Care Quality Commission

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Broadgreen Hospital Site

Quality Report

Broadgreen Hospital
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Date of publication: 16/09/2014
Date of inspection visit: 28-29 Nov 2013, 22 Jan 2014 and 1 July 2014

This report describes our judgement of the quality of care at this hospital. 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.

Summary of findings

Contents

Summary of findings

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. The trust 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.

Broadgreen Hospital is the main location for the trust's elective general, urological and orthopaedic surgery, diagnosis and treatment, along with specialist rehabilitation. We visited all of the five inpatient wards, the day case unit, the outpatients department, the theatre suite (including the eight theatres and recovery unit and the Postoperative Extended Care Unit (PAECU). There is no accident and emergency department, critical care unit or maternity service at this site. The urology service quite often takes referrals from Alder Hey and the A&E department due to its inner city location and will see, treat and stabilise children before transferring them to Alder Hey, though no other children's services are provided here.

If support is needed for patients at their end of life, this is provided by the department at the Royal Liverpool site, who will travel to Broadgreen to review the patient.

This hospital was inspected as part of our new in-depth hospital inspection programme. This is 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 the trust 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 Broadgreen hospital was operating safely and effectively across all key services. 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, to get their views before the inspection. We listened to people's experiences of the hospital and during the inspection we held a public listening event in Liverpool and heard directly from 10 people about their experiences of care. We spoke with 33 patients and relatives throughout the inspection.

We issued a compliance action to the trust in February 2014 in respect of following national and local guidance and policy. We re-inspected to monitor compliance with this compliance action on 1 July 2014. We found that the trust was compliant in respect of the issues contained within the compliance action. Where this follow up inspection reviewed issues at the trust this report has been updated to reflect this.

At the inspection in January 2014 our team included CQC inspectors and analysts, doctors, nurses, Experts by Experience and senior NHS managers. The team spent two days visiting the trust – one in November and then another day in January. We held a focus group and a drop-in session with different staff members from all areas of the hospital and spoke to around 30 members of staff. We looked at patient records of personal care or treatment, observed how staff were providing care, and talked to patients, carers and family members.

Overall, we were impressed with the standard of care provided at this site. Wards were clean, well-maintained and well-staffed. Services at the hospital were delivered by hardworking, caring and compassionate staff. There was evidence of an innovative and responsive surgical department and services had been improved and updated as a result of feedback from patients. The postoperative extended recovery unit was well-staffed and seen to be providing good care. Although we

Summary of findings

witnessed safe care on the medical wards during our visit, the team had some concern with regards to the escalation policy if patients were to deteriorate on those wards. Outpatient areas were clean and well-maintained. However, waiting times were unacceptably long in orthopaedic outpatients, partly due to clinics being overbooked.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

In general we felt that services provided at the Broadgreen site were safe. Patients were pre-operatively assessed to ensure that only appropriate patients underwent their procedures on this site. There was a 24- hours a day, seven days a week acute response service, who were called to see patients with a high National Early Warning Score (NEWS) (an indicator that their condition is deteriorating). Wards were clean and the NHS Safety Thermometer (a way of monitoring the quality of care delivered) was displayed throughout. We were concerned by the apparent lack of learning from when a patient's condition had deteriorated, including those requiring transfer to the Royal Liverpool site.

Following our inspection on 1 July 2014 we found that systems and processes had been put in place to address the issues raised regarding the management and subsequent learning from when a patient's condition had deteriorated, including those requiring transfer to the Royal Liverpool site.

Are services effective?

There was evidence of good multidisciplinary working throughout the Broadgreen site. Daily multidisciplinary team (MDT) meetings and nurse-led discharge helped to ensure the length of stay was kept as short as possible. There was evidence of innovative working in the surgical department, particularly in theatres, where the department hosts one of the few 'barn' style theatres in the UK.

Are services caring?

We found the services at the hospital were delivered by a hardworking, caring and compassionate team of staff. All the people we spoke with were positive about their care and treatment. We observed staff treating people with dignity and respect and delivering care which was of a high standard.

Are services responsive to people's needs?

Services at Broadgreen had been largely designed around patient need. A post-operative extended care unit is in place to look after patients who require more intensive monitoring after their operation to prevent them having to be admitted to a critical care unit. The urology department is purpose-built for one-stop clinics and they have developed additional services as a direct result of patient feedback. Some clinics were found to be overbooked and therefore running significantly behind scheduled appointment times.

Summary of findings

Are services well-led?

We were impressed by the leadership at ward level. Staff were committed to the hospital and their work and there was clear pride in the service they were performing. Some felt that they were seen as second to the Royal Liverpool, but we saw examples of significant investment from the executive team, such as the 'barn' theatre. We were repeatedly told that the senior site team were visible and supportive.

Summary of findings

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

Medical care (including older people's care)

Medical care at Broadgreen is limited to three wards, which provide dermatology, rehabilitation and care of the elderly services. We witnessed good care and treatment being delivered in a caring way by dedicated staff. We had some concern over the escalation procedure for medical patients if they deteriorate on the wards.

Following our inspection on 1 July 2014 we found that systems and processes had been put in place to address the issues raised regarding the management and subsequent learning from patients whose condition deteriorated on the wards.

Surgery

Broadgreen only provides elective general, orthopaedic and urological surgery. We were impressed with the services provided and how they had been developed around patient needs. There were examples of innovative practice, such as the robotic surgery provided by the urology department and the 'barn' theatre.

Intensive/critical care

This site does not have a critical care unit, but instead has a Postoperative Extended Care Unit (PAECU). This provides increased observation for patients who have undergone longer surgical procedures or who were at higher risk of postoperative complications. It was appropriately staffed and clear escalation policies were in place.

Outpatients

The outpatient areas were clean, well-organised and well-staffed. The urology department had one-stop clinics in a purpose-built unit. Some clinics were overbooked, which resulted in patients waiting significantly longer for their appointments.

Summary of findings

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.

In August 2013, 672 people completed the test across the Royal Liverpool and Broadgreen hospitals: 88.8% of inpatients asked were either "likely" or "extremely likely" to recommend the ward they stayed in to friends or family; 561 people completed the test.

NHS Choices had 26 reviews posted by patients of Broadgreen and they have a four and a half star rating. Six comments were negative and 20 positive. In the reviews, there was strong praise for the staff.

