Liverpool Women's NHS Foundation Trust

Quality Report

Crown Street
Liverpool
L8 7SS
Tel: 0151 708 9988
Website: www.liverpoolwomens.nhs.uk

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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.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Liverpool Women's NHS Foundation Trust provides a range of specialist services for women including inpatient and community maternity services that deliver approximately 8,000 babies a year, a neonatal service to support newborn babies needing specialist care, obstetrics, gynaecology, gynaecology oncology, termination of pregnancy and a unique emergency room for patients who have urgent gynaecological problems or for women with problems in early pregnancy (at fewer than 16 weeks). The trust is also a major obstetrics, gynaecology and neonatology research hospital, one of only two specialist trusts in the UK, and the largest women's hospital of its kind in Europe.

Liverpool Women's NHS Foundation Trust serves more than 30,000 patients from Liverpool, the surrounding areas and across the UK.

We carried out this inspection as part of our comprehensive inspection programme.

We carried out an announced inspection of the trust on 18 and 19 February 2015, and we undertook an unannounced inspection between 4pm and 7pm on 4 March 2015. As part of the unannounced visit, we looked at maternity and surgical services.

We rated Liverpool Women's NHS Foundation Trust as good overall, although we found that the community midwifery service required improvement. The trust was developing plans to reconfigure and integrate the community service at the time of our inspection.

The trust had a vision 'To be the recognised leader in healthcare for women, babies and their families'. This vision underpinned all the trust's strategies and plans. The vision and values were well known throughout the organisation. The values were represented in all key documents and strategies as well as being embedded in the staff appraisal process. The trust had recently reviewed its quality strategy and the revised strategy had received board approval in February 2015. All agreed priorities had clear and measurable indicators for success that were subject to regular monitoring and review.

All staff were aware of the trust's priorities and challenges, and understood the plans and actions needed to address them.

After our previous inspections in April and September 2014, the trust made significant improvements to its governance and risk management systems. Governance and risk management systems were more robust and provide good information and assurance in respect of performance and risks.

The senior team was visible and accessible to staff, and managers were seen by staff as supportive and approachable. There were some concerns about the leadership style on the labour ward that managers were committed to exploring and addressing.

Staff were committed and passionate about their work. They were keen to learn and continuously improve the services they offered to patients.

There was a positive and enthusiastic culture throughout the trust. Staff were proud of the services they offered and the work they did.

The trust was open about its financial challenges and was working with commissioners and other key stakeholders to seek solutions that would improve its financial position and secure the future sustainability of services.

Cleanliness and infection prevention and control

- Patients received care in a visibly clean and suitably maintained environment. There was a high standard of cleanliness throughout the trust. Staff were aware of current infection prevention and control guidelines. They were supported by staff training and the adequate provision of facilities and equipment to manage infection risks.
- There were good rates of compliance recorded in hygiene audits across all services provided by the trust.
- Infection rates were low, and staff were proactive and vigilant in the prevention and control of infection.

Incident reporting

- There were established systems for reporting incidents and 'near misses'. Staff had received training and were confident in the use of the incident reporting system. The latest national reporting and learning system (NRLS) data (September 2014) stated that the organisation had a reporting rate of 68.48 per 1000 bed

Summary of findings

days, which was higher than the median of 35.92 for the cluster of acute specialist trusts. The trust were in the highest 25% of reporters. The trust was however slow to upload incidents to the NRLS system with 50% of incidents submitted more than 41 days after the incident had occurred.

- The reporting culture had improved from the previous reporting period. The trust had worked with its staff teams to address this issue and to encourage and support staff to report all incidents appropriately. Managers realised that a low patient safety incident reporting culture could hinder staff in identifying risks and the trust in taking action to prevent avoidable harm to patients.

Safeguarding

- The systems, policies and procedures for safeguarding children were robust, well understood and supported by staff training. All relevant staff had received child safeguarding training. There were good examples of staff acting promptly and appropriately to secure the safety and welfare of children.
- However, the trust had identified that adult safeguarding was less well developed. In response, a comprehensive staff training programme for the safeguarding of vulnerable adults had recently been introduced. Staff were developing their understanding, competency and knowledge in this area at the time of our inspection. Staff training figures indicated that, by March 2015, 95% of relevant staff would have received adult safeguarding training.
- Safeguarding practice was supported by a trust-wide safeguarding team that staff could access for advice and support. However, at the time of our inspection there appeared to be an over-reliance on these key individuals as opposed to sustainable systems and processes to safeguard adults. Also, we found some examples in the surgical service indicating that the approach to the safeguarding of adults needed further development.
- The trust acknowledged at board level that the adult safeguarding systems were not yet robust, and it increased the level of risk on the board assurance framework in relation to safeguarding in December 2014.
- The trust had developed comprehensive plans to address the identified gaps in training and practice.

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Nurse and Midwifery staffing

- Nurses and midwives were caring and compassionate. They treated patients and those close to them with dignity and respect, and they were committed to giving patients a high standard of care and treatment. Appropriate staffing levels were calculated using a recognised tool and regularly reviewed.
- Since our last inspection, there had been a significant increase in the numbers of nurses and midwives employed, and there were now sufficient numbers to meet the needs of patients in all the core services we inspected. There were plans to increase the number of neonatal nurses to meet the British Association of Perinatal Medicine (BAPM) standards. At the time of our inspection, staffing was sufficient to meet the needs of babies being cared for because current neonatal staff were working extra hours to fill gaps in the staffing rota.
- The neonatal service had introduced the Advanced Neonatal Nurse Practitioner (ANNP) role. The ANNPs were having a positive effect in supporting high-quality care for babies needing specialist neonatal support. However, it was acknowledged that more work was required to fully embed and integrate this key role within the service.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff. There were excellent examples of senior doctors providing strong leadership and being actively engaged in the design and development of services.
- There were sufficient numbers of consultants and middle grade doctors to provide good quality care and treatment for patients; however, in maternity – inpatient services, the consultant cover was only 77 hours, which was lower than the 98 hours minimum recommended by the Royal College of Obstetrics and Gynaecology for a unit this size. Junior medical staff were well supported and provided with excellent teaching and learning opportunities.

