the unannounced inspection we spoke with 12 patients who were being cared for on wards which were not the specialty they required. None of them knew they were on an alternative ward or understood the significance of this and the negative effect it was having on the frequency of their review by medical staff.

Also some care records were not personalised and did not contain evidence that patients had been involved in planning their care.

One person in A&E at the Royal Liverpool said, "The treatment is very good; the nurses have been very helpful and cheerful. They have kept the family involved". We saw an instance where a nurse called a patient's family to inform them their relative was going to be admitted overnight. Patients received information and follow-up advice when they left the outpatients department. There were a range of information leaflets, and these were available in different formats and languages. Patients were given information in a format they were able to understand. There was a support group for patients who had received care within the ICU. Staff gave patients information about this group and patients decided for themselves if they wanted to attend the meeting.

The staff were aware of and asked for a "Passport to health" when caring for people with learning disabilities. This document provided information for professionals to aid people's care and support. The staff also told us that if one wasn't available they would complete one.

The trust had dedicated staff to cover a number of specialist roles; in the Accident and Emergency department there were teams to support people with mental health needs, the homeless and those with drug and alcohol problems. The palliative care team had 86 ward-based nurses who linked with them to ensure good practice was observed. They had received additional training and supported people at the end of life.

The Chaplaincy provided a good service to patients and families in the trust and we saw volunteers supporting patients in a number of ways. We also spoke with staff in the mortuary who had taken action to change the way that relatives were received through the development of a family room to ensure caring, compassionate support to bereaved families.

Are services caring?

We spoke with two of the palliative care team's case managers whose role was to support patients in their final days. The case managers told us that they had systems in place to ensure that patient's wants and needs were met efficiently and in a timely manner.

Patient feedback

People were encouraged to share their thoughts and experiences of the trust. For example through surveys and noticeboards on the wards where people could anonymously post suggestions. One ward had a comment board where patients could attach notes containing their views and thoughts while on the ward. This gave patients an opportunity to express their feelings anonymously and enabled staff to understand how patients were feeling while they were delivering care.

Dignity and respect

We observed staff treating people with dignity and respect and offering care to the best of their ability. We saw extra time being given to those patients who required it. Staff ensured that the environment allowed privacy so that they could meet the intimate care, treatment and support needs of the patient. Curtains were drawn around each bed and discussions with patients were sufficiently confidential.

Suitable arrangements were in place for single-sex accommodation, with separate male and female bays on wards which had designated bathroom and toilet facilities. All the patients we talked to gave us positive feedback about the ways in which staff showed them respect and ensured their dignity was maintained. One person described the staff to us as "polite, calm and respectful". We saw that notices were pinned to the curtains in wards while staff were delivering personal care in order to preserve patient dignity.

We visited the mortuary and spoke with the bereavement staff at the Royal Liverpool site. They explained that there were processes in place to support relatives once their loved one had died. This included help with death certificates, how to stop unwanted mail and how to collect personal belongings. The mortuary staff had created a pleasant environment to speak with people and had two rooms where relatives could view the deceased. Staff also told us that they worked closely with spiritual leaders to make sure that people's wishes and traditions were observed after death. For example, they were able to give us examples of Rabbis attending post-mortem examinations to ensure that religious practices were followed.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found the trust had many ways in which they responded to varied needs of people who used the service. We found the palliative care responsiveness was excellent, operating seven days a week and seeing patients within 24 hours of receiving the initial referral. The accident and emergency service was responding to the varied needs of patients experiencing problems with alcohol and drugs, as well as a high number of patients who were homeless, through specific teams commissioned to expedite their safe discharge.

Broadgreen Hospital was able to give us many examples of how services had been developed in response to patient feedback, for example, evening meetings for patients prior to their admission for surgery to discuss any concerns and answer questions. Supernumerary discharge planners were in place on the wards, and nurse led discharges helped to ensure that patients were able to be discharged as soon as they were seen.

However, there were concerns at the Royal Liverpool regarding theatre recovery and the observation room CDU6 in A&E, which were being used as overnight facilities. We also noted that the Royal Liverpool site often had a significant number of patients not on the most appropriate ward. Lack of a robust bed management system meant that clinicians were not always aware of where their patients were currently situated within the hospital.