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

- Prospectively audit the management of patients whose conditions deteriorate whilst an inpatient on the Broadgreen site, including those who are transferred to the Royal Liverpool Hospital. This was found to be met at our inspection on 1 July 2014.
- Ensure ongoing monitoring of the World Health Organisation checklist and safety briefings. This was found to be met at our inspection on 1 July 2014.

Good practice

Our inspection team highlighted the following areas of good practice:

- Purpose built urology department and improved 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.

Broadgreen Hospital Site

Detailed findings

Services we looked at:
Medical care (including older people's care); Surgery; Intensive/Critical care; Outpatients

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 hospital 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 returned to the trust on 1 July 2014 to monitor compliance with the compliance action issued in February 2014 in respect of adherence to national and local policy and guidance.

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 inspected the following core services at this hospital on the 29 November 2013:

- Medical care (including older people's care)
- Surgery
- Outpatients

An additional visit was undertaken on 22 January 2014, which included a visit to the PAECU. This is a service provided to patients who need increased monitoring following their operation. Although it does not provide the same intensive level of treatment as traditional critical care units, for ease of reference we have discussed this service in the critical care section.

Detailed findings

As part of the inspection process, we looked at a variety of information we held about the trust and asked other organisations to share what they knew about it. As part of our inspection we observed how people were being cared for and talked with patients, 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 (at the Royal Liverpool hospital) and interviews with senior staff at Broadgreen as required.

We placed comment boxes around the hospital and held a focus group and drop-in session 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 given an opportunity to talk to us about their experiences and share feedback on how they thought the hospital needed to improve.

We returned to the trust on 1 July 2014 to monitor compliance with the compliance action issued in February 2014 in respect of adherence to national and local policy and guidance.

The team would like to thank all those who attended the focus group and drop in session and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the hospital.

Are services safe?

Summary of findings

In January 2014 we found that, in general, care at Broadgreen hospital was safe. The wards were clean and well staffed. The trust needed to put more emphasis on learning from incidents where patients required transferring between sites. This is to ensure that there was nothing that could have been done earlier that would have prevented the patient from deteriorating.

Following our inspection on 1 July 2014 we found that systems and processes had been put in place to address the issues raised regarding the management and subsequent learning from when a patient's condition had deteriorated, including those requiring transfer to the Royal Liverpool site. We also found that the World Health Organisation checklists and safety briefings were routinely used and audited.

Our findings

Risk assessments

Patients were appropriately assessed for their risk of falls and pressure ulcers on admission. Staff were able to describe the action taken once these risks were identified, and we saw processes that had been put in place to address issues, such as patients at risk of falls being issued with anti-slip socks. Wards displayed their NHS safety thermometer results (a tool developed to help frontline staff measure risk).

Staff were able to tell us how they reported incidents. These were analysed at trust level and fed back to the individual area in which the original concern was raised so that lessons could be learned. We were concerned that there was an inconsistent approach to incidents where patients had required transfer from Broadgreen to the Royal Liverpool. It was not evident to us that sufficient emphasis had been placed on the need to learn from these to ensure that in all cases patients were appropriately assessed prior to their transfer. In addition without performing a detailed case review into patients who deteriorated, it is not possible to identify whether all steps were taken in an appropriately timely manner to have prevented deterioration in the first instance.

At our inspection on 1 July 2014 we found the trust had established a Broadgreen Transfer Group to review all urgent patient transfers from the Broadgreen site which were due to a clinical deterioration and needed a higher level of care. The review will consider the timeliness of clinical interventions and assess the appropriateness of the management of the deteriorating patient.

We found during our visit to theatres at our inspection on 1 July 2014 that the trust was carrying out in practice all aspects of the World Health Authority (WHO) surgical safety checklist.

Escalation policies

There are three main areas from which patients could require transfer to the Royal Liverpool site. Immediately postoperatively (i.e. from the Recovery area), whilst admitted to the PAECU or on the general wards. If patients required transfer from the recovery area this was usually undertaken by the anaesthetist responsible for the patients' care. Whilst the recovery unit remained open there would always be a consultant anaesthetist on site. If the nursing staff on the PAECU (who were all nurses trained in intensive care) had any concerns about a patient, they would ring the consultant anaesthetist on call. They might also ring the junior doctor on site (if out of hours), but we were told by the nursing staff that the consultants had a very low threshold for reviewing patients if they called concerned. If a patient was unwell on the wards the nursing staff would either call the acute response team (a senior nurse practitioner) or the junior doctor. A decision to transfer a patient would not necessarily involve the consultant on call.

Staffing

Staffing levels throughout the hospital were found to be appropriate for the level of care and type of treatment that was delivered. Mandatory training had been undertaken and nursing and medical staff spoke positively about opportunities for training. Where appropriate (for example, with the acute response team and staff on the postoperative extended care unit) staff rotated constantly with the Royal Liverpool site to ensure their skills are up to date.

Infection prevention and control

Throughout the site, areas were found to be clean and well maintained. Alcohol gel was widely available and we saw staff regularly washing their hands.

Are services effective?

(for example, treatment is effective)

Summary of findings

Services provided at Broadgreen were effective. There was evidence of good multidisciplinary team working. There was also evidence of innovative practice, particularly in surgery where the site hosts one of only a few 'barn' style theatres. In addition, the urology department performs over 90% of its prostatic surgery using robotic technology, improving patient outcomes and reducing length of stay.

Our findings

Multidisciplinary team working

We saw evidence of multidisciplinary team (MDT) working throughout the hospital. On the surgical wards, MDTs were held daily, including weekends. Protocols were in place to allow predominantly nurse led discharge.

Innovative working

There was evidence of innovative thinking, particularly in the surgical department. Broadgreen has one of only few 'Barn' style theatres. 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.

Length of stay for patients undergoing prostatic surgery has been reduced from 3.7 days to one day with 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 your bladder) in one place. This means that patients who are originally referred for one problem but are found to have another, they can usually have the problem investigated at the same time without the need for a second appointment.

Are services caring?

Summary of findings

We witnessed caring and compassionate staff throughout our inspections of Broadgreen. Patients and relatives were overwhelmingly positive about the care they received.