Summary of findings

- The tier 1/middle-grade staffing levels were acceptable in terms of establishment but the neonatal unit often operated below the required level. In response to this, the service had introduced an ANNP role to help junior doctors working in the unit.

Mandatory training

- The trust had set targets of 95% and 90% for mandatory training and appraisals, respectively. These targets were not yet being achieved at the time of our inspection. The overall compliance figures reported to the trust board in January 2015 was 91% for mandatory training and 86% for appraisals. There were plans to increase completion rates by the end of the performance year.

Nutrition and hydration

- Patients' religious and cultural needs were considered and food was provided in accordance with their requirements. Staff gave appropriate and discreet support to those patients who needed help with eating and drinking. Specialist dietary support was available to patients whose condition indicated or required a specialist diet.
- The trust had a team of midwives, support workers and infant feeding advisers who helped women to feed their babies. The maternity and neonatal teams were supported by Liverpool Babies & Mums Breastfeeding Information and Support (BAMBIS), a team of peer supporters who offered breastfeeding support and information to pregnant women, breastfeeding mothers and their families.

Outcomes and evidence-based care

- Care and treatment were delivered throughout the trust in accordance with evidence-based guidelines. The trust had a system for receiving, recording, assessing and monitoring compliance with guidance from the National Institute for Health and Care Excellence (NICE). Quarterly reports were provided for commissioners as part of the quality contract requirements, with internal mechanisms monitoring compliance at divisional and trust-wide levels. When guidance could not be implemented in full (for example, if other healthcare providers were involved as part of the patient pathway), this was risk assessed for inclusion on the risk register and in the monitoring reports.
- Maternity outcomes were monitored using a local maternity dashboard and Royal College of Obstetrics and Gynaecology indicators. These monitored key outcomes, such as methods of delivery, still-birth and neonatal death, epidural rates and the number of women receiving-one-to one care during labour. Clinical outcomes in Maternity services were comparable with or better than, those of similar services.
- In gynaecology services senior staff took part in national and local audits to ensure that they were providing care in line with recognised standards. These included the national menorrhagia audit and a local audit to investigate the recurrence rate of infections with Bartholin's gland surgery. The results were comparable with other similar organisations.
- Surgical site infection rates were compared with a peer trust for the 12-month period up to December 2014; the trust was better than or equal to the peer trust on all but one type of infection.
- Care for end of life patients was based on the National Institute for Health and Care Excellence (NICE) guidance. The trust had reviewed its own processes in response to the national review of the Liverpool Care Pathway and produced end of life care guidance for staff
- The neonatal services used a combination of guidelines from National Institute for Health and Care Excellence (NICE), British Association of Perinatal Medicine (BAPM) and Royal Colleges' to determine the care and treatment provided.
- The service benchmarked patient outcomes against similar units in the UK and the USA. Outcomes compared well with other neonatal services. There was also benchmarking against similar units for mortality and morbidity rates. There was evidence that mortality rates were within acceptable ranges and were continuing to decline. Infection rates had also declined and compared well to similar units.

Access to services

- The trust consistently met most of the access targets. These included referral to treatment times in all specialties, booking midwife visits before 12 weeks and foetal anomaly scans between 18 and 20 weeks, and the cancer targets of 31 and 62 days.

Summary of findings

- The trust did not always achieve the 60 minute targets for treatment in its emergency gynaecology service; however, the trust consistently achieved the national 4 hourly access target for emergency departments. Managers were of the opinion that the target for all acute emergency departments was not necessarily the best measure for a specialist department of this nature.

Governance risk and management and quality measurement

- After our previous inspections in April and September 2014, the trust made significant improvements to its governance and risk management systems. The board assurance framework was now a live document that was well understood by the board. The framework was set out under the trust's strategic aims, and had good risk descriptions with clear details of the risk, cause, effect and impact. There was good alignment with the risk register. In addition, controls were appropriate and there were good examples of assurance sources.
- The newly approved quality strategy detailed the quality governance arrangements for the trust and the new arrangements were being implemented at the time of our inspection. The trust had recently introduced a 'patient experience senate' as part of its quality governance arrangements, and it had plans to introduce senates for patient safety and clinical effectiveness. All committee activity related to quality governance ultimately reported to the governance and clinical assurance committee that in turn reported to the trust board. Attendance at some of the committees, such as the corporate risk committee, could have been improved: some members had only attended 4 of the past 9 committee meetings.
- The trust had been an outlier in for its data quality on a number of occasions (CQC 'Intelligent Monitoring' reports). A dedicated data quality committee was now in place to provide challenge and assurance in this regard. A 'gatekeeping' policy had been introduced for secondary uses (SUS) data to ensure that all data was validated before leaving the organisation. We were unable to ascertain the impact of this work at the time of our inspection; however, the trust was confident that data quality would improve as a result of the actions taken.

Innovation, improvement and sustainability

- The trust was a major obstetrics, gynaecology and neonatology research hospital and there was a wide range of ongoing research projects at the time of our inspection.
- There were examples of innovative and outstanding practice for example; the neonatal unit was the first unit in the country to put the HeRo System in practice. This was a monitoring system that monitored the variability in babies heartbeats that helped with the early diagnosis of infections and other complications.
- The trust acknowledged that it was not financially sustainable in its current structure. It was working with partners in 'Healthy Liverpool' (a system wide project with aims to provide a new health and social care system to transform the health of Liverpool citizens). to discuss proposals for the future and how service provision can be developed and sustained.

