Liverpool Women's NHS Foundation Trust

Liverpool Women's Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Maternity (inpatient services)	Good
Maternity (community services)	Requires improvement
Surgery (gynaecology)	Good
Termination of pregnancy	Good
Neonatal services	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

Overall we rated Liverpool Women's Hospital as good although we found that the Community Maternity Service required improvement. There were plans in place to reconfigure and integrate the community service. The plans had not yet been implemented at the time of our inspection.

Our key findings were as follows:

Overall we found that the hospital provided effective care with outcomes comparable with or above expected standards. Patients were very positive about the care and treatment they received at the hospital.

Staff were positive about the additional investment in midwifery and nursing staff and morale within the hospital had improved as a result.

The senior team was visible and accessible to staff and managers were seen as supportive and approachable. Managers were keen to engage and include staff in service development. There were some concerns raised in relation to the leadership style in the Labour Ward that managers have committed to exploring and addressing.

There was a positive and enthusiastic culture throughout the hospital. Staff were committed and passionate about their work and proud of the services they offered to patients. Staff were keen to learn and continuously improve the services they offered to patients.

Nurse and Midwifery staffing

Nurses and Midwives were caring and compassionate and treated patients and those close to them with dignity and respect. They were committed to giving patients a high standard of care and treatment. Staffing levels were calculated using a recognised tool and regularly reviewed.

Since our last inspection there had been a significant increase in the numbers of nurses and midwives employed and there were sufficient numbers to meet the needs of patients. There were plans in place to increase the number of neonatal nurses to meet the British Association of Perinatal Medicine (BAPM) standards. At the time of the inspection, staffing was sufficient to meet the needs of babies being cared for as current neonatal staff were working extra hours to fill in gaps on the staffing rota.

Summary of findings

The neonatal service had introduced the Advanced Neonatal Nurse Practitioner (ANNP) role. The ANNPs were having a positive effect in supporting high quality care for babies requiring specialist neonatal support, however, it was acknowledged that more work was required to fully embed and integrate this key role within the service.

Medical staffing

Medical treatment was delivered by skilled and committed medical staff. There were excellent examples of medical staff providing strong leadership and active engagement in the design and development of services.

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

The tier 1/middle-grade staffing levels were acceptable in terms of establishment but frequently the neonatal unit operated below the establishment. In response to this, the service had introduced an Advanced Neonatal Nurse Practitioner role to help and support junior doctors working in the unit.

Safeguarding

There were robust policies and procedures in place for raising child safeguarding concerns. These processes were supported by staff training. All relevant staff had received appropriate levels of training for safeguarding children.

Staff were aware of the process and demonstrated a good understanding of their role in safeguarding vulnerable children. Interagency working was well developed and there was good communication with relevant professionals in this regard.

Staff training for the safeguarding of vulnerable adults had recently been introduced. Staff were developing their understanding, competency and knowledge in this area at the time of our inspection. Staff training figures indicated that by March 2015 95% of relevant staff would have received Adult safeguarding training.

Safeguarding practice was supported by a trust wide safeguarding team that staff could access for advice and support. However, we did find some examples in the surgical service where the approach to the safeguarding of adults required further development.

There were specialist clinics in place, supported by a Somali health link worker, to identify and address the needs of women who had experienced female genital mutilation (FGM) and designated midwives within the community service to support women whose circumstances had been identified as making them vulnerable.

Incident reporting

There were established systems for reporting incidents and 'near misses'. Staff had received training and were confident in the use of the incident reporting system. The latest national reporting and learning system (NRLS) data (September 2014) stated that the organisation had a reporting rate of 68.48 per 1000 bed days, which was higher than the median of 35.92 for the cluster of acute specialist trusts. The trust were in the highest 25% of reporters. The trust was however slow to upload incidents to the NRLS system with 50% of incidents submitted more than 41 days after the incident had occurred.

The reporting rates had improved significantly from the previous reporting period. Managers had identified that it was 'no harm' and 'near miss' incidents that were not being reported appropriately. This was supported by the NRLS report, which highlighted that the percentage of incidents reported by the trust in which no harm had been caused was 51%, compared with 76% across all acute specialist organisations.

Summary of findings

There was low incident reporting for all types of incidents in the community maternity service. The trust was working with its staff teams to address this issue and to encourage and support staff to report all incidents appropriately. Managers realised that the poor patient safety incident reporting culture could hinder staff in identifying risks and the trust in taking action to prevent avoidable harm to patients.

There were good examples of learning from incidents. Staff in all clinical areas were able to describe changes in practice following incident investigations. To support learning from Serious Incidents, staff were provided with a one-page summary of the key findings and recommendations to disseminate the learning across their service.

Cleanliness and infection control

There was a visibly high standard of cleanliness throughout the hospital. Staff were aware of current infection prevention and control guidelines and observed good practice. Hygiene audits demonstrated a high level of compliance. There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.

Cleaning schedules were in place and displayed throughout the ward areas and departments. There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Staff were vigilant in managing and preventing infection risks. There were services in the hospital whose practice in infection control was exemplary.

Nutrition and hydration

People were given a choice of suitable and nutritious food and drink, and we observed hot and cold drinks available throughout the day.

Patient's religious and cultural needs were considered and food was provided in accordance with their requirements. Staff provided appropriate and discreet support for those patients who needed help with eating and drinking.

Specialist dietary support was available to patients whose condition indicated or required a specialist diet.

The hospital had a team of midwives, support workers and infant feeding advisers who helped support women to feed their babies. The hospital team was supported by Liverpool BAMBIS (Babies & Mums Breastfeeding Information and Support), a team of peer supporters who offer breastfeeding support and information to pregnant women, breastfeeding mothers and their families.