Our findings

Patient experience

All patients spoken to during our inspection were complimentary about the care they had received at Broadgreen. Although the CQC inpatient survey and the national friends and family test publish their results for the overall trust (i.e. the scores from both the Royal Liverpool and Broadgreen), when broken down by ward we saw that all of the wards at Broadgreen were above the trust average.

Dignity and respect

National guidelines for single sex accommodation were adhered to throughout the site, including outpatients. We witnessed staff treating patients with dignity and respect. Patients and relatives corroborated our observations.

Care planning

We saw evidence of care plans being developed in conjunction with patients' wishes. Initiatives such as the 'Enhanced Recovery Ticket to Ride' had been introduced on the orthopaedic wards. Staff had undergone extra training around patients with dementia.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

There was evidence that services at Broadgreen had been developed with patients in mind. The postoperative extended care unit allowed patients to undergo more intense monitoring following their operation without necessitating their admission to a critical care unit. Supernumerary discharge co-ordinators were employed on the wards to ensure that unnecessary delays were avoided. We were disappointed to find that some of the outpatient clinics were regularly overbooked, which resulted in patients waiting for a prolonged period for their appointment.

Our findings

Responding to patients' needs

We saw multiple examples of how services had been developed or adapted in response to patient feedback. Within the urology department they held 'cancer evenings' where patients were invited to come to learn about the procedure they were about to undergo and common things to expect afterwards. One stop clinics allowed patients to have all of their investigations at one visit, and they had worked with other consultants at the region to provide a centralised cancer clinic once a week. This meant patients only had to visit the hospital once to see a number of difference specialists.

Nursing staff rang patients as a matter of routine 48 hours post discharge to ensure that they did not have any questions or concerns now that they were at home.

Discharge planning

Supernumerary discharge planners were in place to help ensure patients got 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.

Access

There was a disparity in the way that outpatient appointments were arranged. Urology patients were given single appointment times and on the day of the inspection we saw no backlog of patients to be seen. In the orthopaedic clinics however, we found that up to five patients had been given the same time. Some patients were also given times that the consultants were not even at the clinic. This meant that some patients were frustrated at having to wait long times before being seen.

Are services well-led?

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

Summary of findings

Staff were proud to work at Broadgreen. They felt well supported in their roles by both their immediate managers and the senior site team. We were repeatedly told that the site team were very visible and well thought of. There was mixed perceptions of the executive team, who were sometimes thought to prioritise the Royal Liverpool site over Broadgreen.

At our inspection on 1 July 2014 we found the trust had established an additional management office base at the Broadgreen site in order to maintain a more visible presence within the hospital.

Our findings

Leadership

Local leadership was consistently reported to us as strong. There was evidence of where improvements had been made to services by the frontline staff, and it was clear that they felt supported in doing so. The ward leaders we met were enthusiastic and compassionate about their service and demonstrated a clear pride in Broadgreen.

Staff development

Staff had attended their mandatory training as expected and annual appraisals had been completed. Staff working on the postoperative extended care unit and on the acute response team rotated through the Royal Liverpool site to ensure that their skills were constantly updated.

Trust oversight

Some staff reported feeling like the 'little sister' to the Royal Liverpool site, and that the executive team prioritised it over them. They also felt that the executive team were not very visible to them spending the vast majority of time at the Royal Liverpool site. That said, some departments (for example, urology) felt that they had had significant support from the trust's leadership in terms of financial investment. They were very complimentary in the vision the executive team had shown when developing the urology service at Broadgreen. In addition, the development of their 'barn' theatre required a significant investment from the trust. The recent move of all of their urology elective work to the Broadgreen site demonstrates vision and an understanding of patient movement.

At our inspection on 1 July 2014 we found the trust had established an additional management office base at the Broadgreen site, with a view to maintaining a more visible presence within the hospital.

Medical care (including older people's care)

Information about the service

The inpatient medical services provided at Broadgreen hospital comprises of dermatology, care of the elderly and rehabilitation medicine. We visited all of the wards which provide these services, which were wards 4, 5 and 8.

During our visit we spoke with patients, visitors and staff and used information from comment cards. We held a focus group and open drop-in session for staff and we observed care being delivered on the wards. We spent time reviewing patient records and spoke with ward managers.

Summary of findings

We had no concerns over the standard of care given at Broadgreen hospital. There were adequate numbers of appropriately trained staff and patients told us they were well cared for. We were concerned however that there were not sufficiently robust processes in place to ensure deteriorating patients were escalated appropriately, and that once transfer to the Royal site had been undertaken that events were reviewed and lessons learnt.

Following our inspection on 1 July 2014 we found that systems and processes had been put in place to address the issues raised regarding the management and subsequent learning from when a patient's condition had deteriorated, including those requiring transfer to the Royal Liverpool site.

Medical care (including older people's care)

Are medical care services safe?

Managing risk

We discussed incident reporting with staff on all the wards and departments we visited and found that they were familiar with the trust's incident reporting system and used it to report incidents and 'near misses'. It is important that near misses as well as incidents are reported so that action can be taken to prevent future adverse incidents taking place.

We saw that there were systems in place to identify patients who were at risk of falls or pressure ulcers. Staff described the action taken to reduce risks once they were identified. These included re-location of patients within the ward so that they were more visible to staff and the use of pressure relieving mattresses. The department was managing these risks and others highlighted by the NHS Safety Thermometer assessment tool. The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month. The trust monitored these indicators and displayed information on the ward performance boards.

There was a 24 hours a day, seven days a week 'acute response team' (ART), which consisted of a senior nurse practitioner. The nurses undertaking this role rotated through the Royal Liverpool site to ensure that their skills were up to date. They all have their advanced life support qualification. The trust has a policy that should a patient score over 4 on the national early warning score (NEWS), then the ART should be contacted. Overnight there was a medical junior doctor (a senior house officer or equivalent) on call for the wards. We were told of situations where patients had deteriorated on the wards and subsequently required transfer to the Royal Liverpool site. This decision was made by the junior doctor on the Broadgreen site in conjunction with the medical registrar at the Royal Liverpool site. It was not trust policy for the patient to be reviewed by the anaesthetic consultant on call prior to transfer. There had been a serious incident as a result of a transfer, and we were not provided with clear evidence that this had been fully investigated and lessons learnt to prevent this from happening again.