We saw several areas of outstanding practice including:

- The implementation of the HeRo system. The neonatal unit was the first in the country to put this system into practice.
- The neonatal unit's benchmarking of its practice and outcomes against other units in the UK and the USA.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Improve the way in which medicines are managed and stored.
- Check the folder of medication data sheets in each room within the neonatal unit at more regular intervals; and confirm with a signature that they have been checked and are valid.
- Store the portable box containing emergency medicines in the high dependency unit securely.
- Provide appropriate neonatal resuscitation equipment in the maternity assessment unit.
- Provide effective controls to prevent the abduction of infants from the labour ward and the Catharine Medical Centre.
- Ensure that risks regarding the storage of formula milk are appropriately assessed, and effective controls implemented to manage those risks.
- Provide operating department practitioners or suitably qualified midwives in theatre recovery outside normal working hours.

Summary of findings

- Ensure that the telephone triage line is staffed at all times.
- Ensure that, when restraint is necessary, it is undertaken in accordance with the relevant regulations and legislation.
- Ensure that paper medical records are of an adequate standard and provide accurate, up-to-date records of the consent, care and treatment provided.
- Ensure that all staff are able to safeguard adults appropriately.

In addition the trust should:

- Review the number of hours of consultant cover in maternity, which were lower than the recommended minimum from the Royal College of Obstetrics and Gynaecology for a unit this size.
- Ensure that issues identified during audits are addressed.
- Review the numbers of incidents reported in all services.
- Ensure that domestic violence referrals from the police are reviewed within agreed timescales.
- Review practice with regard to the artificial rupture of membranes during induction of labour.
- Improve the response rates for the NHS Friends and Family Test.
- Consider including emergency appointments in the induction suite diary.
- Ensure that there is an effective system in place for testing portable electrical appliances.
- Allocate a non-executive director with responsibility for termination of pregnancy services.
- Review the timing of resuscitation decisions so that discussions are initiated with patients at a time when they are well enough to fully consider their wishes.
- Initiate work on advanced care planning with patients at a time when they are well enough to fully consider their wishes.
- Monitor the quality of care planning on the wards against patients' assessed needs.
- Provide dementia training for ward staff.
- Address the leadership issues and staff morale within the intrapartum areas.
- Address the role of the advanced neo-natal practitioners (ANNPs) so they are clear how it fits within the service and take steps to involve them in developments in the neonatal service.
- Consider the provision of newborn life support training for community midwives.
- Consider auditing the availability of patient records.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Liverpool Women's NHS Foundation Trust

Liverpool Women's NHS Foundation Trust is based in Toxteth, Liverpool, and serves more than 30,000 patients from Liverpool, the surrounding areas and across the UK.

The trust has two locations. The first is the Liverpool Women's Hospital, which is a major obstetrics, gynaecology and neonatology research hospital, one of only two specialist trusts in the UK, and the largest women's hospital of its kind in Europe. The second is the Liverpool Women's at Aintree Hospital. This service provides a range of outpatient services for women. These include antenatal and booking clinics, foetal medicine clinics and a full range of gynaecology outpatient services including consultation and treatment.

Our inspection team

Our inspection team was led by:

Chair: Bronagh Scott, Deputy Chief Nurse, NHS England

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included an inspection manager, seven CQC inspectors and a variety of specialists including:

CQC's national professional adviser for maternity; a chief nurse; two obstetrician and gynaecology consultants; a consultant gynaecologist; a cosmetic surgeon; a consultant clinical oncologist; a consultant paediatrician and neonatologist; a senior midwife (acute); two community and acute nurse/midwifes; an independent nursing and healthcare consultant; a senior nurse for older people; a theatre specialist; a charge nurse; a junior doctor (Foundation Year 2); a student nurse and an expert by experience.

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?

Before visiting the trust, we reviewed a range of information we held about Liverpool Women's NHS Foundation Trust and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges' and the local Healthwatch. We held a listening event in Liverpool on 12 February 2015 when people shared their views and experiences of Liverpool Women's Hospital. Some people also shared their experiences by email or telephone.

The announced inspection of Liverpool Women's Hospital took place on 18 and 19 February 2015.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested and held a focus group with the governors.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal

Summary of findings

care and treatment. We undertook an unannounced inspection of Liverpool Women's Hospital between 4pm and 7pm on 4 March 2015. During the unannounced inspection, we looked at maternity and surgical services.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care provided by the trust.

What people who use the trust's services say

The NHS Friends and Family Test response rates were consistently better than the England average and indicated that most patients would be likely to recommend the trust as a place to have care and treatment. However response rates were lower than the national average.

Responses to CQC's Survey of Women's Experiences of Maternity Service in 2013 were comparable to other trusts in England.

The trust actively sought feedback from patients, who were positive about the quality of care and treatment provided.

Before our inspection, we received over 20 patient 'Share your experience' forms via email. All were positive about the care and treatment given to women and their babies.

Facts and data about this trust

Liverpool Women's NHS Foundation Trust. has 157 beds on site (including 48 cots for neonatal care) and in 2013/14 there were 41,316 admissions, 50,843 outpatient appointments and 11,305 emergency department attendances. There are over 1,300 staff.

The trust serves more than 30,000 patients from Liverpool and surrounding areas, and accepts patients from across the UK.

Liverpool is ranked 1 out of 326 local authorities, indicating that it is the most deprived area within the country. Most of the health indicators are worse than the England and regional averages, including breastfeeding initiation, female life expectancy, smoking-related deaths and under-75 cancer rate.

