Royal Liverpool and Broadgreen University Hospitals NHS Trust

Quality Report

Prescot Street
Liverpool
L7 8XP
Tel: 0151 706 2000
Website: www.rlbuht.nhs.uk

Date of inspection visit: 15 - 18 and 30 March 2016
Date of publication: 29/07/2016

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?	Good
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Liverpool and Broadgreen University Hospitals NHS Trust provides services across two sites, comprising of three hospitals: the Royal Liverpool University Hospital, Broadgreen Hospital and Liverpool University Dental Hospital. The dental hospital was not inspected as part of this inspection.

The Royal Liverpool University Hospital is the main site operated by the trust, with a total of 857 beds, 792 of which are inpatient beds and 65 are reserved for day case procedures. This hospital provides a range of services, including urgent and emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, and a range of outpatient and diagnostic imaging services. The hospital also houses St Paul's Eye Unit which provides a range of outpatient services and elective and unplanned ophthalmology surgical services to patients locally, nationally and internationally. The unit sees in the region of 9,000 outpatients each month.

The trust started work on a new Royal Liverpool University Hospital in February 2014 and construction is underway, with the opening planned for 2017. The new Royal will be one of the biggest hospitals in the UK to provide all single en-suite bedrooms on each inpatient ward. There will be 23 wards, including a large clinical research facility and a 40-bedded critical care unit and the new Royal will have 18 state-of-the-art operating theatres. The emergency department will be one of the largest in the North West of England with its own CT scanner and special lifts for patients going straight to the operating theatres on the floor above.

Broadgreen Hospital is the smaller of the two sites operated by the trust and has a total of 98 beds, 58 of which are inpatient beds and 40 are reserved for day case procedures. This hospital provides a range of elective general medicine (including elderly care), elective surgery, day case surgery, and, outpatient and diagnostic imaging services.

The trust was inspected previously in November 2013 and December 2013, then again in June and July 2014. These inspections were conducted as part of the initial pilot phases of our new inspection methodology. No ratings were applied and this is the trust's first comprehensive inspection as part of our new methodology.

The announced inspection took place between 15 – 18 March 2016. We also undertook an unannounced inspection on 30 March 2016 at both the Royal Liverpool University Hospital and Broadgreen Hospital. As part of the unannounced inspection, we looked at the emergency department, medical care wards, surgical care wards and the Academic Palliative Care Unit (APCU).

Overall we rated Royal Liverpool and Broadgreen University Hospitals NHS Trust as 'Good'. We have judged the service as 'good' for safe, effective, caring and well-led care and noted some outstanding practice and innovation. However improvements were needed to ensure that services were responsive to people's needs.

Our key findings were as follows:

Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- Staff generally followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- Almost all of the areas we visited were found to be visibly clean and tidy. However, the podiatry room within the Diabetes Centre was noted to have dust on the work tops and behind the examination couch and the refrigerator contained a box with mould on it.
- Infection prevention and control audits and hand hygiene audits were carried out on a regular basis. These identified good practice and areas for improvement. Key actions were identified to be implemented by staff.
- Between December 2014 and November 2015, the trust reported a total of 42 cases of clostridium difficile, 26 cases of methicillin-susceptible

Summary of findings

staphylococcus aureus (MSSA) and two cases of methicillin-resistant staphylococcus aureus (MRSA) infections, which meant that the trust did not meet the national standard.

Nurse staffing

- The trust used recognised and validated tools to determine the required levels of nursing staff.
- The majority of areas were staffed with sufficient numbers of suitably qualified nurses at the time of the inspection. However, staffing throughout the medical services had been identified as an issue for the trust. The trust were aware of it and had processes in place to escalate issues with staffing but at the time of our inspection we found some areas were still experiencing issues with capacity and ability to manage the wards with the correct staff mix.
- The trust had introduced a red flag system with criteria for staff to raise issues, such as ward staffing. This included a contact number for nurses to call if any situation where, based on professional judgement, patient care was deemed unsafe. The system also had set criteria to aid decision making for the nursing staff, for example a shortfall of more than eight hours or 25% of registered nurse time available.
- Any shortfalls in nurse staffing were generally filled with overtime, bank or agency staff. Matrons attended twice daily staffing huddles to ensure safe levels of nurses on the wards. Staffing was displayed on a live rota using a traffic light system. This included pre-booked staff being allocated to wards as needed.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- The information we reviewed showed that medical staffing was generally sufficient to meet the needs of patients at the time of the inspection.
- The medical staffing skill mix was sufficient when compared with the England average. Consultants made up 37% of the medical workforce at the trust which was similar to the England average of 39%. There were more registrar group doctors who made up 41% of the medical workforce compared with the England average of 38%. Of the medical workforce, 18% were made up of junior doctors, which was higher than the England average of 15%.
- There were generally low levels of locum use, with substantive staff preferring to work additional hours to fill any gaps in rotas.
- The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance states there should be a minimum of one whole time equivalent (WTE) consultant per 250 beds. The trust employed four WTE consultants at the time of the inspection, which was slightly more than recommended.

Mortality rates

- Mortality and morbidity reviews were held monthly in most services and bi-monthly in outpatients and diagnostic imaging services. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent recurrence. However, these were not minuted in some areas.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 1 would mean that the number of adverse outcomes is as expected compared to England. A score of over 1 means more adverse (worse) outcomes than expected and a score of less than 1 means less adverse (better) outcomes than expected. Between October 2014 and September 2015 the trust's score was 1.037, which was within the expected range.
- Critical care services provided continuous patient data contributions to the intensive care national audit and research centre (ICNARC) which allowed outcomes for patients to be benchmarked against similar units nationally. The most recently validated ICNARC data for the period July 2015 to September 2015 showed that the mortality ratio was within the expected range for comparable units. In addition, for the intensive therapy unit (ITU) the data showed that ventilated

patients, patients admitted with severe sepsis and patients admitted following elective or emergency surgery, mortality was similar to or better than similar units nationally.
- Data for the high dependency unit (8HDU) in the same period showed that for elective and emergency surgical admissions the mortality was better than comparable units. However, for admissions with trauma, perforation or rupture, the mortality were was worse than similar units.
- Evidence based pathways were in place for common causes of mortality in the trust using the Advancing Quality programme.
- The renal medicine service had developed a clinical pathway for new dialysis patients. The pathway was designed to address the high 90-day mortality rates by targeting: improved rates of transplantation; better enabling self-care; improved vascular access, better medicines management; earlier access to psychological support.

Nutrition and hydration

- In all the records we reviewed, a nutritional risk assessment had been completed and updated regularly. This helped identify patients at risk of malnutrition and adapt to any ongoing nutritional or hydration needs.
- Staff in surgical services managed the nutrition and hydration needs of patient's well, both pre and post operatively. Patients were given information in the form of leaflets about their surgery and told how long they would need to fast pre-operatively.
- A coloured tray and jug system was in place to highlight which patients needed support with eating and drinking. In addition, there were special plates to meet individual needs including smaller plates for patients' who needed to eat small amounts frequently.
- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns.
- In order to meet the guidelines for the provision of intensive care services (GPICS) standard for dietetic support the unit should have 0.1 whole time equivalent (WTE) of a dietician per critical care bed. However, the current allocation for critical care was 0.04 WTE per critical care bed.
- The trust scored about the same as other trusts of a similar size in England for the one question related to nutrition and hydration in the Accident and Emergency (A&E) survey 2014.

We saw several areas of outstanding practice including:

- The emergency department worked collaboratively with local support groups and charities to provide excellent in reach and outreach services to sections of the local population. This meant patients received the best possible care which met their individual needs.
- The emergency department's practice development team provided excellent support and education to the staff within the department. They were responsive and provided tailored training programmes in response to issues identified through incidents and debriefing sessions which ensured that the staff within the department were equipped with the skills and training necessary to provide high quality patient care.
- The emergency department provided an education programme and outreach service to local education establishments on the dangers of knife crime with the aim of reducing this particular type of crime in the local population.
- The critical care team led by a designated consultant was developing guidance for staff in the application of the Mental Capacity Act 2005 and associated deprivation of liberty safeguards in the critical care setting. It was hope that this guidance once approved would be adopted across both the local and national critical care networks.
- The electronic whiteboard system used across the trust provided staff with information as to the bed allocated to each patient and to whether patients had particular assessments completed, for example venous thromboembolism (VTE). The board was also used to highlight vulnerable patients. We viewed the whiteboard on ward 3X where staff were piloting an increased functionality such as access to the National Early Warning Score (NEWS), referrals, graphs of patient's results over time and interaction with medical staff via the white board. We found this to be good practice and innovative.
- The trust had a comprehensive end of life vision and strategy set out for 2013- 2018. Their vision was to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population. End of life services had partnered with

Summary of findings

Marie Curie Palliative Care Institute Liverpool (MCPCIL) to further research and develop end of life services and collaborated with the Cheshire and Merseyside end of life network group to share research findings. This collaborative working helped support the commissioning and provision of excellent and equitable end of life services for the people of Merseyside and the surrounding boroughs.

- The trust had developed and opened a new Academic Palliative Care Unit (APCU), providing a 12 bedded unit for patients who were at the end of life.
- The trust had a well-established and well-staffed palliative care directorate that worked closely with other organisations to improve the quality of end of life services in Merseyside.
- The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was integral to the trust and had a well-developed and substantial palliative care directorate that was part of the medicine division.
- The trust had a robust education and training programme in end of life care and a formal programme of study days which was co-ordinated by the Hospital Specialist Palliative Care (HSPC) team and provided in conjunction with MCPCIL.
- End of life services had a substantial care of the dying volunteer service to ensure that patients and their families were supported. The volunteer service were winners of the Deborah Hutton award in 2015.
- Through working in partnership with the MCPCIL they had developed and appointed two discharge co-ordinators and implemented a rapid discharge home to die pathway. This had achieved excellent results in ensuring end of life patients were supported to be discharged to their preferred place of care.
- Care provided to patients went beyond most people's expectations. Staff showed care and compassion and went the extra mile to ensure patients at the end of life were well cared for. Care for patients and their families was the responsibility of all staff and not just the HSPC team.
- The mortuary staff were able to carry out reconstruction and camouflage to deceased patients to ensure that bereaved families were able to view their loved one.

However, there were also areas where the trust must make improvements.

Importantly, the trust must:

- Ensure that the trust discharges its responsibilities in relation to the duty of candour for all incidents that meet the criteria.
- Ensure that robust arrangements are in place to govern the fit and proper persons process.