Following our inspection on 1 July 2014 we found that systems and processes had been put in place to address the issues raised regarding the management and subsequent learning from when a patient's condition had deteriorated, including those requiring transfer to the Royal Liverpool site. These systems and processes are described in the well led section of the intensive/critical care report.

During our inspection of theatres undertaken on 1 July 2014 we observed cylinders of medical gases which were out of date. The cylinders were not in daily use and were only kept as back-up equipment. Immediate action was taken by the trust to replace the cylinders.

Infection prevention and control

The wards we visited were visibly clean and well maintained. Patients and relatives we talked to spoke positively about the general level of cleanliness throughout the hospital. Alcohol hand gel was available in several places within the unit and we saw that all staff used it regularly. There were also ample hand washing facilities and liquid soap and hand towel dispensers were adequately stocked.

Pressure ulcers

An analysis of data submitted by the trust revealed that the proportion of patients acquiring grades 3 and 4 (more severe) pressure ulcers had been consistently below the national average since October 2012. We saw equipment was in place to try to prevent pressure ulcers, where necessary, on all wards we inspected. The staff we spoke with told us that this was readily available and that it was delivered "very quickly, usually within an hour or two".

Venous thromboembolism

Reducing the number of patients who develop venous thromboembolism (VTE) is a patient safety target for the trust. VTEs are clots that can develop in patients, often after surgery. In a small number of cases they can be life threatening. Staff we spoke with knew about the importance of risk assessment for the prevention of VTE and we saw these were being completed on the wards we visited.

Staffing levels

Staff working on the medical wards felt that staffing levels were sufficient to allow them to provide safe care to patients and recognised the importance of safe staffing and the impact it had on providing care.

We spoke individually with 30 members of staff at all levels, during the inspection. All the nursing staff felt that they

worked well together as a team and supported each other. We saw evidence of this during our inspection. Several people made comments such as, "we are a good team" and "we work well together".

We spoke with 33 patients and relatives during our inspection of the medical directorate. Everyone we spoke with felt there were enough staff to meet people's needs, but almost everyone commented that staff were very busy. We saw staff working extremely hard on the wards, and they clearly were very busy. We did not find evidence that patients' needs were not being met. We also noted that staff were very visible in patient areas and anticipated people's needs well which meant that patients rarely had to use the nurse call system. However, we observed that when the nurse call system was used, calls were answered promptly.

Training for staff

Mandatory training was up to date or programmed to take place in most areas we visited. Staff we spoke to were happy with the access to training within the trust. They were informed in advance of any mandatory training they needed and the training would be scheduled in. Some training, such as manual handling, was provided by 'core trainers'. These trainers were members of staff who had been trained to deliver the manual handling training. The members of staff we spoke with told us this was a good system as the training was ongoing and "they keep you on your toes when you are on the wards, not just in the classroom on training days". The training was competency-based and everyone thought the training provided within the trust was of a good standard.

Are medical care services effective?
(for example, treatment is effective)

Multidisciplinary working

Many of the patients transferred to the Broadgreen site had undergone their acute phase of treatment and now required more intensive input from physiotherapy and occupational therapy. We saw that patients were seen on a daily basis and multidisciplinary team meetings were held on a regular basis in line with patient need.

Patient care plans

Patient records were kept securely and could be located when needed. Records were legible, appropriately completed and risks, such as falls, malnutrition and breakdown of the skin, were clearly identified. Each patient, where appropriate, had a comprehensive plan of care in place to manage their individual risks.

Quality

Performance boards were visible on every ward. Staff we spoke with were aware of their ward's performance against these targets and their importance in maintaining safety and quality within the trust. There was a 'Policy of the Month' initiative whereby staff read and discussed a different policy each month. Medicines management was the policy of the month on the wards we visited and staff told us this initiative, although not always popular, did mean that policy documents became more relevant to them and the work that they do. One staff nurse told us, "I never really bothered with them before, but now I am starting to see how important they can be."

Are medical care services caring?

Patient feedback

All the patients and visitors we spoke to said that they felt well cared for and that they thought staff were kind and caring. Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment using the Friends and Family Test. All of the medical wards at Broadgreen scored above average for the trust in this test.

Interactions between staff and patients

During our visit to one of the wards where frail elderly people were being cared for, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed many good interactions between staff and patients on this ward and throughout our inspection.

Care planning

Staff planned and delivered care in a way that took into account the wishes of the patient. We saw staff obtaining verbal consent when helping patient with personal care. We saw good examples of recent initiatives within the care planning process which enhanced effective communication with people who had communication difficulties and dementia.

Medical care (including older people's care)

Protected mealtimes
We saw that, where possible, there was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. It meant that staff were available to help serve food and assistance was given to those patients who needed help.

Are medical care services responsive to people's needs?
(for example, to feedback?)

Discharge planning
The introduction of case managers to proactively manage patient discharge from the time of their admission had speeded up the discharge process. Staff informed us that the discharge process normally went smoothly.

Meeting local needs
We spoke with senior staff within the medical directorate who described how the provision of care was developing in line with local needs. This included closer communication and co-operation with GPs and community nursing staff, with a view to getting patients home sooner and preventing re-admission.

Support to maintain adequate nutrition and hydration
All of the patients we spoke with were complimentary about the meals served at the trust. People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day. Staff were able to tell us how they addressed people's religious and cultural needs regarding food. During our inspection we observed staff assisting people who required help with meals sensitively and patiently.

Care for patients with dementia
We reviewed care records and observed care of patients with dementia during our inspection. We saw that appropriate care pathways were in place for people with dementia. We found that staff had received additional training on the care of people with dementia. Staff displayed a good understanding of how to keep patients with dementia safe. We noticed that patients with dementia were calm and did not appear unduly confused or upset. Initiatives such as encouraging family members and those they were familiar with to spend as much time as possible with them were supported.

Patients with additional needs
We observed the approach taken by a staff nurse to the care of a person with a learning disability. Staff were patient and caring and had taken extra care to ensure that this person felt comfortable during their hospital stay. We asked this person to comment on their care and we were told, "This is my hospital, I like it because the nurses and doctors are smashing."

Are medical care services well-led?