The trust has an annual income of around £94 million.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Patients received care in a visibly clean and suitably maintained environment. There was a high standard of cleanliness throughout the trust. Staff were aware of current infection prevention and control guidelines. They were supported by staff training and the adequate provision of facilities and equipment to manage infection risks. The systems, policies and procedures for safeguarding children were robust, well understood and supported by staff training. All relevant staff had received child safeguarding training. There were good examples of staff acting promptly and appropriately to secure the safety and welfare of children. However, the trust had identified that adult safeguarding was less well developed. In response, a comprehensive staff training programme for the safeguarding of vulnerable adults had recently been introduced. Staff were developing their understanding, competency and knowledge in this area at the time of our inspection. Medicines management and storage required improvement in a number of areas; in the inpatient maternity services, medicines were not always stored at the correct temperatures and there was no appropriate tracking system for keys to patient medication lockers. Community midwives were found to be carrying out-of-date medicines. In the surgical service, emergency medicines in the high dependency unit (HDU) were left in an unlocked removable box on top of a cupboard. Because the HDU was not always occupied by patients or staff, this meant that the medicines kept there may have been accessible to the public. There were also at least two occasions in the 9 days before our inspection when the controlled drugs had only been checked once a day rather than twice. Nurses and midwives were committed to giving patients a high standard of care and treatment. Appropriate staffing levels were calculated using a recognised tool and regularly reviewed. Staffing levels were sufficient to meet the needs of patients in all the areas we inspected. Medical treatment was delivered by skilled and committed medical staff. There were excellent examples of senior doctors providing strong leadership and being actively engaged in the design and development of services.	**Requires improvement** 

Summary of findings

There were sufficient numbers of consultants and middle grade doctors to provide good quality care and treatment for patients; however, in maternity – inpatient services, the consultant cover was only 77 hours, which was lower than the 98 hours minimum recommended by the Royal College of Obstetrics and Gynaecology for a unit this size. Junior medical staff were well supported and provided with excellent teaching and learning opportunities.

There were sufficient numbers of consultants and middle-grade doctors to provide good-quality care and treatment for patients. Junior medical staff were well supported and given excellent teaching and learning opportunities.

Duty of candour

- The trust had prepared for its new statutory obligations under the duty of candour regulation (Regulation 20).
- Staff were aware of thresholds for the duty of candour and were able to escalate cases of moderate harm and above for consideration and action under the requirements of this regulation.

Safeguarding

- The systems, policies and procedures place for safeguarding children were robust, well understood and supported by staff training. All relevant staff had received child safeguarding training. There were good examples of staff acting promptly and appropriately to secure the safety and welfare of children.
- However, the trust had identified that adult safeguarding was less well developed. In response, a comprehensive staff training programme for the safeguarding of vulnerable adults had recently been introduced. Staff were developing their understanding, competency and knowledge in this area at the time of our inspection. Staff training figures indicated that by March 2015 95% of relevant staff would have received adult safeguarding training.
- Safeguarding practice was supported by a trust-wide safeguarding team that staff could access for advice and support. However, at the time of our inspection there appeared to be an over-reliance on these key individuals as opposed to sustainable systems and processes to safeguard adults. Also, we found some examples in the surgical service indicating that the approach to the safeguarding of adults needed further development.

Summary of findings

- The trust acknowledged at board level that the adult safeguarding systems were not yet robust, and it increased the level of risk on board assurance framework in relation to safeguarding in December 2014.
- The trust had developed comprehensive plans to address the identified gaps in training and practice.

Incident reporting and management

- There were established systems for reporting incidents and 'near misses'. Staff had received training and were confident in the use of the incident reporting system. The latest national reporting and learning system (NRLS) data (September 2014) stated that the organisation had a reporting rate of 68.48 per 1000 bed days, which was higher than the median of 35.92 for the cluster of acute specialist trusts. The trust were in the highest 25% of reporters. The trust was however slow to upload incidents to the NRLS system with 50% of incidents submitted more than 41 days after the incident had occurred.
- The reporting rates had improved significantly from the previous reporting period. The trust had acknowledged a reduction in incident reporting during 2014/15 in its Complaints, Litigation, Incidents, PALS and safeguarding (CLIPS) reports for quarters 1, 2 and 3. The quarter 3 report stated that incident reporting was 43% lower than in the same period in 2012/13. The trust had identified that it was 'no harm' and 'near miss' incidents that were not being reported appropriately. This was supported by the NRLS report, which highlighted that the percentage of incidents reported by the trust in which no harm had been caused was 51%, compared with 76% across all acute specialist organisations.
- There was low incident reporting for all types of incidents in the community maternity service. The trust was working with its staff teams to address this issue and to encourage and support staff to report all incidents appropriately. Managers realised that the poor patient safety incident reporting culture could hinder staff in identifying risks and the trust in taking action to prevent avoidable harm to patients.
- There were good examples of learning from incidents that were reported. Staff in all clinical areas were able to describe changes in practice following incident investigations. To support learning from serious incidents, staff were provided with a one-page summary of the key findings and recommendations to disseminate the learning across the trust.
- The trust produced quarterly CLIPs reports to analyse any key themes or trends. This report, particularly the one for quarter 3,

showed significant improvements compared with previous inspections. There was an expectation that action plans to address identified themes would be agreed at committee and divisional level.

- An area of concern from previous inspections was the timeliness to complete actions after a serious incident. While this had improved, the latest report to the trust board (December 2014) stated that actions from incidents occurring in 2013 were still ongoing. The trust explained that in some cases the problem had been the planning of actions that were either inappropriate or too ambitious for the timescales set. As well as monitoring the implementing of actions, the trust also tested how embedded the actions were and whether they were making a difference to patient safety. We considered this to be good practice.

Monitoring safety and responding to risk

- The trust had a process in place to monitor the implementing of safety alerts. Action plans for all applicable alerts were monitored centrally with updates requested from the clinical leads. Alerts were not closed internally until evidence had been provided to support completion of all actions. The trust did not have any overdue patient safety alerts reported in the last publication by NHS England (3 February 2015).
- The trust also reviewed all patient deaths to identify areas for learning. Learning from the reviews was shared and applied.