In all areas

- The trust must ensure that fridges used to store medications in all areas are kept at the required temperatures and checks are completed on these fridges as per the trust's own policy.
- Where fridge temperature ranges are recorded outside the recommended minimum or maximum range, steps must be taken to identify if medicines stored in the fridges are fit for use.
- The trust must ensure that medicines, including controlled drugs and intra-venous (IV) fluids, are securely stored in line with legislation.
- The trust must ensure that emergency resuscitation equipment is readily available in each area, to provide timely access to emergency resuscitation equipment. At the time of the inspection we found equipment shared between wards at the Royal Liverpool University Hospital which meant there may be a delay in accessing emergency equipment.
- The trust must ensure that all emergency equipment is checked regularly in line with trust policy and is ready for use in order to be able to respond safely in an emergency situation.
- The checking of medication, including controlled medication must be carried out consistently as per trust policy.
- The trust must ensure the expiration date of medicines is monitored. Drugs that are past their expiry date must be disposed of promptly.

In Medical care

- The service must ensure controlled drugs are stored in line with the legislation on the Acute Medical Unit (AMU) at the Royal Liverpool University Hospital.
- The service must find an acceptable option to ensure its compliance with Health and safety best practice guidance for the storage of portable oxygen.

Summary of findings

In addition, the trust should:

- Take steps to engage with allied health professionals (AHPs) so they are aligned professionally with an executive lead.
- Take steps to improve the oversight of actions arising from serious incidents and clinical audits.
- Take steps to improve the time taken to upload incidents to the national reporting and learning system (NRLS).
- Take steps to monitor the timeliness in reporting serious incidents and instigating the duty of candour.
- Review risk registers and the board assurance framework to provide assurance that risks are recorded correctly, being managed appropriately and mitigated in a timely way.
- Consider how to engage more widely with staff groups that have protected characteristics.
- Review its Equality Delivery System (EDS2) methodology to ensure it achieves the expected outcomes.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Royal Liverpool and Broadgreen University Hospitals NHS Trust

The Royal Liverpool and Broadgreen University Hospitals NHS Trust (the trust) provides acute services across two sites; the Royal Liverpool University Hospital and Broadgreen Hospital. Both hospitals are based close to the city centre, providing care and treatment to patients from across the North West of England, North Wales and the Isle of Man.

The health of people in Liverpool is generally worse than the England average. Deprivation is significantly higher than average 64.4% (303,377 people) and about 25,335 children (32%) live in poverty. Life expectancy for both men and women is lower than the England average.

The Royal Liverpool University Hospital is the main site operated by the trust, with a total of 857 beds, 792 of which are inpatient beds and 65 are reserved for day case procedures. This hospital provides a range of services, including urgent and emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, and a range of outpatient and diagnostic imaging services. The hospital also houses St Paul's Eye Unit which provides a range of outpatient services and elective and unplanned ophthalmology surgical services to patients locally, nationally and internationally. The unit sees in the region of 9,000 outpatients each month.

The trust started work on a new Royal Liverpool University Hospital in February 2014 and construction is underway, with the opening planned for 2017. The new Royal will be one of the biggest hospitals in the UK to provide all single en-suite bedrooms on each inpatient ward. There will be 23 wards, including a large clinical research facility and a 40-bedded critical care unit and the new Royal will have 18 state-of-the-art operating theatres. The emergency department will be one of the largest in the North West of England with its own CT scanner and special lifts for patients going straight to the operating theatres on the floor above.

Broadgreen Hospital has a total of 98 beds, 58 of which are inpatient beds and 40 are reserved for day case procedures. This hospital provides services including, a range of elective general medicine (including elderly care), elective surgery, day case surgery, and, outpatient and diagnostic imaging services.

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliffe, Secondary care clinician, NHS Newcastle Gateshead CCG and retired Surgeon/Medical Director

Head of Hospital Inspections: Ann Ford, Care Quality Commission

Inspection Manager: Simon Regan, Care Quality Commission

The team included 10 CQC inspectors, a senior analyst and a variety of specialists including: a director of nursing, a director, a governance specialist, a safeguarding adults and children lead, a senior associate for equality and diversity, a pharmacy inspector, an emergency department sister, a senior house officer in emergency medicine, a consultant anaesthetist, an advanced nurse practitioner for critical care, end of life care consultant, a clinical nurse specialist in palliative care, a gastroenterologist, a matron for the complex health and social care directorate, a renal doctor, and infection prevention and control nurse, a lead nurse in the post anaesthetic care unit, a consultant ophthalmologist, a junior doctor and a student nurse. We also used two experts by experience who had experience of using healthcare services.

Summary of findings

How we carried out this inspection

The Royal Liverpool and Broadgreen University Hospitals NHS Trust (the trust) was inspected previously in November 2013 and December 2013, then again in June and July 2014. These inspections were conducted as part of the initial pilot phases of our new inspection methodology. No ratings were applied and this is the trust's first comprehensive inspection as part of our new methodology.

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 our inspection we reviewed a range of information we held about the trust and asked other organisations to share what they knew. These included 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 for people who had experienced care at either the Royal Liverpool University Hospital or Broadgreen Hospital on 8 March 2016 in Liverpool. This event was designed to take into account people's views about care and treatment received at the hospital. Some people also shared their experiences by email and telephone.

As part of our inspection, we held focus groups and drop-in sessions with a range of staff in the trust including nurses, trainee doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

The announced inspection of the Royal Liverpool and Broadgreen University Hospitals NHS Trust took place on 15 – 18 March 2016. We also undertook an unannounced inspection on 30 March 2016 on both sites. As part of the unannounced inspection, we looked at the emergency department, medical care wards, surgical care wards and the Academic Palliative Care Unit (APCU).

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

What people who use the trust's services say

- The trust performed 'about the same' as other trusts in the 2014 CQC Inpatient Survey for all but one question. For the question 'did nurses talk about you as if you weren't there' the trust performed better than other trusts.
- There was good performance in the patient-led assessment of the care environment (PLACE) audits in 2013, 2014 and 2015 in relation to cleanliness, the trust scored 99 or 100 in all three years. The trust also performed better than the England average for food, privacy/dignity/wellbeing and facilities in all three years.
- Friends and family test performance at the trust was worse than the England average each month between August 2014 and November 2015, although there had been improvements in the results over that time period, particularly from June 2015 onwards, when performance was 3 – 4% below the national average. In addition, there were some positive results at individual ward and department level.
- There was generally good performance in the Cancer Patient Experience Survey in the 2013/14 financial year. The trust performed in the top 20% of trusts in England for 10 questions, in the middle 60% for 21 questions and in the bottom 20% for 3 questions.

Summary of findings

Areas of good performance included “trust in medical staff”, “staffing levels” and “quality of communication and responses to questions by medical staff”. Areas of poor performance included “communication to patients about free prescriptions” and “support groups available”.

Facts and data about this trust

The Royal Liverpool and Broadgreen University Hospitals NHS Trust (the trust) provides acute services across two sites; the Royal Liverpool University Hospital and Broadgreen Hospital. There are 896 beds across the trust in total with the majority (792) being located on the Royal Liverpool University Hospital site and 98 at Broadgreen Hospital.

The trust is one of the largest hospital trusts in the north of England serving more than 465,000 people in Liverpool and the wider North West of England.

Between 14 December 2014 and 13 December 2015 there were 114,376 emergency department attendances at this hospital. In 2014/15 there were 94,959 inpatient admissions and 696,003 outpatient attendances across the trust. The trust employs over 6,000 members of staff and the full cost of providing services in 2014/15 was approximately £472 million.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated the trust as 'Good' for Safe because; • There were good systems and processes in place to promote the provision of harm free care to patients and there were low rates of avoidable harm including, falls, infections and pressure ulcers. • There was a process to report incidents which was well understood and applied by staff. There was evidence of organisational learning and improvement as a result of incident investigations. • There were sufficient numbers of trained nursing, medical and support staff with an appropriate skill mix to ensure that patients' needs were appropriately met at the time of the inspection. • Both hospitals were generally visibly clean and well maintained. There were robust systems in place for the prevention and control of infection. • There were regular audits of cleanliness and infection control standards with high levels of compliance across the trust. Where audits identified areas that feel short of the required practice, actions were taken to secure improvement. • Staff were aware of their roles and responsibilities and knew how to raise safeguarding concerns appropriately. There was a high compliance with both adult and child safeguarding training (all levels). Most areas we inspected were above, or, in line with the trust's target across all services we inspected. However; • The trust had a process in place to fulfil its obligations in relation to the duty of candour regulations but it was only extended to serious incidents and not moderate harm incidents as outlined in the regulation. • The checking of medication, fridge temperatures and resuscitation equipment was not always carried out consistently as per trust policy. **Cleanliness, infection control and hygiene** • The trust had infection prevention and control policies and procedures in place, which were accessible to staff.	Good 

Summary of findings

- Staff generally followed good practice guidance in relation to the control and prevention of infection. 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- Almost all of the areas we visited were found to be visibly clean and tidy. However, the podiatry room within the Diabetes Centre was noted to have dust on the work tops and behind the examination couch and the refrigerator contained a box with mould on it.
- Infection prevention and control audits and hand hygiene audits were carried out on a regular basis. These identified good practice and areas for improvement. Key actions were identified to be implemented by staff.
- Between December 2014 and November 2015, the trust reported a total of 42 cases of clostridium difficile, 26 cases of methicillin-susceptible staphylococcus aureus (MSSA) and two cases of methicillin-resistant staphylococcus aureus (MRSA) infections, which meant that the trust did not meet the national standard.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust had a process in place to fulfil its obligations in relation to the duty of candour regulations. However, this process was only extended to serious incidents and not moderate harm incidents as outlined in the regulation. There were examples of where staff had formally apologised to patients when incidents of moderate harm had occurred but this was not routinely applied or monitored by the trust. We raised this with the trust and they provided us with an action plan to address this by the end of April 2016. We have issued the trust with instructions that they must take steps to become compliant with this regulatory requirement.
- There was evidence that the trust was open and honest with patients in the serious incidents we reviewed. Records showed that a formal apology had been given as required, along with an explanation of the actions that would be taken to prevent the issue happening again.
- The majority of staff we spoke to were aware of the need to be open and transparent under the duty of candour regulation.

Summary of findings

Safeguarding

- There were trust-wide safeguarding policies and procedures in place, which were supported by staff training.
- Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately, including issues relating to domestic violence, child sexual exploitation and Female Genital Mutilation (FGM).
- Compliance rates were high for both adult and child safeguarding training (all levels). Most areas we inspected were above, or, in line with the trust's target across all services we inspected.
- Staff described how they had dealt with safeguarding incidents and how advice had been accessed from the safeguarding team.
- The trust had a safeguarding team in place that provided guidance to staff during weekdays.
- Staff had access to senior nurses within the hospital management team outside of normal working hours and at weekends to seek advice and guidance on safeguarding issues.