Visibility of senior management
Staff told us that the senior management of the hospital were highly visible. A member of staff told us, "It's a small hospital, so we know everyone and they're always around". Staff told us that the senior team was very supportive and approachable. However staff told us they rarely saw the trust executive team.

The ward and therapy managers and senior medical staff demonstrated passion, energy, compassion, direction, and they were aware of the trusts and their own priorities. One member of staff told us, "there is a good atmosphere here; this is how it should be". Other staff agreed and told us that their wards were well-led.

Staff feedback
Staff told us they attended regular staff meetings and that their immediate line managers were accessible and approachable. We spoke with junior medical staff who told us they had good support from senior clinicians and that they were keen to develop junior doctors. A nurse told us, "This is the best place I have worked and the best manager I have ever had."

Staff development
All the staff we spoke with had received an annual appraisal and had set learning and development objectives for the following year. Mandatory training was up to date or programmed to take place in most areas we visited. Staff were happy with the access to training within the trust. They were informed in advance of any mandatory training they needed and the training would be scheduled in. The training was competency based and everyone thought the training provided within the trust was of a good standard. One person told us, "I have been supported by the trust to do a module related to my work as part of my master's

degree, they have been really good". Occasionally staff, particularly senior nursing staff, were unable to attend training due to shortages of staff on the ward, however this was unusual.

Surgery

Information about the service

The surgical care services at Broadgreen are provided on wards 1 and 2. There is a theatre suite, which consists of four stand-alone theatres and four further theatre areas within a 'barn theatre'. There is also a 12-bedded recovery area and a day case unit. All areas were visited during our inspection.

Summary of findings

We were impressed with the surgical services provided at this site. The urology department was innovative and demonstrated good evidence of working hard to improve patient experience. The state of the art 'barn theatre' was one of the first of this kind nationally and subsequently led to doubling of the departments' throughput as well as reducing their infection rates.

The wards were clean, organised and well-run. Patients spoke positively of their experience and the care that they received.

Surgery

Are surgery services safe?

Staffing arrangements

We saw that the trust decided on the number of staff in clinical areas according to local assessment of patients' needs. When staff vacancies occurred, managers arranged for cover to enable safe care. Staff in operating theatres told us that safe staffing levels were ensured prior to commencing operating lists. We looked at staffing rotas which indicated staffing levels were safe. This meant that staff provided care safely and at appropriate times.

Risk of harm

Staff had documented patients' risk assessments to identify potential problems such as falls and pressure ulcers and the formation of clots following surgery. We saw that patients' care records included well completed documentation of risks and the care actions that were needed in order to minimise these risks. Staff told us that they were aware that people having operations may be at risk of pressure ulcers during their anaesthetic or in their recovery. Staff gave examples of where they had identified specific risks and ensured that additional care was taken.

Any untoward incidents were recorded using the trust's electronic incident reporting system and analysis was made to identify causes of untoward incidents, near misses and trends in or across clinical areas. Senior managers had a good overview of this analysis, and lessons were distributed to all relevant teams. Screens in the operating theatres displayed safety information and we were told by staff that communication was good throughout the theatre areas. There were regular meetings to discuss incidents and safety improvements. This effective governance system meant that the care of people in the perioperative period was safe and efficient.

We were told that the trust always used the World Health Organization safer surgery checklist, however this had only recently been audited and the results were not available at the time of our visit. On the day of our inspection we witnessed a team briefing take place at the beginning of the surgical list. We were informed that until recently two of the orthopaedic surgeons had not been fully engaged in the process, but this issue had now been resolved.

We found at our inspection on 1 July 2014, during our visit to theatres, that the trust was carrying out in practice all aspects of the World Health Authority (WHO) surgical safety checklist. This was introduced to reduce harm during the perioperative period by encouraging theatre teams to consistently apply evidence based practice and safety checks to all patients and records following five steps to safer surgery. These are a pre-operative briefing for all the operating team, a sign in (before induction of anaesthesia), time out (before surgical incision), sign out (before leaving theatre) and a de-briefing after the theatre list to learn from what went well and what did not. We noted that the pre-operative team brief was led by different members of the team and not necessarily the consultants. For example, the scrub nurse or the operating department practitioner (OPD) led the briefing discussions. This approach is recognised as good practice as it helps to facilitate a more inclusive discussion where every member of the team feels able to contribute.

Equipment

All the equipment that we examined in the operating theatres was in good working order and appropriately maintained. We examined records that showed that staff regularly checked resuscitation trolleys on the surgical wards and in different areas of the operating theatres.

There was a significant amount of equipment stored in the corridor. We were informed by staff that this was because there were insufficient storage areas within the theatre areas.

Infection prevention and control

Alcohol hand gel was available in several places within each of the surgical areas and we saw that all staff used it regularly. There were ample hand washing facilities and liquid soap and hand towel dispensers were adequately stocked.

There were appropriate arrangements for nursing patients with infections in side rooms. Warnings and instructions for staff and visitors were clearly displayed on the side room doors. We observed staff using the appropriate personal protective equipment (such as gloves and aprons) before entering the rooms. We also observed staff washing their hands in between treating patients.

Medicines management

Throughout the surgical directorate we found that medicines were stored securely and that arrangements were in place to ensure that they were stored at the correct temperature. Patients we spoke with told us that they were not left in pain and that their medicines were usually

administered on time. On the day case unit and surgical ward, we discussed arrangements with staff for accessing medicines for patients to take home on discharge. Most of these medicines were kept on the ward and we observed the procedure of checking these medicines and advising patients on their use prior to discharge. Staff told us this system worked well for routine medicines and that the pharmacy would supply any other medicines very quickly.

This meant that patients' discharges were not delayed while they waited for routine medicines to be dispensed by the pharmacy and transported to the ward.

Are surgery services effective?
(for example, treatment is effective)

Broadgreen Hospital is the main location for the trust's elective general, urological and orthopaedic surgery. It is the regional centre for complex urological cancers for Cheshire and Merseyside and undertakes almost all prostate surgery using robotic equipment. They are also expanding this service further. Use of robotic assisted surgery has improved outcomes for patients undergoing this type of surgery by reducing the average the length of stay from 3.7days to approximately one day and reducing post-operative complications. Staff from the urology department were currently mentoring other surgical teams throughout the country wanting to develop a similar service.