Medicines management

- Medicines management and storage required improvement in a number of areas; in the inpatient maternity services medicines were not always stored at the correct temperatures and there was no appropriate tracking system for keys to patient medication lockers. Community midwives were found to be carrying out-of-date medicines. In the surgical service, emergency medicines in the high dependency unit (HDU) were left in an unlocked removable box on top of a cupboard. Because the HDU was not always occupied by patients or staff, this meant that the medicines kept there may have been accessible to the public. There were also at least two occasions in the 9 days before our inspection when the controlled drugs had only been checked once a day rather than twice.

Nurse and Midwifery staffing

- Appropriate staffing levels were calculated using a recognised tool and regularly reviewed. They were sufficient to meet the needs of patients in all the areas we inspected.

Summary of findings

- Since our last inspection, there had been a significant increase in the numbers of nurses and midwives employed, and there were now sufficient numbers to meet the needs of patients in all the core services we inspected. There were plans to increase the number of neonatal nurses to meet the British Association of Perinatal Medicine (BAPM) standards. At the time of our inspection, staffing was sufficient to meet the needs of babies being cared for because current neonatal staff were working extra hours to fill gaps in the staffing rota.
- The neonatal service had introduced the Advanced Neonatal Nurse Practitioner (ANNP) role. The ANNPs were having a positive effect in supporting high-quality care for babies needing specialist neonatal support. However, it was acknowledged that more work was required to fully embed and integrate this key role within the service.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff. There were excellent examples of senior doctors providing strong leadership and being actively engaged in the design and development of services.
- There were sufficient numbers of consultants and middle grade doctors to provide good quality care and treatment for patients; however, in maternity – inpatient services, the consultant cover was only 77 hours, which was lower than the 98 hours minimum recommended by the Royal College of Obstetrics and Gynaecology for a unit this size. Junior medical staff were well supported and provided with excellent teaching and learning opportunities.
- The tier 1/middle-grade staffing levels were acceptable in terms of establishment but the neonatal unit often operated below the required level. In response to this, the service had introduced an ANNP role to help and support junior doctors working in the unit.

Are services at this trust effective?

Good

Care and treatment were delivered throughout the trust in accordance with evidence-based guidelines. The trust had a system for receiving, recording, assessing and monitoring compliance with guidance from the National Institute for Health and Care Excellence (NICE). Quarterly reports were provided for commissioners as part of the quality contract requirements, with internal mechanisms monitoring compliance at divisional and trust-wide levels. When

guidance could not be implemented in full (for example, if other healthcare providers were involved as part of the patient pathway), this was risk assessed for inclusion on the risk register and in the monitoring reports.

Clinical outcomes were comparable, with or better than, similar services. The trust benchmarked its performance against national indicators when appropriate, or similar trusts when national indicators were not applicable.

Multidisciplinary working was well established throughout the trust. Doctors, nurses and allied health professionals worked well together to provide a person-centred approach to care and treatment. The sharing of information across the disciplines was well managed. Each discipline listened to and valued the contribution of their colleagues.

The trust had invested in training and providing expert support for staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, there was still work to be done before all staff fully understood their role and responsibilities in supporting patients who lacked capacity to make decisions for themselves. There were examples in the surgical service where staff were not clear about how to appropriately seek or support patients who lacked capacity.

Evidence-based care and treatment

- Care and treatment were delivered throughout the trust in accordance with evidence-based guidelines. The trust had a system for receiving, recording, assessing and monitoring compliance with NICE guidance. Quarterly reports were provided for commissioners as part of the quality contract requirements, with internal mechanisms monitoring compliance at divisional and trust-wide levels. When guidance could not be implemented in full (for example, if other healthcare providers were involved as part of the patient pathway), this was risk assessed for inclusion on the risk register and in the monitoring reports.
- The trust participated in a range of clinical audits, and actions were taken in response to the findings to improve patient outcomes and experiences. The audit programme was developed annually in partnership with the clinical lead from each division and support from the clinical audit team. The programme included trust priorities, responses to incidents, national audits, audits against NICE guidance and any re-audits that were due during the year. Implementing the audit plan was

monitored by the clinical audit team and reported to the divisions and governance committees. The monitoring reports also covered the implementing of agreed actions following clinical audits.
- To share the findings of clinical audit and research projects, there were monthly breakfast meetings that were open to all staff involved in the area audited.

Patient outcomes

- Care and treatment were delivered throughout the trust in accordance with evidence-based guidelines. The trust had a system for receiving, recording, assessing and monitoring compliance with guidance from the National Institute for Health and Care Excellence (NICE). Quarterly reports were provided for commissioners as part of the quality contract requirements, with internal mechanisms monitoring compliance at divisional and trust-wide levels. When guidance could not be implemented in full (for example, if other healthcare providers were involved as part of the patient pathway), this was risk assessed for inclusion on the risk register and in the monitoring reports.
- Maternity outcomes were monitored using a local maternity dashboard and Royal College of Obstetrics and Gynaecology indicators. These monitored key outcomes, such as methods of delivery, still-birth and neonatal death, epidural rates and the number of women receiving-one-to one care during labour. Clinical outcomes in Maternity services were comparable with or better than, those of similar services.
- In gynaecology services senior staff took part in national and local audits to ensure that they were providing care in line with recognised standards. These included the national menorrhagia audit and a local audit to investigate the recurrence rate of infections with Bartholin's gland surgery. The results were comparable with other similar organisations.
- Surgical site infection rates were compared with a peer trust for the 12-month period up to December 2014; the trust was better than or equal to the peer trust on all but one type of infection.
- Care for end of life patients was based on the National Institute for Health and Care Excellence (NICE) guidance. The trust had reviewed its own processes in response to the national review of the Liverpool Care Pathway and produced end of life care guidance for staff

Summary of findings

- The neonatal services used a combination of guidelines from National Institute for Health and Care Excellence (NICE), British Association of Perinatal Medicine (BAPM) and Royal Colleges' to determine the care and treatment provided.
- The service benchmarked patient outcomes against similar units in the UK and the USA. Outcomes compared well with other neonatal services. There was also benchmarking against similar units for mortality and morbidity rates. There was evidence that mortality rates were within acceptable ranges and were continuing to decline. Infection rates had also declined and compared well to similar units.
- The trust used approximately 300 indicators for performance or quality outcomes and was reviewing how these could be best used; 170 of the indicators were reported to the trust board. The associate director of operations was tracking all the indicators so that the numbers reported to the board could be condensed. This was to enable the board to discuss performance exceptions in greater detail. The performance report detailed actions taken for all the areas that were not achieving agreed targets.