Incidents

- The trust had a policy and an electronic system for the reporting and management of incidents.
- Staff in all areas were aware of the types of incident they should report and were able to give us recent examples where they had reported them.
- There was evidence that incidents, including serious incidents, were investigated. Any lessons learnt as a result of them were fed back to staff who were involved and shared more widely to prevent recurrence. There were also examples of learning displayed on 'quality boards' at the time of the inspection.
- We saw evidence that staff were involved in the investigation process. Staff told us they felt positive about this and they felt the process was constructive not punitive.
- The latest national reporting and learning system (NRLS) data (published September 2015, covering incidents reported to the NRLS between the 1st October 2014 and the 31st March 2015) stated that the trust takes a median of 91 days to upload an incident to the NRLS and reported 4,308 patient safety incidents during this period. The NRLS showed that for all incidents that were submitted to the NRLS for similar trusts, 50% were reported more than 26 days after the incident occurred. This means that the trust takes longer than most acute trusts to upload its incidents. The reporting rate of 31.5 patient safety incidents per 1,000 bed days, which is slightly below the median average of 35.3 for acute trusts but still within the

middle range for 50% of reporters. This had been an area of focus for the trust and there are signs of improvement. The trust was previously in the lower quartile for patient safety incident reporting and had increased incident reporting.

- Serious incident management was undertaken on a case by case basis. The process for this, following completion of the investigation, was to include it on the risk register until all actions had been completed. However, there was no corporate overview of the actions across the board or process for identifying themes or duplication in actions. We were told that this was done by the risk management team through experience and memory as opposed to a systematic approach. We requested the monitoring reports for serious incident performance and were told that this does not happen; this was in terms of number of days taken to report and investigation timescales.

Mortality

- Mortality and morbidity reviews were held monthly in most services and bi-monthly in outpatients and diagnostic imaging services. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent recurrence.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 1 would mean that the number of adverse outcomes is as expected compared to England. A score of over 1 means more adverse (worse) outcomes than expected and a score of less than 1 means less adverse (better) outcomes than expected. Between October 2014 and September 2015 the trust's score was 1.037, which was within the expected range.
- Critical care services provided continuous patient data contributions to the intensive care national audit and research centre (ICNARC) which allowed outcomes for patients to be benchmarked against similar units nationally. The most recently validated ICNARC data for the period July 2015 to September 2015 showed that the mortality ratio was within the expected range for comparable units. In addition, for the

intensive therapy unit (ITU) the data showed that ventilated patients, patients admitted with severe sepsis and patients admitted following elective or emergency surgery, mortality was similar to or better than similar units nationally.

- Data for the high dependency unit (8HDU) in the same period showed that for elective and emergency surgical admissions the mortality was better than comparable units. However, for admissions with trauma, perforation or rupture, the mortality were was worse than similar units.
- Evidence based pathways were in place for common causes of mortality in the trust using the Advancing Quality programme.
- The renal medicine service had developed a clinical pathway for new dialysis patients. The pathway was designed to address the high 90-day mortality rates by targeting: improved rates of transplantation; better enabling self-care; improved vascular access, better medicines management; earlier access to psychological support.

Nursing staffing

- Staffing levels were reviewed every six months using the 'safer nursing care tool' (SNCT). This is an evidence based tool which allows nurses to assess patient acuity and dependency and to determine the recommended number of staff. Each ward or department had a planned nurse staffing rota and any shortfalls in staff numbers were reported on a daily basis to senior managers.
- There were sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients' needs were appropriately met at the time of the inspection. There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty.
- Wards and departments displayed nurse staffing information on a board in most areas. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirements.
- In medical services, managers told us they were having difficulty in providing the correct expected staffing levels on due to a high level of staff nurse vacancies and a sickness rate ranging from 5.8% on cardiology, 4.4% on respiratory and 7% on gerontology. At the time of our inspection data provided by the trust showed there were 120 registered nursing staff vacancies.
- Senior managers met daily to discuss staffing and ensure there was adequate cover and skill mix of staff across medical services. Managers informed us that, to ensure patient safety,

extra bank health care workers were used to fill the shortfalls and provide assistance to the nursing staff. Nurses also used a 'red flag' system, whereby a senior nurse could be contacted if there were particular concerns, which included staffing. Managers responded appropriately and worked hard to maintain appropriate staffing levels in all services.

Medical staffing

- Medical treatment was delivered by skilled and committed medical and surgical staff.
- The information we reviewed showed that medical staffing was generally sufficient to meet the needs of patients at the time of the inspection.
- The percentage of medical staff who were consultants working in the hospital was 37% which was slightly below the England average of 39%. The percentage of registrars was 41% which was higher than the England average of 38%. The percentage of junior doctors was 18% which was higher than the England average of 15%. Middle grade levels were 3% which was lower than the England average of 9%.
- The intensive care society standard for consultant to patient ratio states that the ratio should not exceed from 1:8 up to 1:15. With only one consultant on at night there were times when this standard was not being met.
- The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance states there should be a minimum of one whole time equivalent (WTE) consultant per 250 beds. This trust has 896 beds which equates to in excess of three WTE consultants. The trust employed four WTE consultants at the time of the inspection, which was slightly more than recommended, which is positive.
- Specialist palliative care, advice and support was available 24 hours per day seven days per week.
- There was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by consultants and their medical teams.
- The radiology department was staffed by consultant radiologists and due to an increase in imaging complexity and activity, a shortage of radiologists was recorded on the risk register. Monitoring of activity was continuing and a workforce review was in progress.

Are services at this trust effective?
We rated the trust as 'Good' for Effective because;

Good

Summary of findings

- Care and treatment was generally evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.
- Nutrition and hydration was well managed, with appropriate assessments documented and onward referrals to dieticians made where required.
- There was good use of clinical audit to monitor and improve performance. Where audits highlighted areas for improvement the trust developed, implemented and monitored action plans.
- Outcomes throughout the trust were generally above; or, similar to national averages, although there was some poor performance in some areas.
- There was good performance in the National Care of the Dying Audit for Hospitals (NCDAH) in 2013/14 and in the 2015 End of Life Care Audit: Dying in Hospital.
- Effective multidisciplinary team (MDT) working was well established across the wards and departments we inspected. Assessments were focussed on securing good outcomes for patients in all of the services we inspected; they were regularly reviewed by all team members and kept up to date.
- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.

However;

- There was poor performance in some audits, such as the 2014 National Emergency Laparotomy Audit (NELA).
- Not all of the clinical audits that were planned took place in 2014/15 financial year.
- Although the trust were monitoring actions as a result of clinical audits, the actions were not weighted to indicate what was the most important and some actions were overdue at the time of the inspection.

Evidence-based care and treatment

- Care and treatment was generally evidence-based and the policies and procedures, assessment tools and pathways followed recognised and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE) and the relevant Royal Colleges'. However, the critical care service was not fully compliant with NICE guidance 83, "Rehabilitation after Critical Illness".

- Clinical pathways and care bundles were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards.
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.
- Evidence based pathways were in place for all common causes of mortality in the trust using the Advancing Quality programme.
- In surgery, when considering the order of theatre lists, a patient's medical condition was taken into account. For example, patients with a diagnosis of diabetes were allocated first on operating lists in line with best practice guidance.
- In medical services, there was evidence of regular audit meetings and they were able to demonstrate specific improvements to the quality of care provided for patients. An example of this was the introduction of the frailty pathway.
- In the emergency department, a range of evidence based clinical care pathways were available. These included fracture neck of femur, sepsis, stroke and overdose of paracetamol. The pathways included prompts and treatment steps for staff to follow. Patients were placed on appropriate pathways as soon as their condition was diagnosed which ensured that they received timely and appropriate interventions.
- We were provided with the trust-wide clinical audit annual report for 2014/15. This highlighted that there were more audits planned for the year than completed, with some of them being carried forward to the next year.
- There was a process in place for monitoring any subsequent improvement actions that had been identified as part of audits. We were provided with a divisional template as an example of this process. The monitoring system highlighted that there were a number of actions still outstanding at the time of the inspection and in some cases; they had passed the target date for completion. There did not appear to be any weighting in the monitoring tool to determine the level of importance for each action to inform whether it was appropriate for them to go past the completion date in favour of progressing more high risk actions.

Nutrition and hydration

- Records showed that patients had an assessment of their nutritional needs using the Malnutrition Universal Screening Tool (MUST) and were referred to a dietician where indicated. In

all the records we reviewed, a nutritional risk assessment had been completed and updated regularly. This helped identify patients at risk of malnutrition and adapt to any ongoing nutritional or hydration needs.

- Staff in surgical services managed the nutrition and hydration needs of patient's well, both pre and post operatively. Patients were given information in the form of leaflets about their surgery and told how long they would need to fast pre-operatively.
- A coloured tray and jug system was in place to highlight which patients needed support with eating and drinking. In addition, there were special plates to meet individual needs including smaller plates for patients' who needed to eat small amounts frequently.
- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns.
- In order to meet the guidelines for the provision of intensive care services (GPICS) standard for dietetic support the unit should have 0.1 whole time equivalent (WTE) of a dietician per critical care bed. However, the current allocation for critical care was 0.04 WTE per critical care bed.
- The trust scored about the same as other trusts of a similar size in England for the one question related to nutrition and hydration in the Accident and Emergency (A&E) survey 2014.

Patient outcomes

- There was clear evidence of involvement in local and national audit. Outcomes throughout the trust were generally above; or, similar to national averages, although there were some areas for improvement.
- Medical services participated in the joint advisory group on gastrointestinal endoscopy (JAG) and were JAG accredited. The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2013/14, showed a mixed response for the service. The number of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI - a type of heart attack) seen by a cardiologist prior to discharge was better than the national average at 97% (the national average was 94%). Seventy-four percent of patients with an N-STEMI were admitted to a cardiology ward. This was better than the

national average of 55%. The percentage of patients who were referred or had an angiograph (an investigation that looks into the blood vessels of the heart) was 65% which was worse than the England average of 78%.

- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. This highlighted that the service performed well in the July to September 2015 quarter. The trust scored in the top 80% in all but two of the team centred and patient centred domains. The trust scored in the lower 50% in the three quarters from January 2015 to September 2015 for the provision of speech and language therapy.
- The 2013/14 heart failure audit showed the hospital performed better than the England average for all but one of the indicators (discharge planning).
- In the national diabetes inpatient audit 2013, the trust had a mixed performance with 12 positive findings and nine negative findings.
- In medical care services, they had developed per-Oral Endoscopic Myotomy (POEM) for achalasia (a disorder of the gullet). Patients were able to be discharged the same day as the procedure. This was an alternative method of performing a myotomy (cutting the muscle) other than the surgical route. Data provided by the trust showed a success of over 90%, which was comparable with the established surgical procedure.
- The respiratory directorate implemented a series of consultant rota improvements that enabled the delivery of a seven-day led consultant ward round on their respective wards. Data provided by the trust showed an improvement in length of stay by 75% from an average of 12-14 days reduced to four days.
- There was good performance in the national bowel cancer audit in 2014, which showed that the all indicators were better than the England average, with the exception of the number of patients experiencing a length of stay above five days, which was marginally higher (worse) than the England average.
- The Liverpool Lung Cancer Unit (which was a partnership with a neighbouring trust) performed well in the 2014 lung cancer audit, with a multidisciplinary team (MDT) discussion rate and a computerised tomography (CT) rate before bronchoscopy above 99%, which were both higher (better) than the England and Wales average.
- The trust participated in the 2014 National Emergency Laparotomy Audit (NELA). The results showed some areas of poor performance. For example, less than half of patients received a consultant surgeon review within 12 hours

admission or a pre-operative review by a consultant surgeon and anaesthetist. In addition, less than half of patients had a consultant surgeon or anaesthetist present at their procedure and less than half of patients aged over 70 had an assessment by a medical crises in older people (MCOP) specialist. There was an action plan in place that, at the time of inspection. This plan included a wide range of trust services that included use of the Enhanced Peri-Operative Care for High-risk patients (EPOCH) trial and trust SEPSIS campaign.

- The trust performed better than the England average for seven out of eight indicators in the 2015 hip fracture audit although the trust's own performance had deteriorated in four of the areas from the previous year. The trust had an action plan, as part of the hip fracture database, to transfer patients from the emergency department to the acute orthopaedic ward in four hours by 'ring fencing' beds, and then supporting early discharge systems, however; this was overdue review. There was also an action plan regarding compliance with NICE Care guideline124: Cognitive assessment & recording in fragility fracture patients. This included the education and supervision of junior doctors and the development of a discharge summary, however; it was overdue a review.
- Performance in the Patient Reported Outcome Measures (PROMs) audit for the 2014/15 financial year was similar to the England average for groin hernias and slightly worse than the England average for hip replacements and knee replacements.
- There were patient-led care pathways in place, such as the accelerated post-operative recovery pathway in colorectal surgery. Prior to its implementation, recovery used to be 10 to 14 days, whereas it was approximately five days at the time of the inspection.
- In medical care services, the readmission rates trust-wide were slightly worse than the England average for all elective procedures. For non-elective medical care procedures, the relative risk of readmission was slightly higher (worse) for general medicine when compared to the England average but slightly lower (better) for cardiology and gerontology.
- In urgent care services, the unplanned re-attendance rate within seven days was consistently higher (worse) than the England average between October 2014 and October 2015. This meant that more patients re-attended A&E in this trust when compared with similar trusts. The trust had regular directorate and service level meetings where measures to reduce the re-

attendance rates were discussed. A number of measures were in place to reduce this rate including outreach programmes for vulnerable patients, which offered support in the community to reduce the risk of re-attendance.

- In surgical services, the risk of readmission was similar to the England average for all non-elective specialities at the Royal Liverpool University Hospital. However, it was higher (worse) than the England average for all elective specialities and nearly double the expected range for general surgery.
- In surgical services at Broadgreen Hospital, the risk of readmission was lower (better) than the England average for elective urology, and, trauma and orthopaedics, and similar to the England average for ear, nose and throat (ENT).
- In surgical services, the average length of stay for the both hospitals operated by the trust was higher (worse) than the England average across all specialities for elective and non-elective surgery between September 2014 and August 2015.
- We were provided with the latest validated and published Intensive Care National Audit and Research Centre (ICNARC) data for the period July to September 2015, which benchmarked the intensive therapy unit (ITU) and high dependency unit (8HDU) against comparable units nationally.
- For the period July 2015 to September 2015, the ITU data showed that for ventilated patients, patients admitted with severe sepsis and patients admitted following elective or emergency surgery mortality was similar to or better than similar units nationally, although the mean average length of stay was longer (worse) than the national average. In terms of unit acquired infections in blood, for ventilated patients the unit performed within the expected range when compared with similar units nationally but for elective and emergency surgery there were no cases of unit acquired infections in blood.
- For the period July to September 2015, the 8HDU data showed that for elective and emergency surgical admissions the mortality and length of stay was better than comparable units. However, for admissions with trauma, perforation or rupture, the mortality and length of stay for the period was worse than similar units. There had been no instances of unit acquired infections in blood for any emergency or elective surgical admissions to 8HDU.
- The latest available ICNARC data showed that the unit was performing within the expected range for early readmissions and post unit hospital deaths, when compared with similar units. Early readmissions are classified as being unit survivors

that are subsequently readmitted to the critical care unit within 48 hours of discharge and post unit deaths are classified as being unit survivors that die before ultimate discharge from acute hospital, (excluding those discharged for palliative care).

- The hospital specialist palliative care (HSPC) team aimed to see at least 90% of patients within 24 hours. In every month from August 2015 to January 2016 the HSPC team recorded that they exceeded the percentage of people seen. In January 2016 they saw 98.1% of patients within 24 hours despite seeing an increased number of referrals (161).
- The team completed a snap shot audit from the care of the dying document to ensure all patients who were at the end of their life received an assessment and symptom control for the five symptoms which could develop in the last hours or days of life. The audit looked at pain, agitation, nausea, vomiting and respiratory tract secretions. In December 2015, the data showed, in 16 documents reviewed, 100% of patients at the end of their life had received an assessment and symptom control for all five symptoms that could occur. The audit was completed again in January 2016 and found, from 22 documents reviewed, 95.7% of patients at the end of life had evidence of an assessment and symptom control.
- The trust had participated in the National Care of the Dying Audit of Hospitals (NCDAH). The findings from the 2013/14 audit showed the trust achieved all seven of the organisational key performance indicators, and achieved excellent performance in terms of the clinical key performance indicators, scoring 84% and above in each indicator, which was above the national average in every indicator.
- The findings for the 2015 End of Life Care Audit: Dying in Hospital, which replaced the NCDAH were published at the end of March 2016. The audit showed that the trust again achieved excellent results in all of the clinical and organisational key indicators. For example, where a death was expected this was documented in 100% of cases (excluding unexpected deaths) compared with a national average of 93%. The trust also scored 100% in patients being regularly reviewed, and discussions taken place with family, compared to a national average of 91% and 95%.
- In outpatients, the trust's rate of follow up appointments in relation to new appointments was similar to the England average between September 2014 and September 2015.

Multidisciplinary working

- Effective multidisciplinary team (MDT) working was well established across the wards and departments we inspected. It

was evident from discussions with staff, observations of inspection and reviews of records that there was a joined-up and thorough approach to assessing the range of people's needs.

- Assessments were focussed on securing good outcomes for patients in all of the services we inspected; they were regularly reviewed by all team members and kept up to date.
- It was evident that professionals from all disciplines valued each other's contribution and that relationships between them were positive and productive.
- The Liverpool Lung Cancer Unit (which was a partnership with a neighbouring trust) performed well in the 2014 lung cancer audit, with a multidisciplinary team (MDT) discussion rate above 99%, which was higher (better) than the England and Wales average.
- There was an outreach team available across the trust, Monday to Friday from 8am to 5pm and they worked closely with the critical care team both in following up recently stepped down or discharged patients and in discussing deteriorating patients on the wards.
- In the end of life service, MDT working was integral to the delivery of an effective service at the trust. The records we reviewed showed that patients regularly had input into their care from other health professionals, including physiotherapy, occupational therapy, speech and language therapy, and dietician services.
- There was a weekly Hospital Specialist Palliative Care (HSPC) MDT meeting to discuss treatment and plans for new and current patients. This was also attended by the chaplaincy team who then visited patients and offered them non-clinical spiritual support.
- The HSPC team had close links with community partners, general practitioners, district nursing teams and social care services to ensure each were aware that a patient being discharged had continuity of care. We observed an end of life patient being discharged from the Academic Palliative Care Unit (APCU) and found that the HSPC staff contacted all community partners to inform them of the discharge arrangements and ensured all onward care was in place before proceeding.
- The HSPC staff also attended other speciality site specific multidisciplinary meetings including respiratory, gastroenterology, and haematology meetings.
- The rapid assessment and interface discharge (RAID) team who were employed by a neighbouring trust; provided mental health services and worked closely with staff to ensure patients

were supported on discharge. Staff across all areas told us that they had access to this team and we saw examples of them working with emergency department staff to facilitate the safe discharge of a patient.

- The diagnostic imaging, therapies and outpatients departments were staffed by a range of professionals working together as a multidisciplinary team to provide a comprehensive service to patients. Weekly multidisciplinary meetings were attended by staff from the pain clinic involving pain consultants, specialist nurses and psychologists.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.
- The trust had audited consent processes across a number of surgical specialities and theatres. The audits looked at eight standards which included things such as whether serious occurring risks were documented on consent form and whether confirmation of consent has been completed. Compliance with the audit standards were generally good. When specific areas fell below the standards required, an action plan was developed and a re-audit date set to check for improvements.
- Staff had knowledge and understanding of procedures relating to Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interests of the person, and there is no other way to look after them. This includes people who may lack capacity.
- In the computerised tomography (CT) department we observed a patient being asked to consent to treatment. The patient refused but appeared to lack capacity so the staff member checked for a Deprivation of Liberty Safeguard in their health record. The ward was contacted, as no record was present. The radiographer then acted appropriately and returned the patient to the ward until the appropriate documentation had been put in place.
- In medical care services, we saw examples of Deprivation of Liberty Safeguards (DoLS) paperwork but the completion and application was variable. Despite this, when best interest decisions where recorded, we found them to be appropriately documented.

Summary of findings

- In critical care services, there was a consultant lead for mental capacity and deprivation of liberty safeguards who was working at a local and national level to develop guidance for staff working in critical care regarding the application of deprivation of liberty safeguards for critical care patients. This was innovative work as the applicability of the Mental Capacity Act 2005 in a critical care setting was generally little understood.

Are services at this trust caring?