Our findings

Bed management

The patient flow management team aimed to place each patient in the appropriate bed for their problem or, when this was not possible, ensure they were looked after by the right consultant. At the end of every shift they checked to see which beds were available and moved patients as required. However, patients that were not on the appropriate ward were not monitored appropriately and the systems did not ensure that patients were allocated an appropriate consultant or that they were reviewed by their specialist medical team in a timely manner. This meant that patients were at increased risk of inappropriate care or treatment due to less frequent specialist review. This was demonstrated on the morning of the unannounced inspection when we were provided with the current outlier information. The information showed 26 patients in the appropriate bed for their problem although no patient identification numbers were used on the document. Of these 26 patients, 10 did not have a consultant allocated and one patient was in the emergency department. Of the 12 people we spoke with two did not know they were not on the right ward, one person's discharge had been delayed, one person had been reviewed less frequently than if they had been on the relevant ward and one person had received no review by the specialist team despite being in the hospital for two days. These concerns were raised with the trust at the time and the assured us they would address the concerns.

The staff we spoke with in theatres at the Royal Liverpool Hospital told us they were concerned about the pressures they were under to move patients through the theatre suite. There were systems and process in place to help to manage the volume of patients that were treated. However during our inspection we found that theatre lists were regularly changed and operations were cancelled so patients were not operated on in the order that had been originally planned. The theatre staff told us that they often had difficulty in finding the patients on the wards as they were often not on the wards where they should have gone to. At times, surgeons had to stop operating as the recovery area was full and there was nowhere for the patients to go. Some staff we spoke with appeared to deal with constant changes better than others but it was clear that it was a stressful environment for staff.

Access

Between April and June 2013 the trusts bed occupancy was 93.7% compared to the England average of 86.5%. It is generally accepted that when occupancy rates rise above 85% it can start to affect quality of care provided to patients and the orderly running of the hospital.(Dr Foster guide 2012)

There is a national Department of Health (DH) target for 95% patients to be discharge, transferred or admitted within four hours of arrival at A&E. The trust performance has varied but overall it was not meeting this target between April 2012 and October 2013. In June 2013 it reached around 100% for patients waiting less than four hours in A&E, but in March 2013 it dipped to 88%, the Trust's poorest performance, and 90% in October 2013.

Are services responsive to people's needs?

(for example, to feedback?)

In the emergency department we saw a number of ways in which the service was responding to the needs of the population of Liverpool. They routinely dealt with a high number of patients experiencing problems with alcohol and drugs, as well as a high number of patients who were homeless. The trust had responded to these needs and commissioned specific teams to treat patients and reduce their time in hospital. There was a hospital alcohol nurse specialist team; a hospital outreach worker for homeless people which tried to ensure that no one was discharged back onto the street and offered referral to various shelters throughout Liverpool. We saw positive relationships between the services and saw this enhanced patient care.

The vascular services at the Royal Liverpool Hospital had been redesigned to include patients from a much larger geographical area. This resulted in many more patients within the vascular service than there were beds, so patients were given beds on other wards. On one day during our inspection there were 30 vascular patients on other wards because all of the beds on the vascular unit were full. This increased the workload of the junior doctors and it meant that they were consistently working around four hours extra each day. The junior doctors thought that they were gaining excellent experience within the surgical rotation but were obviously concerned about their working hours. The vascular patients were often placed on medical wards and some of the doctors we spoke with expressed concern about the nurses' ability to care for these patients as this was not their area of expertise.

Theatre staff at the Royal Liverpool Hospital told us that the vascular surgery lists often over run and this impacted on the work and finishing times of theatre staff. At Broadgreen Hospital some of theatre staff told us that each theatre list was scheduled to start at 8.30am but this rarely happened as the surgeons were not present. We were told that no action had been taken to address this.

There was a formal critical care network with other local trusts to ensure that the needs of patients were met effectively. For example, patients who required neurological care (conditions affecting the brain and the nervous system) were transferred to another local hospital. Staff also contacted the network when they had a patient who required ICU or HDU care and there were no beds available at the Royal Liverpool Hospital. This ensured that patients received the most appropriate level of care, although it may not have been at their local hospital.

We were concerned that from 1 September 2013, 250 patients were kept in the recovery area at the Royal Liverpool for longer than required. The vast majority of these delays occurred because beds were not available either in the Post-Operative Critical Care Unit (POCCU) or on the wards. Staff told us that they spent a lot of time trying to secure beds on the wards for patients. Most of delays that occurred were longer than an hour but were less than six hours. It was clear that this was not effective use of the recovery area; however we were most concerned about the privacy and dignity of the patients. Since September 2013, the theatre records showed that 11 patients had stayed in the recovery area overnight. When we visited for the unannounced inspection we found that one person had stayed overnight in the theatre recovery area as there was no bed in the POCCU for them. This situation occurred only very rarely at the Broadgreen site as it admitted elective patients only. This meant the pressures on the beds were far less and as a result surgical lists were able to run far more smoothly.