Multidisciplinary working

- Multidisciplinary working was well established throughout the trust. Doctors, nurses and allied health professionals worked well together to provide a person-centred approach to care and treatment. The sharing of information across the disciplines was well managed. Each discipline listened to and valued the contribution of their colleagues.

Consent, Mental Capacity Act & Deprivation of Liberty Safeguards

- The trust had invested in training and providing expert support for staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, there was still work to be done before all staff fully understood their role and responsibilities in supporting patients who lacked capacity to make decisions for themselves. There were examples in the surgical service where staff were not clear about how to appropriately seek or support patients who lacked capacity.
- There was one case when a patient had been detained under the Mental Health Act. The trust had applied for registration to enable it to detain patients who were at risk; however, the

application had not been determined at the time of the patient's detention. We raised this with the trust management team who confirmed that they would not use powers of detention until an application to register had been approved.

Are services at this trust caring?

Good

Care and treatment were delivered to patients in a person-centred and sensitive way. Patients and those close to them were extremely positive about the caring and supportive attitudes of staff.

Staff were motivated and keen to provide care that promoted people's dignity. Relationships between people who used the service, those close to them and staff were caring and supportive.

Patients and parents were active partners in care, and most patients told us they felt involved in the decision-making process. People's individual preferences and needs were reflected in how care was delivered.

Patients, parents of babies needing special care and those close to them understood their treatment and the choices available to them. Meeting people's emotional needs was recognised as important by all staff disciplines, and staff were skilled and sensitive in supporting patients and those close to them during difficult and stressful periods. This was particularly evident in the care provided by the neonatal team.

Compassionate care

- Care and treatment were delivered to patients in a person-centred and sensitive way. Patients and those close to them were extremely positive about the caring and supportive attitudes of staff.
- Staff were motivated and keen to provide care that promoted people's dignity. Relationships between people who used the service, those close to them and staff were caring and supportive.
- The NHS Friends and Family Test showed a high level of satisfaction during the last quarter of 2014 of between 97% and 100%. However, it should be recognised that this data relates to small numbers analysed as a result of a low response rate.
- Inpatient survey

Understanding and involvement of patients and those close to them

- Care was planned and delivered in a way that took into account the wishes of the patients and the parents of the babies who needed special care.

Summary of findings

- Patients were active partners in their care. They felt involved in the decision-making process and were well informed regarding their care and treatment options.

Emotional support

- Meeting people's emotional needs was recognised as important by all staff disciplines, and staff were skilled and sensitive in supporting patients and those close to them during difficult and stressful periods. This was particularly evident in the care provided by the neonatal team.

Are services at this trust responsive?

Good

Services were planned to meet the diverse needs of patients. The trust consistently met national access targets. These included referral to treatment times in all specialties, booking midwife visits before 12 weeks, foetal anomaly scans between 18 and 20 weeks, and the cancer targets of 31 and 62 days).

Urgent 2-week referral timescales were also met, and there were a number of rapid access clinics available. The trust provided 'one-stop' clinics, such as the Wednesday oncology clinic, that aimed to meet all the needs of a patient during one visit.

The trust also provided a unique gynaecological emergency service that did not require a doctor's referral.

Patients' religious and cultural needs were met and there was an interpreter service available for patients whose first language was not English.

There was good support for parents whose babies needed specialist care. A counselling and bereavement service supported patients during these difficult and stressful times.

There were excellent examples of staff employed by the trust working collaboratively to meet the individual needs of patients.

Service planning and delivery to meet the needs of local people

- Services were planned to meet the diverse needs of patients living in the local area.
- There were good examples of services being planned and designed in response to patient feedback and consultation.

Meeting people's individual needs

Summary of findings

- A link booking clinic was held at Liverpool Women's Hospital for women whose first language was not English. The birth choices clinic provided support throughout pregnancy to women with tokophobia (fear of childbirth) and a vaginal birth after caesarean section (VBAC) clinic was also available.
- There was a specialist clinic, supported by a Somali health link worker, to identify and address the needs of women who had experienced female genital mutilation (FGM), as well as designated midwives within the community service to support women who had been identified by their circumstances as being vulnerable.
- Patients' religious and cultural needs were met through a multi-faith chaplaincy.
- There was an interpreter service available for patients whose first language was not English.
- The trust also provided a bereavement service for parents and those close to them who had lost their babies. In response to feedback, the trust had developed a midwifery bereavement suite.
- The Mulberry and Orchid suites had been made available to give patients at the end of life privacy and dignity.
- There were excellent examples of staff employed by the trust working collaboratively to meet the individual needs of patients. These included arranging a wedding at short notice for a patient who was terminally ill.

Access to services

- The trust consistently met national access targets. These included referral to treatment times in all specialties; booking midwife visits with before 12 weeks, foetal anomaly scans between 18 and 20 weeks, and the cancer targets of 31 and 62 days).
- Urgent 2-week referral timescales were also met, and there were a number of rapid access clinics available. There trust provided 'one-stop' clinics, such as the Wednesday oncology clinic, that aimed to meet all the needs of a patient during one visit.
- The trust also provided a unique gynaecological emergency service that did not require a doctor's referral. The trust did consistently achieved the 4-hourly access targets for time to treatment in its emergency gynaecology service. Managers were of the opinion that the target for all acute emergency departments was not necessarily the best measure for a specialist department of this nature..