Good

We rated the trust as 'Good' for Caring because;

- Care and treatment was delivered by caring, committed, and compassionate staff. Staff in all disciplines treated patients and those close to them with dignity and respect.
- Staff were open, friendly and helpful, many went out of their way to help and support patients.
- Patients were positive about their interactions with staff. We saw some excellent examples of staff 'going the extra mile' and providing care in an individualised and person-centred way.
- We were told numerous stories that demonstrated the compassion, kindness and thoughtfulness of the staff delivering palliative and end of life care. For example, staff told us about a wedding that took place on the ward to support the dying wishes of a patient and how pets had been brought in to comfort dying patients.
- The trust took steps to ensure that no one would die alone. There were many well trained care of the dying volunteers to support patients and their families at the end of life. This allowed for a period of respite to families or just for them to sit with patients who had no close family to ensure they had comfort and support in their last hours of life.
- Staff actively involved patients and those close to them in the planning of their care and treatment. Patients felt included and valued by staff.
- Staff took the religious and cultural needs of patients into account when delivering care and treatment.

However;

- NHS Friends and family test performance at the trust was worse than the England average each month between August 2014 and November 2015, although there had been improvement in the results over that time period. In addition, there were some positive results at individual ward and department level.

Summary of findings

Compassionate care

- Care and treatment was delivered by caring, committed, and compassionate staff. Staff at all grades treated people with dignity and respect. Patients were very positive about their interactions with staff.
- Staff were open, friendly and helpful, many went out of their way to help and support patients.
- Staff providing palliative and end of life care demonstrated flexibility and kindness when meeting people's wishes. They told us that they had been able to facilitate a wedding on the ward to enable a dying person to get married in the last days of their life. The ward laid out a large buffet for the guests with tables and flowers.
- The hospital specialist palliative care (HSPC) team reported that the trust had enabled the wish of a dying patient to see her pet dog as a comfort to her in the last few days of life. On the respiratory ward they described a time when a football club brought in the European cup to show a dying patient. The patient had her photographs taken with the team and passed away 'happy' four hours later.
- In the cancer patient experience survey for inpatient stays during 2013/14, the trust performed in the top 20% of trusts in England for 10 questions, in the middle 60% for 21 questions and in the bottom 20% for three questions. Areas of good performance included trust in medical staff, staffing levels and quality of communication and response to questions by medical staff. Areas of below average performance included communication to patients and availability of support groups.
- The trust consistently performed better than the England average in all four parts of the patient-led assessments of the care environment (PLACE) in 2013, 2014 and 2015. These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey for all but one question. For the question "did nurses talk about you as if you weren't there" the trust performed better than other trusts.
- Friends and family test performance at the trust was worse than the England average each month between August 2014 and November 2015, although there had been improvement in the results over that time period. In addition, there were some positive results at individual ward and department level.

Understanding and involvement of patients and those close to them

- Patients and those close to them were encouraged and supported to be an active partner in their care.

Summary of findings

- Patients and those close to them confirmed that staff kept them informed about their treatment and took in to account their wishes and preferences when delivering care and treatment. Information about care and treatment was provided in a manner they understood.
- The trust took steps to ensure that no one would die alone. There were many well trained care of the dying volunteers to support patients and their families at the end of life. This allowed for a period of respite to families or just for them to sit with patients who had no close family to ensure they had comfort and support in their last hours of life.
- Ward staff helped families to complete 'this is me' documentation, for patients living with dementia. The documentation included patient's preferences, for example food likes and dislikes.

Emotional support

- Staff recognised that meeting people's emotional needs was important and they were sensitive and compassionate in emotional or stressful situations.
- Chaplaincy services were available on site to provide additional emotional support and staff were able to tell us how they would access these for patients.
- There was a bereavement support service to provide staff and relatives with help and emotional support following a bereavement or stressful situation. Counselling services were offered throughout the journey of patients and relatives. We found that relatives were offered support on the wards, through to the mortuary and bereavement service.
- Clinical nurse specialists, such as breast care nurses and stoma nurses, were available to provide support to patients in times of need.
- The emergency department worked closely with a local project which supported patients who had experienced domestic abuse. This collaboration provided in reach by the project workers to the department to provide support and safe places for patients experiencing domestic violence.

Are services at this trust responsive?

Requires improvement

We rated the trust as 'Requires Improvement' for Responsive because;

- Bed occupancy rates trust-wide, delayed transfers of care and discharges had an impact on the flow of patients throughout the hospital, although this was more prevalent at the Royal Liverpool University Hospital site.

Summary of findings

- There were many patients who were medically fit to leave hospital but were unable due to other factors including waiting for social care packages.
- Data provided by the trust showed that for 33 days out of the six months prior to our inspection patients had needed to sleep in beds on the acute medical unit (AMU) due to a lack of beds elsewhere in the hospital.
- There were issues with access and flow within critical care, which were related to the wider access and flow pressures within the hospital. These regularly resulted in delayed discharges and the associated cancellation of elective surgery.
- We found the trust was not always accurately recording the time of patient's journeys in the emergency department, including the decision to admit timings. We raised this with the senior management team and they addressed this quickly and appropriately.
- The emergency department frequently experienced issues with access and flow and there was overcrowding in the department during our visit. From September 2013 to September 2015, the total time patients spent in the emergency department (average per patient) was consistently higher (worse) than the England average.
- The Department of Health target for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival was not met from July 2014 to November 2015, the trust only met this target for two months out of twelve, although performance was routinely above the England average during this period.
- At our last inspection we found "outliers" were a concern. At this inspection we found that improvements had been made with the tracking of outliers but they were still a concern for the trust. For example, on the acute stroke ward we found that more than half of patients were gerontology (elderly care) not patients who had suffered a stroke.

However;

- We found the trust had a wide range of services in place to meet the needs of its population across a wide geographical area.
- There were systems in place to meet the needs of patients whose circumstances made them vulnerable, including those patients living with dementia or a learning disability.
- The trust consistently performed above the England average when compared with similar trusts in meeting 18 week referral to treatment times (RTT) for medical and surgical specialities.

Summary of findings

- The trust performed above the England average for referral to treatment times for non-admitted pathways and incomplete pathways between September 2014 to November 2015.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was higher (better) for the trust compared to the England average each quarter between Q3 2013/14 and Q2 2015/16.
- Between May 2015 and February 2016 the trust met the national standard for diagnostic imaging waiting times with the exception of January 2016. In the same period, the trust met the national standard for ultrasound waiting times.
- The trust had a target that 70% of patients approaching the end of life would be followed through to discharge to their preferred place of care. The trust performed above the 70% target in every month from August 2015 to January 2016.

Service planning and delivery to meet the needs of local people

- We found the trust had a wide range of services in place to meet the needs of its population across a wide geographical area. It was noted the service had worked within its commissioning arrangements to streamline some services and make best use of resources.
- The new hospital was being built on a site adjacent to the existing hospital. The new build had been designed to provide patients with an improved experience, abetter and easier layout, green space, and a more attractive and welcoming building and site. Staff had been consulted as part of the design.
- In the emergency department, staff told us that there had been an increase in knife crime in the local area. In response to this, they had developed an awareness program on the dangers of knife crime and delivered this to local schools and education establishments.
- The medical service had worked with its partners in Merseyside to introduce the frailty unit and pathway to support frail older people with complex needs in the most appropriate setting either in the acute or community setting. The plan involved partnership working with other agencies to ensure patients were quickly seen and safely discharged. The plan highlighted the actions and responsibilities to be taken by each service to ensure continuity of services.

- Arrangements were in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital. The trust was part of the Cheshire and Merseyside major trauma network collaborative between local NHS trauma units at other hospitals within the network.
- Routine engagement and collaboration took place with staff from neighbouring specialist trusts, such as on-site outpatient clinics and regular multidisciplinary team meetings.
- The hospital specialist palliative care (HSPC) service was widely embedded in all clinical areas across the trust and had been involved in planning and delivering end of life services.
- An Academic Palliative Care Unit (APCU) opened in January 2016 providing 12 end of life beds for patients. The unit was developed to support the trust's vision to provide a model of best end of life care and to drive up the quality of end of life services. The trust had engaged advisors from Australia and Germany to support with the project, and Marie Curie Palliative Care Institute Liverpool (MCPCIL) to help develop the research and academic element to the unit.
- The APCU was a newly designed area and was bright and well organised. There was a large family room with seating, a quiet room, an oasis room for alternative therapies, and a large adapted bathroom for patients and visitors in wheelchairs. Following feedback from patients and visitors, a full length mirror had been installed and soap dispensers fitted at wheelchair height to enable the facilities to be used more effectively.
- In the end of life service, family members wishing to stay over on general wards were provided with recliner chairs and accommodation was available close to the hospital if they wished. Comfort packs were given to families who wanted to stay overnight. The packs were beautifully presented in bags made by local children and contained the necessary items to stay overnight.

Meeting people's individual needs

- There was a pathway for patients living with dementia or a learning disability which guided staff on how best to treat and meet the needs of these patients this pathway would follow the patient throughout their hospital journey. Staff also had access to specialist teams for advice and support.
- The trust had implemented a number of schemes to help meet people's individual needs, such as a yellow symbol to indicate that a patient was at risk of falls and a tree symbol for people living with dementia.

Summary of findings

- For those patients living with dementia or a learning disability, there were link nurses to support patients, families and staff. A 'this is me' booklet was used to support communication between patients and staff. The booklet was completed by close family members expressing likes and dislikes and history of the patient.
- The trust also used a health passport document for patients with learning disabilities. Patient passports provided information about the person's preferences, medical history, and support needs.
- A quality mark had been awarded on ward 2B at the Royal Liverpool University Hospital site for the dementia friendly environment. This was to ensure patients received appropriate care, reduced the stress for patients, and increased patient safety.
- The critical care service had developed dementia champions and all staff undertook dementia training (e-learning) as part of their mandatory training subjects.
- There were volunteers available for activities such as arts and crafts, dominoes, card games and reminiscence games.
- Patients who were at the end of life and had only hours or days to live had a full, comprehensive multi-disciplinary assessment under the care of the dying patient guidance document. The assessment took into account the patients' needs and was reviewed daily. A full, formal multi-disciplinary review took place every 72 hours. From the records we reviewed we saw this was completed.
- Staff told us that they always ensured patients had someone with them in their last hours of life. The Palliative care team had a team of 22 volunteers to help care for and support patients and their families at the end of life. The service had a counsellor to offer professional support to families. The volunteers sat with the patients to ensure the dying person was not alone, this offered a period of respite for the families. The volunteers used small cards to update families of any important messages or discussions.
- For those patients that had only a few hours to live and wished to return home, a member of the specialist palliative care team would travel in the ambulance to provide the support and reassurance the patient needed.
- There were 'hearing loops' readily available on all the wards we visited for patients with hearing impairments.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.

- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities, and in braille for patients who had a visual impairment.
- Access to psychiatric support was readily available from the rapid assessment and interface discharge (RAID) team which was provided by a neighbouring trust.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric (obese) patients.
- The emergency department had a designated homelessness link nurse who provided support and advice to homeless patients who presented to the department. This link service also worked closely with external charities and support organisations to ensure patients who were homeless received the best possible care and support.
- The trust also had a comprehensive strategy to help and support individuals experiencing domestic violence. This included working with charities and support organisations to provide in reach and outreach services to victims of domestic abuse.
- The trust was working with the local voluntary groups as part of Down's syndrome awareness week and was also planning events as part of dementia awareness.

Access and flow

- Bed occupancy rates trust-wide, delayed transfers of care and discharges had an impact on the flow of patients throughout the hospital, although this was more prevalent at the Royal Liverpool University Hospital site.
- Between January 2015 and December 2015, bed occupancy rates for medical services ranged from 95-100% above the national benchmark of 85%. This meant there were more patients needing medical beds than were available. Evidence has shown that when bed occupancy rises above 85% then it can start to affect the quality of care to patients and the orderly running of the hospital.
- At our last inspection we found "outliers" were a concern. At this inspection we found that improvements had been made with the tracking of outliers but they were still a concern for the trust. For example, on the acute stroke ward we found that more than half of patients were gerontology (elderly care) not patients who had suffered a stroke.
- At the time of the inspection, 168 patients were ready for discharge; of which, 39 were due to NHS community, 60 related

to social care assessment and place of care. However, for 69 of those, the trust held primary responsibility for the delay. Data provided by the trust indicated that on average 140 patients were ready for discharge each day.

- On the acute medical unit (AMU) at the Royal Liverpool University Hospital, we were told that the assessment room was often unavailable due to the number of patients in beds on the unit. We found two patients who had been on the unit for over 48 hours without moving to a ward. Data provided by the trust showed that for 33 days out of the six months prior to our inspection, patients had needed to sleep in beds on the AMU due to lack of beds elsewhere in the hospital.
- Data showed the majority of wards did not routinely move patients after midnight with the majority of wards moving under five patients a month. However, this was in contrast to the AMU results which showed an average of 200 patients per month moved after ten o'clock at night.
- Since our last inspection, the trust had introduced a 'live' interactive whiteboard' which could be accessed from a tablet, as part of a trust-wide system, as well as the wall display boards. The whiteboard held information electronically about which patients were in each bed on each ward at a glance. This information was used in the twice daily matron 'huddles' to monitor staffing levels.
- There is a Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival. From July 2014 to November 2015, the trust only met this target for two months out of twelve. For seven out of 14 months the department saw less than 95% of patients within this four hour target. However, performance was routinely above the England average during this period.
- From August 2014 to November 2015, the percentage of emergency admissions waiting four to 12 hours from decision to admit until being admitted was reported as being below (better) than the England average. This meant that on average patients waited less time when being admitted to hospital than in other trusts of a similar size in England.
- We found the trust was not always accurately recording the time of patient's journeys in the emergency department, including the decision to admit timings. We raised this with the senior management team and they addressed this quickly and appropriately.
- From September 2013 to September 2015, the total time patients spent in the emergency department (average per

patient) was consistently higher (worse) than the England average. This meant that, on average, patients spent more time in this emergency department than at other departments of a similar size across England.

- There were issues with access and flow within critical care, which were related to the wider access and flow pressures within the hospital. These regularly resulted in delayed discharges and the associated cancellation of elective surgery.
- In the event that no critical care bed was available for a patient in theatre, there were occasions when patients were cared for in theatre whilst a bed was awaited.
- Medical services consistently performed above the England average when compared with similar trusts in meeting 18 week referral to treatment times (RTT) for all specialities. From April 2015 to October 2015 the trust had achieved 100% for dermatology, gerontology and rheumatology with cardiology achieving 98% and gastroenterology achieving almost 100%. Endoscopies were carried out within six weeks.
- In surgical services, performance for national referral to treatment time (RTT) targets averaged 90% trust-wide from September 2014 to August 2015, which was above the England average for the whole period.
- Between September 2014 and August 2015, hospital episode statistics (HES) showed that the average length of stay for elective medicine at the Royal Liverpool University Hospital was more than three times higher than the national average for a number of specialties including clinical haematology and gastroenterology (the overall trust average was 10.8 days compared to the England average of 3.8 days). For non-elective medicine the rates were variable with a slightly worse length of stay for general medicine of 7.8 days but slightly better for cardiology at 5.6 days (the England average was 6.8 days).
- The hospital specialist palliative care (HSPC) team had a target that 70% of patients would be followed through to discharge to their preferred place of care. This ensured continuity for the patient and their families. From August 2015 to January 2016 the HSPC team achieved above 87% in every month, and in December 2015 achieved 100% of patients being followed through to their preferred place of care.
- The trust performed above the England average for referral to treatment times for non-admitted pathways between September 2014 to November 2015. Non-admitted pathways means those patients whose treatment started during the month and did not involve admission to hospital.

Summary of findings

- The trust performed above the England average for incomplete pathways between September 2014 and November 2015. However, performance dipped slightly in December 2015 and January 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- The percentage of people seen by a specialist within two weeks of urgent GP referral was slightly higher (better) than the England average between Q3 2013/14 and Q2 2015/16 with the exception of a dip in performance in Q2 and Q3 2014/15.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment for all cancers was slightly lower (worse) than the England average for each quarter from 2014/15 onwards.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was higher (better) for the trust compared to the England average each quarter between Q3 2013/14 and Q2 2015/16.
- Between May 2015 and February 2016 the trust met the national standard for diagnostic imaging waiting times (that is less than 1% of patients waiting more than six weeks) with the exception of January 2016 which showed 1.89 % of patients waited longer than 6 weeks.
- Data from the trust showed that in March 2016 46% of inpatient radiology examinations and 26% of outpatient radiology examinations were reported on within one day and 98% and 79% respectively were reported on within seven days. The figures for CT scan reporting were 94% of inpatient examinations and 38% of outpatient examinations were reported on within one day and 99% and 85% respectively were reported on within seven days.
- Information from the trust showed that laboratory reporting times were significantly below the nationally recommended turnaround time in January 2016. In the week commencing 4 January 2016, 37% of cases were reported in 10 working days compared to a target of 90%. At the time of our inspection a recovery plan was in place which included investment in equipment and increasing consultant reporting sessions. Data for February 2016 showed that reporting rates had increased and between 69% and 80% of cases had been reported within 10 days.
- The trust had a number of patients who failed to attend for their appointments. The 'did not attend' (DNA) rate was higher than the England average at all sites within the trust. The trust used a text service to remind patients a week and also a day

before their appointment. An '18 week pathway improvement workstream' had been initiated, which included a project to improve patient contact options, including use of a web form to request appointment changes.
- Patients told us they had a choice of appointments and 'hot' clinic appointments were available within vascular clinic.
- Between September 2015 and December 2015 the percentage of clinics cancelled within six weeks ranged from 2% to 3% and clinics cancelled over six weeks ranged between 2% and 4%. The main reasons for cancellation were annual leave, study leave and sickness.
- Patients told us some clinics regularly ran late and appointments were running 30 minutes late in St Paul's eye unit outpatients department on 16 March 2016 during our inspection. Display boards were in operation to advise patients of delays as well as verbal notification provided by staff. However, staff and managers told us that information regarding waiting times following arrival was not routinely collected.

Learning from complaints and concerns

- There was a trust-wide policy in place for managing concerns and complaints. Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Staff would deal with complaints informally if possible to aid timely resolution for the complainant.
- Managers discussed information about complaints during staff meetings to facilitate learning.
- Information about complaints procedures were available in all areas we visited. There were details on cards and leaflets about the patient advice and liaison service (PALS).
- The senior managers of the HSPC team reviewed all complaints where a patient had died, even if they had not been referred to the HSPC team. This ensured the response to the complaint was thorough and expressed empathy and sympathy to the bereaved relative. Responses were written and sent to the Chief Executive to be reviewed before being sent. Complaints were discussed weekly at patient experience meetings and learning shared through quality governance meetings. Managers informed us that outcomes from complaints were used to inform teaching. We reviewed letters sent out to bereaved families and found they were sent via the Chief Executive and offered deepest sympathy and had regard to duty of candour.
- After small falls each year between 2010/11 and 2013/14, the numbers of complaints trust-wide increased from 277 in 2013/14 to 419 in 2014/15.

Summary of findings

- The trust told us that complaints had been an area of challenge for them. Changes were made to the complaints policy and there was a process to devolve responsibility to the divisions and reduce the central control of complaints. An independent complaints review was commissioned to evaluate this work. The review showed improvement in the response times from 28% to 49%. However, it should be recognised that the time frame also increased in the policy at this time from the standard 25 days to 35 days.
- Another of the improvements highlighted by the review was learning from complaints. At the first stage of the review in October 2015 it was reported that learning was very limited with no systematic approach in place whereas the February 2016 review found improvement plans linked to all complaints with clear escalation processes. We were told that there has been positive feedback from staff regarding the changes in process. The review did not assess if there had been an impact on the number of complaints reopened.

Are services at this trust well-led?

Good

We rated the trust as 'Good' for Well-led because;

- The trust had a vision and strategy with clear aims and objectives. The trust's vision was 'to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population over our two hospital sites'.
- Staff were aware of the trust's vision and strategic themes and were able to articulate the vision and values for the trust. This vision was embedded in the trust and services strategies.
- There was a comprehensive end of life vision and strategy set out for 2013- 2018. The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was integral to the trust and had a well-developed and substantial palliative care directorate.
- The trust generally had a well embedded and improving approach to governance and risk management that had developed over time. There was a clear governance reporting structure and a strong committee structure in place that supported challenge and scrutiny of performance, risk and quality.
- Leaders were knowledgeable about the trust's priorities and challenges. Staff were included when considering actions to achieve and address them.
- Leaders demonstrated a commitment to quality, patient safety and continuous improvement.

Summary of findings

- There was a positive culture throughout the trust. Staff were proud of the work they did and proud of the services they provided.
- We found many examples of innovation and collaborative working. The trust was working under significant capacity demand pressures and was striving to sustain the level of care whilst looking at new ways of working.
- Nursing staff were engaged and felt that the Chief Nurse was a positive professional role model.