The palliative care team operated seven days per week and aimed to see in patients within 24 hours of receiving the initial referral. In the meantime they offer telephone support for both patients and professionals. Patients were seen and assessed promptly. We observed that the team also worked closely with ward staff to support them to deliver good end of life care. This showed that the team was responsive to the needs of patients.

Treatment of vulnerable patients

We observed a variety of systems used throughout the Trust to alert staff when a person was vulnerable. However, there was no common system throughout the Trust, which meant there was a risk of nurses who moved between wards misinterpreting the information symbols.

The trust had nurses who were specially trained in dealing with patients with learning disabilities who were referred to as "Learning Disability Champions". The nursing staff told us they would ask for a "Passport to Health", which is a document which captures the patients care needs, and if one was not available, they would complete one. We saw signage and posters to encourage staff to adhere to this system.

The emergency department at the Royal Liverpool routinely dealt with a high number of patients experiencing problems with alcohol, drugs as well as a high number of patients that were homeless. The hospital had responded

Are services responsive to people's needs?

(for example, to feedback?)

to these needs and commissioned specific teams to expedite their discharge. The department had a team in place to treat patients with mental health issues. We saw a dedicated team in place who were part of the Mersey Care NHS Trust. There were a number of support staff as well as a mental health nurse specialist who assessed any potential patients.

Staff were aware of the Mental Capacity Act and it's implication for patients in their care. On one of the wards we saw that the correct procedures had been followed for a patient who was not able to consent to the treatment themself. A "best interest" meeting had also been held and appropriate staff had been involved. This meant that the rights of person who could not make some of their own decisions had been protected.

Accessible Information

Patients told us they had received all the information they needed about their care and treatment in a way that they could understand. A welcome pack was available on all the wards and contained information about the trust including visiting times and how to make a complaint. However, some of the welcome packs were in an old format and contained out-of-date information.

We saw a variety of information leaflets were available. These were available in many languages on the Trust intranet and could be downloaded by staff when needed. Interpreter services were available on all wards, either by the use of a telephone or face-to-face.

Discharge planning

The 2012 Department of Health Adult Inpatient Survey showed the trust was performing better than expected in relation to delayed discharges. Staff on most of the wards we visited at the Royal Liverpool told us that patient discharges were not always managed as efficiently as they could be, particularly for the elderly patients with complex needs. The introduction of case managers to proactively manage patient discharge from the time of their admission had speeded up the discharge process, but staff were aware that some discharges were still subject to avoidable delays. We found patients still experienced delays in obtaining their medicines to take home resulting in some patients going home without their medicines and others waiting long times for medicines when there was a very high demand for beds.

The hospital discharge lounge at the Royal Liverpool site (an area where some patients waited for transport to take them home) was not well staffed. One nurse was unable to take their meal break until one hour before the end of their shift. Some patients we talked to had used the discharge lounge before and although they had waited for up to three hours they were happy with the care they received. They had been provided with appropriate food and hot drinks while they waited.

When patients leave the ward at the Royal Liverpool they are recorded as discharged on the hospital computer system even though they are still on the premises awaiting transport. This means that if an enquiry is made, inaccurate information could be given regarding the whereabouts of the patient. We observed an example of a staff member trying to unsuccessfully locate a patient who was to be taken home by ambulance when family rang to check the situation as they had been discharged from the computer when they were sent to the discharge lounge.

At Broadgreen, supernumerary discharge planners had been put in place to help ensure patients were discharged home as soon as possible after their operation. At the preoperative assessment, patients who were identified as needing increased support once home saw an occupational therapist. This meant that equipment was ordered prior to the patient attending hospital in anticipation of it being required. On many of the surgical wards there were clear protocols in place for nurse-led discharge, which meant patients could be discharged as soon as they were ready to go rather than having to wait to be seen by a doctor.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

We found there was an open culture where staff could raise concerns. Doctors and nurses felt supported in their roles and training was available; they were very dedicated, compassionate and proud to work at the trust and we saw monitoring of the quality of the service was happening. Leadership at service level was apparent and at the Broadgreen site we were told repeatedly that the site team were very visible.

However, some staff said they felt that more senior staff within the organisation did not always listen to their views, despite attempts by the executive team to engage with the 'frontline' following feedback from the NHS staff survey. They felt the executive management team did not fully appreciate their workload or the effect that perceived low levels of staffing had on their morale. The risk management system failed to recognise some areas of concern despite them being recognised and reported by staff and these were not clearly acknowledged at either division or board level. The process for the analysis of incident and complaints information meant the trust was not making full use of the information, only being directed by strategic targets and serious incidents.