The 'barn' operating theatre was one of the first of its kind to be introduced in the UK and was designed specifically for Broadgreen hospital. Barn style theatres are more common in Europe and are seen to be beneficial because they increase productivity of surgical department and can decrease infection rates. They also allow for increased collaborative learning and sharing of best practice between theatre staff and we were told they had improved relationships within the department as a result.

Teamwork

Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions with members of several surgical teams, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team. We saw that teams met at various times throughout the day to review patient care and plan for discharge and that staff on the day case unit met at lunchtime to plan for anyone who may not be well enough to go home that day. A daily MDT meeting was held seven days a week at 8.30am on the orthopaedic wards to facilitate discharge. Physiotherapists were on the ward throughout the week, and occupational therapists worked six days out of seven.

Nurse-led discharge was encouraged and had been embraced by all of the orthopaedic consultants. There was a clear protocol in place which had recently been updated and reauthorised.

Are surgery services caring?

Patient experience

All of the patients we spoke with were very complimentary about the care they had received. We noted that there was a calm and relaxed atmosphere on the wards that we visited and staff were cheerful and positive with patients. One patient told us, "you couldn't get better care than I have had here, the place is spotless and all the staff are second to none".

Patient-centred care

When we visited the wards we found that they were well organised and had appropriate patient information on display. We saw examples of the general information patients were given on discharge from all surgical areas and also more specific information relating to the surgical procedure they had undergone. On one surgical ward we were informed that twice a week a member of the team would ring all the patients recently discharged to check on their progress and answer questions they may have. A record of this call and any advice given was made. Patients were also given the ward telephone number to ring if they had concerns following their surgery, or needed advice.

We observed that call bells were answered quickly and patients' care was delivered promptly and efficiently. We were also informed of thriving patient support groups which were managed by members of the surgical team.

Dignity and respect

Patients told us that they were treated with dignity and respect at all times. We saw examples of this throughout our inspection, such as patients being taken to a private room to discuss sensitive issues and doors and curtains being closed when personal care was being delivered.

Surgery

Are surgery services responsive to people's needs?
(for example, to feedback?)

Care of people with dementia
We found that the trust had supported staff in developing skills for caring for people with dementia who may be admitted to surgical services. All staff were able to explain the implications of the Mental Capacity Act and how they would make decisions in the best interests of a patient.

We were also informed of measures taken recently for a patient with a learning disability who had been shown around the day case unit and theatres and introduced to staff prior to admission to reduce their anxiety. This had made the experience of attending the hospital for surgery easier and less traumatic for the patient.

Interpreting services
There was no-one on the surgical unit at the time of our inspection who needed interpreting services. However, staff told us that access to both language interpreters and British Sign Language interpreters for the deaf was very good. They also told us that continuity of interpreter was good and they could usually book the same interpreter if they were needed again, which the patients liked and appreciated.

Responding to patients' needs
Following feedback from patients who had been discharged from the urology ward, the department established evening meetings for patients. This was because they discovered that following the reduction in length of stay for patients admitted to have part or their entire prostate removed there was less time for them to adapt to the changes postoperatively. The department therefore arranged for these evening meetings for men to attend prior to the operation. There they learn what to expect after their procedure – for example, using a catheter and how to give themselves the required blood thinning injections. In addition all patients are offered penile rehabilitation (to help with erectile dysfunction which can be a complication post procedure).

Are surgery services well-led?

The ward and therapy managers and senior medical staff demonstrated passion, energy, compassion, direction, and they were aware of the trusts and their own priorities. Staff told us they were well supported by the senior management team and told us they were very proud to work at Broadgreen Hospital. Theatres and recovery appeared organised and well-run.

There was mixed feedback with regards to the executive team. The urology department felt that they had been well supported with regards to their facilities and equipment. They acknowledged that without that support they would not have been able to develop the unit in the way that they had. Other staff members stated that they could feel like the 'poor sister' to the Royal Liverpool site, and that their hard work was not always recognised.

Intensive/critical care

Information about the service

The Broadgreen site hosts a Postoperative Extended care unit (PAECU). The unit is set within one of the bays on Ward 2 and can accommodate between two to four patients. It provides care for patients who have undergone surgery and require ongoing monitoring and support. It is staffed by two permanent intensive care unit trained nurses with consultant anaesthetist support on site from 8am to 8pm. Out of these hours there is an on call surgical senior house officer (or equivalent) who is resident on site. It does not provide all of the services that an intensive care unit would but allows the hospital to monitor the patients' condition and provide effective pain relief. If patients require cardiac or respiratory support they are transferred to the critical care unit at the Royal Liverpool site.

As there is no critical care unit at this site, there is not a critical care outreach team. However a senior nurse practitioner rotates to the site and provides 24 hours a day seven days a week cover.

We are including this unit in the critical care section, though we do acknowledge that it is not a critical care unit in terms of the intensity of the support or type of treatment given to patients.

Summary of findings

We were happy with the standard and quality of care provided by the unit. There were clear guidelines and procedures in place to ensure that appropriate patients were treated in the unit, and it was well staffed by sufficiently trained senior and qualified nurses. We were disappointed that previously there did not appear to be a robust system in place to ensure appropriate learning took place in the case of patients requiring transfer to the Royal Liverpool site.

Following our inspection on 1 July 2014 we found that systems and processes had been put in place to address the issues raised regarding the management and subsequent learning from when patients required transfer to the Royal Liverpool site due to a deterioration in their condition.

Intensive/critical care

Are intensive/critical services safe?

Staffing

All of the nursing staff rotate between the Royal Liverpool intensive care unit and the Broadgreen PAECU. This ensures they remain sufficiently skilled to undertake the monitoring required. There is always a senior nurse and a staff nurse on the unit.

There is a dedicated anaesthetist from 12pm to 8pm who is responsible for the recovery area and PAECU. They see patients postoperatively in recovery and decide if they are appropriate for the PAECU. If transferred to the unit they are responsible for initial care and treatment plan. At 8pm they hand over to the on-call surgical Senior House Officer (SHO), after which there are consultant anaesthetists on call from home (this provision covers the Royal Liverpool site as well). The following morning patients are seen from 8am and are assessed for their suitability to be stepped down to the ward. This step down must be agreed by both the PAECU consultant and the operating consultant surgeon.