Learning from complaints and concerns

Summary of findings

- The trust had significantly improved its processes for learning from experiences, concerns and complaints. During the inspection in April 2014, the inspection team could not find the Patient Advice and Liaison Service (PALS) or any information on how to raise concerns or complaints. The PALS team was now located next to the entrance of the hospital, and posters and leaflets were prominent throughout with information on how to share comments or complaints with the trust. The PALS contacts had more than doubled following the relocation of the service and issuing of the posters. There had been a small increase in the numbers of complaints, although this had started to stabilise. PALS contacts continued to increase.
- There had been a reduction in the percentage of complaints responded to within agreed timescales: specifically, a steady reduction from 100% in August 2014 to 70.6% in December 2014. However, further changes had been made to the process and the trust was confident that performance had improved and that this would be reflected in the next issue of data. One of the reasons for the response times not being met was the decision to approve extensions to the timescales only in exceptional circumstances. The patient experience team reported that the process was now more robust and a reminder system had been implemented to prompt responses from the clinical areas in a timely way.
- Escalation processes had also been introduced for when there were persistent problems or delays. One of the key changes had been to allocate a patient experience officer to manage a complaint from receipt to completion of any actions in response to it. We reviewed a sample of 25 complaints and could see that all had been through this process with remedial actions recorded and monitored in relation to implementation.

Are services at this trust well-led?

Good

The trust had a vision 'To be the recognised leader in healthcare for women, babies and their families'. This vision underpinned all the trust's strategies and plans. The vision and values were well known throughout the organisation. The values were represented in all key documents and embedded in the staff appraisal process. All staff were aware of the trust's priorities and challenges, and understood the plans and actions needed to address them.

After our previous inspections in April and September 2014, the trust made significant improvements to its governance and risk management systems.

Summary of findings

The trust had recently reviewed its quality strategy and the revised strategy had received board approval in February 2015. All agreed priorities had clear and measurable indicators that were subject to regular monitoring and review.

The senior team was visible and accessible to staff, and managers were seen by staff as supportive and approachable. There were some concerns about the leadership style on the labour ward that managers were committed to exploring and addressing.

Staff were committed and passionate about their work. They were keen to learn and continuously improve the services they offered to patients.

There was a positive and enthusiastic culture throughout the trust. Staff were proud of the services they offered and the work they did.

The trust was open about its financial challenges and was working with commissioners and other key stakeholders to seek solutions that would improve its financial position and secure the future sustainability of services.

Vision and strategy

- The trust had a vision 'To be the recognised leader in healthcare for women, babies and their families'. This vision underpinned all the trust's strategies and plans. The vision and values were well known throughout the organisation. The values were represented in all key documents and embedded in the staff appraisal process. All staff were aware of the trust's priorities and challenges, and understood the plans and actions needed to address them.
- The quality strategy had recently been revised and approved by the board. The new strategy was to be launched in the early spring along with the organisation's development strategy 'Putting people first strategy – 2015–2018'.

Governance, risk management and quality measurement

- After our previous inspections in April and September 2014, the trust made significant improvements to its governance and risk management systems. The board assurance framework was now a live document that was well understood by the board. The framework was set out under the trust's strategic aims, and had good risk descriptions with clear details of the risk, cause, effect and impact. There was good alignment with the risk register. There was good alignment with the risk register. In addition, controls were appropriate and there were good examples of assurance sources. The introduction of

subcommittee escalation reports to the board made it simple to see the management of the framework risks at subcommittee level, and the sharing of information or actions for escalation to the board.

- The trust had undertaken a self-assessment of its risk management arrangements using the HM Treasury risk management framework. This framework uses a scoring system of 1 to 5, which is a range of 'no evidence' to 'excellent'. The self-assessment determined that the trust was at level 2, which is classified as 'satisfactory'. These findings were taken into consideration for the latest version of the risk management strategy (December 2014). The next stages of improving risk management within the trust had been identified as determining and applying appetite for risk, alongside further improvements to the risk registers.
- The risk registers had been much improved since previous inspections, especially in terms of risk descriptions, ratings, actions and review. There was still work to do on closing risks once actions had been completed. This was linked to the trust's plan to introduce appetite for risk and set its tolerance for acceptable levels of risk. The trust had worked with the Institution of Occupational Safety and Health (IOSH) to be the first NHS trust to deliver IOSH-accredited risk management training to continue its improvement in this area.
- In addition to the self-assessment for risk management, the trust had also completed an external review of quality governance. An outside company undertook the review against the well-led framework from September 2014. The findings were reported to the board in February 2015. Part of the process was for the trust to undertake a self-assessment against the framework; the overall score was that the trust assessed itself at the same level as the external company. The trust had developed a comprehensive plan to respond to the recommendations in the external report to secure further improvement.
- The newly approved quality strategy detailed the quality governance arrangements for the trust that were being implemented at the time of our inspection. The trust had recently introduced a 'patient experience senate' as part of its quality governance arrangements, and it had plans to introduce senates for patient safety and clinical effectiveness. All committee activity regarding quality governance ultimately reported to the governance and clinical assurance committee

that then reported to the trust board. Attendance at some of the committees, such as the corporate risk committee, could have been improved; some members had only attended 4 of the past 9 committee meetings.

- The trust had been an outlier for its data quality on a number of occasions (CQC 'Intelligent Monitoring' reports). A dedicated data quality committee was now in place to provide challenge and assurance in this regard. A 'gatekeeping' policy had been introduced for secondary uses (SUS) data to ensure that all data was validated before leaving the organisation. We were unable to ascertain the impact of this work at the time of our inspection; however, the trust was confident that data quality would improve as a result of the actions taken.