Our findings

Leadership and vision

The trust board had four directors who had been with the trust for some time; the Chief Executive had joined the trust in 2012 from another acute NHS trust. However the Director of Nursing who had also held the chief operating officer role left the trust shortly before our inspection and an interim Director of Nursing had been in post for only five weeks. The chief operating officer role was being covered by the Chief Executive until they could recruit to the position.

The trust presented to the inspection team prior to the inspection sharing the strategy of the trust. This included plans for a new hospital which is due to be completed in 2017. Separating the vast majority of their elective work to Broadgreen demonstrated vision and understanding of patient movement. As the Broadgreen site does not accept emergency patients, their elective work is not interrupted by bed pressures.

Leadership at service level was apparent. We spoke with a large number of clinical staff including, consultants, nurses, junior doctors, student nurses and domestic staff. Some staff told us there was an open culture where they could raise concerns and these would be acted on others felt their suggestions and opinions were listened to and valued by their immediate line managers. However they told us they felt the executive management team did not fully appreciate their workload or the effect that low levels of staffing had on their morale.

The three critical care units on the Royal Liverpool Hospital and the PAECU at the Broadgreen Hospital were under the nursing leadership of a matron and there were clear lines of accountability in place.

Some service areas were proactively managing risks for example, on critical care the leaders were clear about issues within their service and they had taken action where this was required including submitting two business cases: one to reduce the amount of money spent on agency staff and another to increase the number of critical care beds on the Royal Liverpool Hospital. However, at the time of our visit, neither of these business cases had been approved but they demonstrated that staff had a clear idea of where improvements could be made.

However, staff in other areas for example theatres, were not assured that the information they raised about concerns was being escalated as they did not see improvements based on their concerns. This was supported by the lack of information regarding the concerns we have identified in theatres, at higher levels.

An example of management response to busy periods which supported safe practices was when the A&E department was extremely busy and a red status was in place, all training was cancelled and the staff worked their respective shifts.

Training

The trust had training available for its staff to access and appraisals were undertaken to identify further training needs of individuals. Staff reported higher non-attendance due to shortages of staff on the wards.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Most of the staff had received an appraisal during 2013, which included a discussion regarding their learning and development needs. Senior staff informed us that the way in which the training for staff was organised did not work efficiently, as consideration was not given to the staff off-duty rotas prior to the Learning and Development staff booking them onto training courses. Details of bookings on training courses were given to staff after their duty rotas had been organised and meant that some staff were unable to attend as they were on night duty or annual leave. The staff in the CCOT told us that there were more acutely ill patients being cared for on the wards. They ran training courses for staff in recognising deteriorations in patients' conditions and appropriate care and treatment for patients who were acutely unwell but these were poorly attended as staff could not be released from the wards. This meant the ward staff were less able to respond to the needs of deteriorating patients. There were no plans in place to resolve this situation

The staff we spoke with were very positive about the support they had received. All the staff confirmed they had received mandatory training, and told us there were opportunities for continuing professional development for them to enhance their skills. There was evidence of regular teaching sessions for junior doctors. This included weekly teaching and one-to-one teaching with a consultant. Every junior doctor was supported by a clinical supervisor. Doctors we spoke with confirmed they felt well supported and were able to approach their seniors if they had any concerns. The nurses we spoke with felt supported in their roles and told us they had good access to training. The training figures supplied by the trust current to October 2013 showed that 83% of the training had been completed.

We were also told of a recent initiative to ensure people who were "neck breathers" were supported appropriately should they face a breathing problem when visiting the hospital. This initiative had resulted in the production of a DVD educational tool which staff across all areas had been trained in. The tool had also been utilised outside the trust by other agencies.

Valuing staff

Clinical and nursing staff were very dedicated and compassionate about their jobs. Staff said they were proud to work at the hospital. Staff we spoke with said there was good morale in the hospital and things work well but it was the great staff that kept things going not the leadership.

Some staff felt undervalued and some told us they felt they had not been consulted regarding changes to services for example the redesign of the vascular services when staff had good ideas on what could work well and what would cause problems but felt they had not been heard.

At the Broadgreen site, some staff reported feeling like the 'little sister' to the Royal Liverpool site, and that the executive team prioritised it over them. They felt that the executive team spent the vast majority of their time at the Royal Liverppol site. However, some departments (e.g. Urology) specifically commented that they had had significant support from the trust's leadership in terms of financial investment.