Overnight if a patient deteriorates the nursing staff will call either (or both) the acute response team or the surgical SHO. If it is felt the patient is sufficiently unwell they will call the consultant anaesthetist for advice, who is required to attend if the attending team are concerned. If the patient is sufficiently unwell to need immediate attention, the nursing staff will call for a critical care transfer (a priority 999 call) to transfer the patient to the Royal Liverpool site. Ideally this transfer will be planned and the team will liaise with the Royal Liverpool site, and if necessary the consultant anaesthetist will attend to ensure safe transfer of the patient. There is an Operating Department Practitioner (ODP) on site 24 hours a day to assist with preparing the patient for transfer.

We were informed that there had been occasions where transfer to the Royal Liverpool site was required, but we were provided with very limited audit data describing the frequency of this. It appeared that it was a relatively recent initiative that transfers should be considered a clinical incident and thus an incident form completed. The clinical lead for the department was in the process of compiling these alongside data from the North West Ambulance Service (NWAS) in order to understand the number of transfers undertaken in the past year. Although the anaesthetic department (cross site) met monthly, and they met jointly with the surgical division quarterly, it was not evident that lessons learnt from transfers between the sites were a sufficiently high enough priority for the trust.

At our inspection on 1 July 2014 we found that systems and processes had been put in place to address the issues raised regarding the management and subsequent learning from when patients required transfer to the Royal Liverpool site due to a deterioration in their condition. These systems and processes are described in the well led section of the intensive/critical care report.

Appropriate patients

Patients are robustly screened preoperatively to assess their suitability for surgery on the Broadgreen site. The anaesthetic department have developed an in-house decision making tool to assist with ensuring that all patients undergo the appropriate investigations prior to their operation. If the patient is deemed to be high risk by this tool, the patient will be assessed by the preoperative anaesthetic consultant who may then decide that the patient should undergo the operation on the Royal Liverpool site. Any patient deemed requiring level 2 or 3 care postoperatively would automatically undergo their surgery at the Royal Liverpool site.

Capacity

There was capacity and staffing for 4 patients to be admitted to the unit, but we were told (and witnessed) that usually only 3 patients would be admitted at a time. The unit closed over the weekend, and capacity was assessed prior to patients undergoing their operation. If it was deemed that the unit did not have the capability of admitting them (which was rare) then they would not undergo their procedure.

Incidents and infection control

The unit reports incidents in line with trust policy. The staff on the unit did not appear to be aware of any recent cases of pressure ulcers, falls or unit acquired infections, though there was no evidence on display confirming this. There were no facilities for isolation on the unit, and if a patient required this, only bedside infection control (separate hand washing, and protective clothing) could be undertaken.

Intensive/critical care

Are intensive/critical services effective? (for example, treatment is effective)

As part of the trusts critical care department, the PAECU contributes data to the Intensive Care National Research and Audit centre (ICNARC). The mortality data from the unit is within the expected range.

We discussed the effectiveness of the unit with the clinical lead for anaesthetics and critical care. It was acknowledged that as yet there are no national benchmarks for units such as this, and therefore outside of the ICNARC data, it was difficult for them to assess their effectiveness. However we did not see evidence of them benchmarking themselves against other units with similar remits.

Are intensive/critical services caring?

Staffing ratios on the unit allow for individualised care to be given to patients admitted there. Staff were witnessed to be treating patients with care and dignity. Although the unit was small, it was calm, clean and well organised.

We had no concerns about the care being provided in this unit.

Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Mixed sex arrangements

In line with national expectations, as a higher dependency area the unit is mixed sex. Bedded areas are separated by curtains and the operating procedure for the unit stated 'High levels of observation and nursing attendance mean that all patients have their modesty preserved.'

Response to patient needs

We did not see evidence of individual patient feedback being used to improve the services provided. However, the unit itself was developed in order to improve patient experience post operatively, and allow for patients who previously might have needed to stay longer in recovery or have their operation on the Royal Liverpool site to undergo their operation at Broadgreen. It is increasingly recognised that the concept of an 'intensive recovery unit' improves patient experience, and negates the need for critical care admission postoperatively. The operating procedure for the unit, corroborated by the sister in charge of the unit, states that medically unwell patients requiring more intensive support should not be admitted. This ensures that flow through the unit is not disrupted and as a result capacity is available for postoperative patients.

In response to feedback from the nursing staff a second anaesthetist had been rostered to cover the unit and recovery between the hours of 12pm and 8pm. This consultant did not have any other clinical duties at this time, meaning that they were always available to provide senior input, and that patients arriving on the unit had clear treatment plans in place. Regular handovers took place at 5pm and at 9pm with the nurse practitioner and the junior doctors to ensure that everyone was aware of any patients who there were potential concerns with. The morning anaesthetic lists had been organised in such a way that a specific consultant anaesthetist was available to do an early morning review of patients in the PAECU, and ensure they were ready to be stepped down to the wards.

Are intensive/critical services well-led?

Local leadership

The unit always had a senior experienced intensive care nurse on the unit. Staff rotate through the Royal Liverpool site to ensure that they keep their skills continually updated and work with all of the consultant anaesthetists across the sites. This meant that if they have concerns about any of the patients, they felt very comfortable contacting the on-call consultant directly for early advice. The nursing staff we spoke with were happy working in the unit and felt well supported by their consultant colleagues. If the unit was not open and they were meant to be working at the PAECU they would travel over to the Royal Liverpool site to support staff there.

The anaesthetic department met monthly and quarterly with the surgical division to discuss any concerns or issues as well as their mortality and morbidity data. We raised our concern that there was not sufficient scrutiny undertaken following required transfer between the sites and this was acknowledged by the unit. We were informed that an audit currently underway to look back at the transfers in 2013 and that it was now expected practice to file an incident

report following a transfer. This would ensure that all transfers in future would be investigated. This is important as the site is taking on increasingly complex surgery and patients with higher levels of physical health needs.

At our inspection on 1 July 2014 we found the trust had established a Broadgreen Transfer Group. Reporting to the Mortality and Patient Safety Group (MAPS), this group had been set up to review all urgent patient transfers from the Broadgreen site which were due to a clinical deterioration and needed a higher level of care. The review will consider the timeliness of clinical interventions and assess the appropriateness of the management of the deteriorating patient. All such cases were recorded on the trust's system for recording incidents and adverse events.