However;

- Further work was required to engage and support allied health professionals (AHPs) as some expressed that they did not feel they were aligned professionally with an executive lead in the trust.
- There were opportunities to improve oversight of actions arising from serious incidents and clinical audits, as well as the operational performance in relation to the timeliness of instigating duty of candour and reporting serious incidents.
- At the time of the inspection, the internal systems designed to support the fit and proper persons requirement were not robustly governed, nor applied.

Vision and strategy

- The trust had a vision and strategy with clear aims and objectives. The trust's vision was 'to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population over our two hospital sites'. The trust's values were based on five qualities they expected to see all staff display in their daily working lives which were; patient centred, professional, open and engaged, collaborative and creative.
- The trust's incorporated a number of strategic themes including improving patient experience, making the trust one of the most sought after places to be treated, improving the quality of life for patients by providing excellent, safe and accessible healthcare, developing a world-class workforce, to achieve international recognition for research and innovation and ringing new therapies from the bench to the bedside. Each strategic theme listed key objectives that were all aligned to the governance and assurance framework.
- Staff were aware of the trust's vision and strategic themes and were able to articulate the vision and values for the trust. This vision was embedded in the trust and services strategies.

- At the time of the inspection, the trust were in the process of building a new purpose-built hospital which is due to open in 2017. It was evident that staff were well sighted on the developments in the new hospital and they were engaged in the design process.
- The trust had strategies for individual services that were linked to the trust's overall corporate objectives, vision and values. For example, there was a comprehensive end of life vision and strategy set out for 2013- 2018. The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was integral to the trust and had a well-developed and substantial palliative care directorate.

Governance, risk management and quality measurement

- The trust generally had a well embedded and improving approach to governance and risk management that had developed over time. There was a clear governance reporting structure and a strong committee structure in place that supported challenge and scrutiny of performance, risk and quality.
- There were however, opportunities to improve oversight of actions arising from serious incidents and clinical audits, as well as the operational performance in relation to the timeliness of instigating duty of candour and reporting serious incidents.
- Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through divisional performance meetings. Staff on wards and departments had good access to performance information and were able to describe the risks and mitigating actions for their service.
- The trust produced an assurance report for the Board, which summarised key discussions, risks and decisions from the assurance committees. This gave the board a clear overview from each of the assurance committees in addition to the minutes.
- The trust board received a monthly dashboard. The dashboard considered indicators and risks to provide an overview of how the trust was performing. We noted that there were a large number of risks on there that had been on the risk register longer than 2 years, with 10 of the 34 risks identified in 2012 or earlier. Two risks had been on the risk register since November 2006. The descriptions were very brief and the 'main controls' were largely actions as opposed to controls. There was no target risk or indication of what actions would be taken and by

when they would be required to address these issues. The governance leads we spoke to acknowledged that this could have impacted on the volume of historic risks not closed down and that this would provide clarity in direction for the management of each risk.

- The Board Assurance Framework (BAF) was reviewed quarterly by the Executive Team and the trust board. The BAF had 9 strategic risks, which were aligned to the trust's strategic themes, departmental risks, performance activity, incidents and other quality indicators. A summary was provided at the beginning of the BAF, which linked the risks to the 5 strategic themes and provided an overview of any risk movements. The risk ratings provided were the initial risk score, previous quarter risk score and current risk score. Whilst this helped to track movement, there did not appear to be a target risk score and there was no risk appetite assigned to each strategic risk. It was therefore difficult to ascertain what the board was aiming to achieve and what the lowest level of risk that could be achieved in each financial year was. A second overview was also provided that aligned key performance indicators to each risk, which we found to be a useful way of presenting the assurance data. Each strategic risk clearly identified potential causes, consequences, controls, assurances, reporting mechanisms and gaps in controls or negative assurances. This was on one page for each risk and gave a comprehensive overview. However, some of the 'positive assurances' were over two years old and may not necessarily still be relevant. It was also not clear from the document what the planned actions were, who was responsible and when they will be completed as many had passed the completion date and simply have a 'next update' date. Some of the actions in the 'action plan' were described as 'action plan in place'.
- The board received a paper in February 2016 entitled 'Risk Management – update on action plan'. The initial review was undertaken in 2014, with a board workshop presentation of the findings in June 2014 and final report in August 2014. Actions that had not been completed at the time of the paper had been given extension dates. The board had originally planned for the recommendations of the report to be implemented fully by April 2015 but this had since been extended to December 2016 – over two years after the review was undertaken.

Leadership of the trust

- Leaders were knowledgeable about the trust's priorities and challenges. Staff were included when considering actions to achieve and address them.

Summary of findings

- Leaders demonstrated a commitment to quality, patient safety and continuous improvement.
- In all areas we inspected, staff felt there was clear leadership from managers. Staff could explain the leadership structure within the trust and within their own areas.
- Nursing staff were engaged and felt that the Chief Nurse was a positive professional role model. However, further work was required in relation to engagement with allied health professionals (AHPs) as some expressed that they did not feel they were aligned professionally with an executive lead in the trust.
- Senior managers were visible at the time of the inspection and staff confirmed they were regular visitors to wards and departments.
- Managers were seen as knowledgeable, approachable and supportive. Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings and other staff forums.
- In the 2015 national NHS staff survey, staff scored being supported by their managers out of five. This score was 3.79 which was above the national average of 3.66.

Culture within the trust

- There was a positive culture throughout the trust. Staff were proud of the work they did and proud of the services they provided.
- The culture in the trust appeared to be open and friendly, with a genuine eagerness to learn. For example, on the occasions where feedback was provided to leaders on challenging areas, such as compliance with duty of candour regulations and the fit and proper person process, leaders demonstrated openness, acceptance of the issues and a commitment to solve problems as soon as possible.
- Staff were encouraged to speak freely and to raise concerns so that action could be taken. Some concerns were raised about infection, prevention and control processes by a former member of staff at the time of the inspection. The trust had responded and taken action to address the concerns.
- In the 2015 national NHS staff survey the trust scored 3.82 out of five which is slightly above the national average of 3.76 for staff who would recommend the trust as a place to work or receive treatment. This was an increase on the previous 2014 survey. We also noted that staff motivation at work had improved compared with the previous survey to 3.84 but it was below the national average of 3.94.

Summary of findings

Equality and Diversity – including Workforce Race Equality Standard (WRES)

- As part of the new Workforce Race Equality Standard (WRES) programme we have added a review of the trusts approach to equality and diversity to our well led methodology. The WRES has 9 very specific indicators by which organisations are expected to publish and report as well as put action plans into place to improve the experiences of it Black and Minority Ethnic (BME) staff. As part of this inspection we looked into what the trust was doing to embed the WRES and race equality into the organisation as well as its work to include other staff and patient groups with protected characteristics.
- The equality & diversity function was overseen by an Equality & Diversity Sub-Committee, chaired by the Director of Human Resources, which exhibited a good commitment to the agenda.
- The trust published its WRES Report as required by NHS England and it has monitored its workforce across the protected characteristics since 2012. The trust had a reasonable proportion of staff disclosing their ethnic origin, even though there haven't been significant improvements over the past few years in this respect. Besides following the national trends on experience of black and minority ethnic staff as compared to white staff, the data indicated issues in the areas of leadership representation, access to non-mandatory training and staff progression.
- The trust did not routinely collect recruitment data across the protected characteristics in the reporting period due to the function being outsourced, which raised the question whether Equality Analyses were routinely undertaken on any major decision, given its lack of availability. In addition, the trust's report did not indicate that any engagement with staff had been undertaken or that the trust had an action plan for improvements in the area of WRES.
- Site visits and interviews informed the actions that the trust took to address the discrepancies identified through the implementation of the Workforce Race Equality Standard. The trust's campaign to reduce bullying & harassment experienced by black and minority ethnic staff over the past year showed some evidence of success, having improved the 2015 staff survey results in this area. Similarly, good practice had been identified around the use of third sector organisations and overseas options in recruitment as well as the launch of mandatory unconscious bias training for any recruiting managers.

- Whilst a number of areas of good practice had been identified, site visits revealed that some black and minority ethnic staff did not feel that their voice was being heard in a meaningful way in the organisation.
- Staff seemed to support each other in an informal way, but there was a formal engagement process missing. This finding is supported by our observations of the Equality Delivery System (EDS2) report and methodology, which identified that only staff side representatives had been engaged to assess the trust on goal 3 of the tool. However, it appeared that the trust engaged more widely with patients, public and third sector organisations to assess goals 1 and 2.
- Whilst the trust collected a large amount of patient and workforce data, these did not seem to be used in a systematic way to inform improvements and the EDS2 assessment. Furthermore, the trust did not publish the 2015/16 EDS2 reporting template on its website as required by NHS England.
- Site visits and interviews during the inspection also identified low morale and aspirations among black and minority ethnic staff. The reasons given were largely related to wider issues in the trust, such as understaffing. Factors such as this appeared to have contributed to increased sickness, reduced motivation, reduced aspirations and consequently, lack of ethnic representation in leadership positions. Additionally, the staff survey findings indicated that similar issues were experienced by staff with other protected characteristics, notably staff living with a disability.

Fit and Proper Persons

- The trust was aware of its obligations in terms of the fit and proper persons regulation. This regulation ensures that directors of NHS providers are of good character and have the appropriate skills and background to carry out their roles.
- The trust policy on pre-employment checks covered criminal record, financial background, identity, employment history, professional registration and qualification checks.
- Recruitment processes were in place and included relevant personal, professional and financial checks. However, there were gaps in some of the required documentation for board members. At the time of the inspection, the internal systems designed to support the fit and proper persons requirement were not robustly governed, nor applied. This was an area that required improvement and we have issued the trust with instructions that they must take steps to become compliant with this regulatory requirement.

Summary of findings

Public engagement

- Staff routinely engaged with patients and their relatives to gain feedback about their experiences and the quality of services. Feedback was used to improve practice and enhance the patient experience.
- The trust's website hosted a section on the 'New Royal', which provided information for the public on the development of the new hospital being built. This included information about the plan for all patients to be cared for in single en-suite rooms.
- Carer questionnaires were provided within information packs. These were also supported with telephone surveys providing individual patient feedback.
- The end of life service took part in the Care Of the Dying Evaluation (CODE) which sought the views of bereaved relatives and actions taken to improve performance. Invitations were also sent to bereaved families to ask them to take part in a bereavement services guideline development group to help the hospital specialist palliative care (HSPC) team support bereaved relatives.
- The volunteer programme was well established and offered local citizen's opportunities to contribute to patient care. Volunteers were very positive about the scheme and felt valued and included by the wider staff team.
- The end of life volunteer service provided patient and families with support. Volunteers would sit with patients to offer families a break and would stay with patients who had no family available to ensure they had company in their last hours or days of life.
- The trust was working with the local voluntary groups as part of Down's syndrome awareness week and was also planning events as part of dementia awareness.