Leadership of the trust

- The executive team were visible and approachable. Clinical directors and nurse managers worked closely with the executive team regarding the development and improvement of services.
- Staff felt able to contribute and influence service design and delivery.
- Line managers were seen as knowledgeable, responsive and accessible. Staff reported that they felt heard and valued. There were some excellent leadership role models for staff in all disciplines.
- The trust had recently approved a 'Putting people first strategy – 2015–2018'. This built on the previous workforce and organisational development strategy and maintained the same vision and values. The strategy included much improved measurable indicators that were clearly articulated. The trust was planning to launch it alongside the quality strategy in the early spring of 2015.
- Throughout the life of the previous workforce and organisational development strategy, the trust had secured improvements in the NHS Staff Survey, particularly in relation to staff engagement and staff recommending the trust as a place to work and receive treatment.
- There had been a significant increase in the numbers of midwifery and nursing staff that was having a positive effect on staff morale. Staff were positive about their new colleagues and the contribution they made.

Culture within the trust

Summary of findings

- There was a positive and enthusiastic culture throughout the trust. Staff were proud of the services they offered and the work they did.
- Staff were committed and passionate about their work. They were keen to learn and continuously improve the services they offered to patients.
- The NHS staff survey indicated improvements in staff reporting the trust as a good place to work and receive care and treatment. Results were better than the national average in this regard.

Fit and proper persons

- The trust had prepared to meet the requirements of the Fit and Proper Persons regulation (FPPR). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust policy on pre-employment checks covered criminal record, financial background, identity, right to work, employment history, professional registration and qualification checks.
- It was already part of the trust's approach to conduct a check with any and all relevant professional bodies, and to undertake due diligence checks for senior appointments.

Public and staff engagement

- The trust was proactive and committed to securing patient feedback, and used it to inform and improve patients' experience.
- Staff routinely engaged with patients and those close to them to seek their views about their experiences at the trust. Staff received communications from managers in a variety of ways, such as in newsletters, emails, briefing documents and meetings.

Innovation, improvement and sustainability

- The trust was a major obstetrics, gynaecology and neonatology research hospital and there was a wide range of ongoing research projects at the time of our inspection.
- The trust acknowledged that it was not financially sustainable in its current structure. It was working with partners in 'Healthy Liverpool' to discuss proposals for the future and how service provision can be developed and sustained.

Overview of ratings

Our ratings for Liverpool Women's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (inpatient services)	Requires improvement	Good	Good	Good	Good	Good
Maternity (community services)	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Surgery (gynaecology)	Requires improvement	Good	Good	Good	Good	Good
Neonatal services	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Termination of pregnancy	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Liverpool Women's at Aintree

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Our ratings for Liverpool Women's NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Good	Good	Good	Good

Overview of ratings

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for maternity – community services or outpatients and diagnostics.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The implementation of the HeRo system. The neonatal unit was the first in the country to put this system into practice.
- The neonatal unit's benchmarking of its practice and outcomes against other units in the UK and the USA.

Areas for improvement

Action the trust MUST take to improve
Importantly, the trust must:

- Improve the way in which medicines are managed and stored.
- Check the folder of medication data sheets in each room within the neonatal unit at more regular intervals; and confirm with a signature that they have been checked and are valid.
- Store the portable box containing emergency medicines in the high dependency unit securely.
- Provide appropriate neonatal resuscitation equipment in the maternity assessment unit.
- Provide effective controls to prevent the abduction of infants from the labour ward and the Catharine Medical Centre.
- Ensure that risks regarding the storage of formula milk are appropriately assessed, and effective controls implemented to manage those risks.
- Provide operating department practitioners or suitably qualified midwives in theatre recovery outside normal working hours.
- Ensure that the telephone triage line is staffed at all times.
- Ensure that, when restraint is necessary, it is undertaken in accordance with the relevant regulations and legislation.
- Ensure that paper medical records are of an adequate standard and provide accurate, up-to-date records of the consent, care and treatment provided.
- Ensure that all staff are able to safeguard adults appropriately.

In addition the trust should:

- Review the number of hours of consultant cover in maternity, which were lower than the recommended minimum from the Royal College of Obstetrics and Gynaecology for a unit this size.
- Ensure that issues identified during audits are addressed.
- Review the numbers of incidents reported in all services.
- Ensure that domestic violence referrals from the police are reviewed within agreed timescales.
- Review practice with regard to the artificial rupture of membranes during induction of labour.
- Improve the response rates for the NHS Friends and Family Test.
- Consider including emergency appointments in the induction suite diary.
- Ensure that there is an effective system in place for testing portable electrical appliances.
- Allocate a non-executive director with responsibility for termination of pregnancy services.
- Review the timing of resuscitation decisions so that discussions are initiated with patients at a time when they are well enough to fully consider their wishes.
- Initiate work on advanced care planning with patients at a time when they are well enough to fully consider their wishes.
- Monitor the quality of care planning on the wards against patients' assessed needs.
- Provide dementia training for ward staff.
- Address the leadership issues and staff morale within the intrapartum areas.
- Address the role of the advanced neo-natal practitioners (ANNPs) so they are clear how it fits within the service and take steps to involve them in developments in the neonatal service.

Outstanding practice and areas for improvement

- Consider the provision of newborn life support training for community midwives.
- Consider auditing the availability of patient records.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The provider has not ensured that each service user 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. The provider does not have suitable arrangements in place to deal with foreseeable emergencies. Regulation 9(1)(a)(b)(i)(ii)(2)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines 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 the safe storage of medicines. Regulation 13.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The provider has not protected the service user against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record of the care and treatment provided. Regulation 20 (1)(a).