Trust oversight

Broadgreen is an elective 'cold' site, without an intensive care unit or the support that comes with such a unit. It was apparent that the trust was very aware of this and had made appropriate arrangements. All the junior doctors and ODP's were expected to have up to date advanced life support training. Anaesthetists were witnessed taking full responsibility for their patients, and it was agreed that if there had been a perioperative complication requiring transfer to the other site, that they would accompany their patient. We were told from multiple sources, that Broadgreen 'erred on the side of caution' and that if there was any concern about a patient they would be transferred 'in anticipation of a problem rather than as a result of one.'

Outpatients

Information about the service

The hospital runs a range of outpatient clinics. Around 640,000 outpatients are seen over the two hospital sites each year.

Outpatient appointments are offered within the Alexandra wing as well as in the orthopaedic and urology areas. We inspected both the orthopaedics and urology centres during our visit.

Summary of findings

On the whole patients received effective, safe and appropriate care. The outpatient areas were clean and well maintained. The urology department had been designed specifically to improve the patient pathway and facilitate one stop clinics.

We did find that there were some issues around the patient experience within the outpatient services. Waiting times were still unacceptably long in orthopaedic outpatients partly due to clinics being overbooked and several patients were found to have been given the same appointment time.

Outpatients

Are outpatients services safe?

Staffing

Staffing throughout the department was found to be adequate to meet the needs of the people using the service in the majority of cases. The analysis of diagnostic tests and assessments were undertaken by qualified staff and advice was sought from other healthcare professionals, where necessary. However, one consultant expressed concern regarding the reduction in registrar numbers which they felt had already had an impact on patient waiting times and would get worse once a further reduction was introduced later in 2014.

Environment and equipment

The outpatients clinic was purpose built and was spacious and well laid out with a good patient flow between waiting, consultation and treatment areas. Equipment was clean, well maintained and readily available.

Cleanliness and prevention of infection

The outpatient areas were clean and well maintained. There were infection control measures in place. We discussed the decontamination of some urology equipment which was undertaken within the clinic area. Staff were able to demonstrate how they decontaminated equipment and the maintenance of an audit trail for equipment from decontamination to use. This is important as, should the patient develop an infection following a procedure; it is possible to establish which piece of equipment was used and how and when it was cleaned and decontaminated. Staff were aware of their responsibilities in infection prevention and control. These ensured patients were protected from the risk of infection.

Patient records

Patient records were kept securely and could be located when needed. Records were legible and appropriately completed. Staff we spoke with told us that patient records were rarely unavailable and that the service regarding access to patient records was good.

Are outpatients services effective?
(for example, treatment is effective)

Clinical audit

Regular audits had been introduced as part improving outpatient services. This meant that many issues that arose could be quickly addressed.

Are outpatients services caring?

Patient experience

We spoke with outpatients who told us that overall they were satisfied with the service they received though they sometimes experienced long waits. On the day of our inspection two patients had been waiting more than an hour to be seen in the orthopaedic clinic.

We looked at the way in which appointments were booked in both clinics and found that urology patients were given a booked time and only one patient was given this time. There was no backlog of patients waiting in this clinic. Some orthopaedic clinics gave up to five patients the same appointment time. This inevitably meant that some patients would have a long wait and does not show respect for the people who arrive on time and have to wait to be seen.

Dignity and respect

Induction T loops were available in all clinic areas for the use of people who wore a hearing aid. We noted that if English was not a patient's first language an interpreter could be booked in advance of their appointment.

We observed a mini-bus which transported patients around the hospital site and stopped at the main entrance to the out patients department. This meant that those patient who had difficulties with their mobility who accessed the hospital by public transport could easily get to the out patients department.

We observed separate male and female waiting areas within the urology outpatients clinic for use when patients were undergoing procedures which required them to undress. This preserved patients' dignity.

Are outpatients services responsive to people's needs?

Outpatients

(for example, to feedback?)

Access

Waiting times for an initial consultation were monitored by the trust. The urology clinic had recently experience a large increase in referrals to the diagnostic clinic for people who have noticed blood in their urine. This increase had been attributed to a public health campaign and although measures had been taken in advance of the campaign to deal with the anticipated demand, the service was overwhelmed with referrals. This had resulted in longer waits for appointments for some people. This situation has now been resolved.

Regional cancer multidisciplinary team meetings

In order to improve patient experience and prevent them from having to attend multiple different appointments on different sites, Broadgreen had established a weekly multidisciplinary clinic. This means different speciality consultants from all over the region attend so that patients can be seen by the right person the first time. The multidisciplinary team meeting is organised for that afternoon, so that joint decisions can be made to prioritise patients and make informed treatment decisions.

Are outpatients services well-led?

Leadership and vision

The outpatient department reports though the Division of Core Clinical and Support services. The previous Director of Nursing established an outpatient improvement group in 2011 in response to feedback from patients, which told them they did not always have the best experience.

Much improvement has taken place and addressing clinic templates and waiting times was one of the priorities. We noted that the new nursing director was a relatively recent appointment and observed that many of the improvements that had been made were recent. The nursing director and their staff addressed some of our concerns during our inspection and provided us with further information about other improvements they had made, for example the new audit systems. This meant that there were clear leadership structures in place and they were aware of the issues around the outpatients department and were working proactively to address them. The trust told us that there are still some specialties that overbook clinics, but these will continue to be monitored through the outpatient improvement group.

Risk management

We looked at clinical governance arrangements to assess whether there was staff engagement from board level and assurance processes were in place to monitor patient safety. We found there were systems in place for the reporting and management of risk.

Good practice and areas for improvement

Areas of good practice

- Purpose-built urology department and improved 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.
- Specially designed 'Barn' theatre.

Areas in need of improvement

Action the hospital MUST take to improve

- Prospectively audit the management of patients whose conditions deteriorate whilst an inpatient on the Broadgreen site, including those who are transferred to the Royal Liverpool Hospital. This was found to be met at our inspection on 1 July 2014.
- Ensure ongoing monitoring of the World Health Organisation checklist and safety briefings. This was found to be met at our inspection on 1 July 2014.