Risk management

Reported incidents were dealt with at local, service and trust level but if the incident was resolved locally the opportunity for more widespread learning from that incident was lost. This challenges the openness and transparency for dealing with incidents and risks.

The risk management system failed to recognise some areas of concern despite them being recognised and reported by staff and these were not clearly acknowledged at either division or board level. The process for the analysis of incident and complaints information meant the trust was not making full use of the information, only being directed by strategic targets and serious incidents.

An example of this is the level of concern raised by staff working in theatres about patients being kept in the recovery area for longer than required , including those who stayed overnight in the recovery area. They had reported the incidents and raised it with managers. Despite this the staff had seen no improvement. It was not recorded on the risk register that we were shown. The Clinical Director for theatres told us that they asked the commissioners of the service if they could open the extra beds in the Intensive Care Unit and High Dependency Units to try to relieve some of the pressure but this request had been declined. This was because the commissioners believed that there were sufficient numbers of critical care beds across all of the neighbouring hospitals. It was not clear from the information that we were given if the trust Board were aware of issues with patients being kept in the recovery area for extended periods of time. The trust was unable to provide documented evidence of discussions or actions taken to address the issues.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Complaints

Copies of the complaints procedure were available throughout the wards we visited. There were also details of how to complain and how to give feedback in the trust's welcome pack. Patients we spoke with were aware of the Patient Advice and Liaison Service (PALS) and how to access their services should this be necessary.

A review of the complaints team and introduction of the complaints manager had seen significant improvements in the response times and quality of the letters sent to complainants. However, information from complaints was not routinely used to improve services.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that each service user in theatres is protected against the risk of receiving care or treatment that is inappropriate or unsafe through the planning and delivery of care and treatment to meet their individual needs or to ensure their safety and welfare. Regulation 9(b)(i)(ii)(iii)

Regulated activity	Regulation
Surgical procedures	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that each service user in theatres is protected against the risk of receiving care or treatment that is inappropriate or unsafe through the planning and delivery of care and treatment to meet their individual needs or to ensure their safety and welfare. Regulation 9(b)(i)(ii)(iii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that each service user in theatres is protected against the risk of receiving care or treatment that is inappropriate or unsafe through the planning and delivery of care and treatment to meet their individual needs or to ensure their safety and welfare. Regulation 9(b)(i)(ii)(iii)

This section is primarily information for the provider

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Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Surgical procedures	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that service users, staff or others, in the accident and emergency department, are protected against identifiable risks of acquiring an infection by

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means of an effective operation of systems designed to assess the risks of and prevent, detect and control the spread of health care associated infection and the maintenance of appropriate standards of cleanliness and hygiene relating to premises, equipment and reusable medical devices used for the purpose of carrying on the regulated activity.

Regulation 12 (1)(a)(b)(c); 12(2)(a) and (c)(i)(ii)

Regulated activity	Regulation
Surgical procedures	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that service users, staff or others, in the accident and emergency department, are protected against identifiable risks of acquiring an infection by means of an effective operation of systems designed to assess the risks of and prevent, detect and control the spread of health care associated infection and the maintenance of appropriate standards of cleanliness and hygiene relating to premises, equipment and reusable medical devices used for the purpose of carrying on the regulated activity. Regulation 12 (1)(a)(b)(c); 12(2)(a) and (c)(i)(ii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that service users, staff or others, in the accident and emergency department, are protected against identifiable risks of acquiring an infection by means of an effective operation of systems designed to assess the risks of and prevent, detect and control the spread of health care associated infection and the maintenance of appropriate standards of cleanliness and hygiene relating to premises, equipment and reusable medical devices used for the purpose of carrying on the regulated activity.

This section is primarily information for the provider

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Regulation 12 (1)(a)(b)(c); 12(2)(a) and (c)(i)(ii)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected the service user against the risks associated with the unsafe use and management of medicines with regards to patients having their medicines at the times they need them. Regulation 13

Regulated activity	Regulation
Surgical procedures	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected the service user against the risks associated with the unsafe use and management of medicines with regards to patients having their medicines at the times they need them. Regulation 13

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected the service user against the risks associated with the unsafe use and management of medicines with regards to patients having their medicines at the times they need them. Regulation 13

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures	Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not always made suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17 (1)(a)

Regulated activity	Regulation
Surgical procedures	Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not always made suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17 (1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not always made suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17 (1)(a)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Surgical procedures	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22
Treatment of disease, disorder or injury	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22