Staff engagement

- Staff engagement was generally well managed and staff felt supported by leaders and managers.
- The intranet hosted a newsletter to ensure that staff were aware of the current priorities and what was happening within the trust.
- The trust held listening events for the staff to put forward ideas.
- The Director of Nursing held 'cake, coffee and chat' meetings on a monthly basis for nursing and allied health professional staff to discuss any issues, ideas or concerns.
- Staff were involved in decisions for making improvements to services and were given opportunities to influence the design and move to the new hospital in 2017.

- There was a range of reward and recognition schemes that were valued by staff. Staff were supported and encouraged to be proud of their service and achievements. Successes were acknowledged and celebrated.
- All the staff we met as part of our inspection were committed and motivated to delivering compassionate care.
- Staff were positive about the methods used to seek their views, comments and ideas.

Innovation, improvement and sustainability

- An analysis of the 2015 staff survey results showed 71% of staff at the trust, who responded, felt they were able to make suggestions to improve the work of their team or department. This was better than the national average of 69%.
- We found many examples of innovation and collaborative working. The trust was working under significant capacity demand pressures and was striving to sustain the level of care whilst looking at new ways of working.
- The emergency department had won a number of awards for a handbook which had been developed in house. This handbook was available as a mobile device application.
- There were new surgical care pathways being trialled, such as for reversal of ileostomy, trans-endoscopic micro (TEM) surgery and pancreatectomy.
- There was a consultant lead for mental capacity and deprivation of liberty safeguards who was working at a local and national level to develop guidance for staff working in critical care regarding the application of deprivation of liberty safeguards for critical care patients. This was innovative work as the applicability of the Mental Capacity Act 2005 in a critical care setting was generally little understood. It was hoped that the guidance being developed, once approved, would be adopted more widely across the critical care networks and would provide some much needed support and clarity for staff and patients in respect of this important legislation.
- The trust had developed the Academic Palliative Care Unit with support from international hospitals in Germany and Australia to support international benchmarking and quality improvements in hospital palliative care. The unit provided the opportunity for academic research alongside Marie Curie Palliative Care Institute Liverpool (MCPCIL) to further enhance end of life services.
- The HSPC team had appointed two discharge co-ordinators so that palliative and end of life patients reached their preferred place of care as quickly as possible. They worked closely with community partners to ensure that patients received care to

meet their needs once discharged from hospital. Through working in partnership with the MCPCIL they had implemented a rapid discharge home to die pathway and achieved excellent results in ensuring end of life patients were supported to be discharged to their preferred place of care.

- Complaints were dealt with sensitively and compassionately by the senior management from the HSPC team, even if the patient was not known or referred to the HSPC. This ensured high quality responses were given to bereaved families.
- End of life services had a substantial care of the dying volunteer service to ensure that patients and their families were supported. The volunteer service were winners of the Deborah Hutton award in 2015.
- The trust was working towards a fully functional Electronic Palliative Care Co-ordinating System (EPACCS) across relevant sites to enable service providers across boundaries to share information.
- In partnership with MCPCIL the HSPC team hosted monthly seminar meetings, and invited guest speakers to share their work and experience. The trust told us that they had guest speakers from Uganda and Germany.
- The HSPC team supported the mortality peer review process, attending complex mortality peer reviews, helping to identify lessons to be learnt and supporting any education and training issues. We saw evidence that there was a clear process to be followed with eleven steps to follow in the peer review process. The process was used to highlight concerns and learning points.
- The sexual health service was the main human immunodeficiency virus (HIV) centre for the region and had presented papers at national conferences including 'Developing a new virtual HIV Network: our region's experience'. The service was also involved in ongoing recruitment for research projects such as a randomised control trial of human papilloma virus vaccine (HPV) for treatment of genital warts.
- A specialist ocular oncology service was provided within St Paul's eye unit and the Clinical Eye Research Centre worked closely with a local academic establishment.
- The endocrine service within nuclear medicine had developed a nurse-led neuro-endocrine service and been awarded Team of the Year 2014.
- The nuclear medicine and radiopharmacy teams had developed a diagnostic agent for imaging prostate cancer. The teams had again been nominated for team of the year at the trust awards.

Overview of ratings

Our ratings for Royal Liverpool University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
End of life care	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Requires improvement	Good	Good

Our ratings for Broadgreen Hospital

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

Overview of ratings

Our ratings for Royal Liverpool and Broadgreen University Hospitals NHS Trust

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Outstanding practice and areas for improvement

Outstanding practice

- The emergency department worked collaboratively with local support groups and charities to provide excellent in reach and outreach services to sections of the local population. This meant patients received the best possible care which met their individual needs.
- The emergency department's practice development team provided excellent support and education to the staff within the department. They were responsive and provided tailored training programmes in response to issues identified through incidents and debriefing sessions which ensured that the staff within the department were equipped with the skills and training necessary to provide high quality patient care.
- The emergency department provided an education programme and outreach service to local education establishments on the dangers of knife crime with the aim of reducing this particular type of crime in the local population.
- The critical care team led by a designated consultant was developing guidance for staff in the application of the Mental Capacity Act 2005 and associated deprivation of liberty safeguards in the critical care setting. It was hope that this guidance once approved would be adopted across both the local and national critical care networks.
- The electronic whiteboard system used across the trust provided staff with information as to the bed allocated to each patient and to whether patients had particular assessments completed, for example venous thromboembolism (VTE). The board was also used to highlight vulnerable patients. We viewed the whiteboard on ward 3X where staff were piloting an increased functionality such as access to the National Early Warning Score (NEWS), referrals, graphs of patient's results over time and interaction with medical staff via the white board. We found this to be good practice and innovative.
- The trust had a comprehensive end of life vision and strategy set out for 2013- 2018. Their vision was to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population. End of life services had partnered with Marie Curie Palliative Care Institute Liverpool (MCPCIL) to further research and develop end of life services and collaborated with the Cheshire and Merseyside end of life network group to share research findings. This collaborative working helped support the commissioning and provision of excellent and equitable end of life services for the people of Merseyside and the surrounding boroughs.
- The trust had developed and opened a new Academic Palliative Care Unit (APCU), providing a 12 bedded unit for patients who were at the end of life.
- The trust had a well-established and well-staffed palliative care directorate that worked closely with other organisations to improve the quality of end of life services in Merseyside.
- The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was integral to the trust and had a well-developed and substantial palliative care directorate that was part of the medicine division.
- The trust had a robust education and training programme in end of life care and a formal programme of study days which was co-ordinated by the Hospital Specialist Palliative Care (HSPC) team and provided in conjunction with MCPCIL.
- End of life services had a substantial care of the dying volunteer service to ensure that patients and their families were supported. The volunteer service were winners of the Deborah Hutton award in 2015.
- Through working in partnership with the MCPCIL they had developed and appointed two discharge co-ordinators and implemented a rapid discharge home to die pathway. This had achieved excellent results in ensuring end of life patients were supported to be discharged to their preferred place of care.
- Care provided to patients went beyond most people's expectations. Staff showed care and compassion and went the extra mile to ensure patients at the end of life were well cared for. Care for patients and their families was the responsibility of all staff and not just the HSPC team.
- The mortuary staff were able to carry out reconstruction and camouflage to deceased patients to ensure that bereaved families were able to view their loved one.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- Ensure that the trust discharges its responsibilities in relation to the duty of candour for all incidents that meet the criteria.
- Ensure that robust arrangements are in place to govern the fit and proper persons process.

In all areas

- The trust must ensure that fridges used to store medications in all areas are kept at the required temperatures and checks are completed on these fridges as per the trust's own policy.
- Where fridge temperature ranges are recorded outside the recommended minimum or maximum range, steps must be taken to identify if medicines stored in the fridges are fit for use.
- The trust must ensure that medicines, including controlled drugs and intra-venous (IV) fluids, are securely stored in line with legislation.
- The trust must ensure that emergency resuscitation equipment is readily available in each area, to provide timely access to emergency resuscitation equipment. At the time of the inspection we found equipment shared between wards at the Royal Liverpool University Hospital which meant there may be a delay in accessing emergency equipment.
- The trust must ensure that all emergency equipment is checked regularly in line with trust policy and is ready for use in order to be able to respond safely in an emergency situation.
- The checking of medication, including controlled medication must be carried out consistently as per trust policy.
- The trust must ensure the expiration date of medicines is monitored. Drugs that are past their expiry date must be disposed of promptly.

In Medical care services

- The service must ensure controlled drugs are stored in line with the legislation on the Acute Medical Unit (AMU) at the Royal Liverpool University Hospital.
- The service must find an acceptable option to ensure its compliance with Health and safety best practice guidance for the storage of portable oxygen.

In addition, the trust should:

- Take steps to engage more meaningfully with allied health professionals (AHPs) so they are aligned professionally with an executive lead.
- Take steps to improve the oversight of actions arising from serious incidents and clinical audits.
- Take steps to improve the time taken to upload incidents to the national reporting and learning system (NRLS).
- Take steps to monitor the timeliness in reporting serious incidents and instigating the duty of candour.
- Review risk registers and the board assurance framework to provide assurance that risks are recorded correctly, being managed appropriately and mitigated in a timely way.
- Consider how to engage more widely with staff groups that have protected characteristics.
- Review its Equality Delivery System (EDS2) methodology to ensure it achieves the expected outcomes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors **How the regulation was not being met:** The trust's processes for managing the fit and proper person's process were not robust. This is because: There were gaps in some of the required documentation for board members. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 5 (3) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did not do all that was reasonably practicable to mitigate risks. This is because: Checks on fridges used to store medications in all areas were not always completed as per the trust's own policy. Where fridge temperature ranges were recorded outside the recommended minimum or maximum range, steps were not always taken to identify if medicines stored in the fridges were fit for use. Medicines, including controlled drugs and intra-venous (IV) fluids, were not always securely stored. At the time of the inspection we found equipment shared between wards which meant there may be a delay in accessing emergency equipment. Emergency equipment, including resuscitation trollies were not always checked regularly in line with trust policy and in some cases, despite them being checked, there were out of date items present.

This section is primarily information for the provider

Requirement notices

The checking of medication, including controlled medicines were not always carried out consistently as per trust policy. Out of date medication was identified in some areas.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:** The trust had a process in place to initiate the duty of candour for all serious incidents. However, this did not extend to incidents of moderate harm as defined by the regulation. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 20 (2)(a)