Access to services

Services were planned to meet the diverse needs of patients using the hospital and community based service. There were access points designed so that pregnant women without a GP could self-refer. There was a unique gynaecological emergency service that provided immediate support to women who again could self-refer.

A link booking clinic was held at Liverpool Women's Hospital for women whose first language was not English. The Birth Choices Clinic provided support throughout pregnancy to women with tokophobia (fear of childbirth) and a vaginal birth after caesarean section (VBAC) clinic was also available.

There was a specialist clinic, supported by a Somali health link worker, to identify and address the needs of women who had experienced female genital mutilation (FGM) and designated midwives within the community service to support women whose circumstances had been identified as making them vulnerable.

We saw several areas of outstanding practice including:

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

Summary of findings

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

Importantly, the hospital must:

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

In addition the hospital should:

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity (inpatient services)	Good	Overall we found that the inpatient maternity service was providing a good service to women and their babies.There had been a significant improvement in the numbers of midwifery staff across the service, and this was having a positive impact on patient safety as there were more midwives to deliver care to women and their babies. However, there were areas relating to safety that required improvement. The maternity assessment unit did not have any equipment with which to resuscitate a newborn baby. Medicines were not always stored at the correct temperatures and an appropriate tracking system for keys to patient medication lockers was not in place.The storage of formula milk was not well managed. Effective controls were not in place to prevent the abduction of infants from the labour ward and the Catharine Medical Centre. Midwifery staffing levels were satisfactory across the service; however the number of hours of consultant cover (77 hours) were lower than the recommended minimum (98 hours) from the Royal College of Obstetrics and Gynaecology for a unit this size. The ward and clinical areas were visibly clean and well maintained. National guidelines were followed in treating patients and the outcomes for patients were comparable with other trusts nationally, although a small number of women were unable to access their chosen method of pain relief during labour. Patient care and treatment were delivered effectively by a multidisciplinary team 7 days a week both within and outside normal working hours. Midwives required to work in theatre recovery needed additional training. Integration between the hospital and community teams could be further developed. Maternity services were delivered by caring and compassionate staff. Staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients. The services were, in the main, responsive to patients' needs. They were planned and delivered to meet the

Summary of findings

needs of women; however, there were capacity issues within the induction of labour suite that sometimes meant low-risk patients waiting several hours for induction of labour. Timely advice and support via the telephone triage line was not always available. Leadership within maternity inpatient services was good overall and staff spoke highly of managers with the exception of those in the labour ward. Midwives working in this area found it difficult to raise concerns because doing so was not always met with a positive response. In addition, staff working in this area reported that staff meetings felt punitive in nature and that staff who were involved or witnessed serious incidents were not always well supported. Risks were managed satisfactorily and performance was monitored appropriately, but action was not always taken, or monitored, to address issues highlighted during audits.

Maternity (community services)

Requires improvement

There were systems in place for reporting actual and 'near miss' incidents in the community maternity service. The service monitored all its risks and had local risk registers. However, we did not see evidence that identified risks had been addressed and mitigated. Additional areas of concern included equipment that was not regularly maintained and medicine stocks, carried by community midwives, that were out of date. Midwifery staffing levels were calculated using a recognised dependency tool and were sufficient to meet the needs of patients. Staff had a good knowledge and understanding of the policies and procedures to promote the safeguarding of women and babies at risk of abuse and neglect. Staff observed, understood and followed best practice infection control guidance. Services were delivered by caring and compassionate staff. We observed that staff treated women with dignity and respect, and planned and delivered care in a way that took women's wishes into account. Emotional support was available for both mothers and those close to them. Most women were offered a choice with regard to their preferred place of birth and the service ran an on-call system for women choosing home birth. The caseload ratio (midwife to

Summary of findings

woman) was 1:92, which was similar to the national average of 1:96. Integration between the hospital and community teams could be further developed.

Surgery (gynaecology)

Good

Surgical services at Liverpool Women's Hospital were caring, effective, responsive and well-led. There were some concerns about the comprehensiveness of patient records, medical handovers, medicines management and storage, safeguarding practices and levels of staff training, which meant that safety required improvement. There were processes and procedures used in practice both pre and postoperatively to ensure that people received good care and treatment that resulted in a short hospital stay. Systems were in place to monitor the quality and performance of the various wards and areas, and these resulted in actions to improve care when necessary. Staff had access to the information they needed to deliver care to their patients. Patients reported that staff were kind and patient, protecting their privacy and dignity while providing a high level of care and support. The gynaecology service responded to the needs of the local population by providing services where gaps had been identified. Joint working with other organisations had also resulted in improved access to services for patients. Staff were proud of working at the trust and described a culture of openness in which they could discuss concerns or ideas with the managers.

Termination of pregnancy

Good

There were robust systems for the reporting of incidents and the management of risk within the Bedford Centre. The centre was visibly clean, medicines were safely stored and well managed, and the standard of record keeping was good. There were sufficient well-trained nurses to provide safe and effective care.The multi-disciplinary team worked well together, using national guidelines to treat patients. Access to information was good and there were robust processes in place to gain consent. Services were delivered by caring and compassionate staff who treated patients with dignity and respect. Care and treatment was planned and delivered in a way that took into account the wishes of the

patient. Access to treatment, advice and information was good both during procedures and after discharge. Complaints were well managed. The trust's vision and values for the organisation had been well communicated to staff. There was a 'no blame' culture that gave staff confidence to report incidents and 'near misses'.We saw individual members of medical and nursing staff who displayed good leadership skills and were positive role models for staff generally.

Neonatal services

Good

We found that, overall; the neonatal services provided were good. There was a sense of pride in the service and staff were committed to providing high-quality services. Neonatal nurses and doctors worked well together to achieve the best outcomes for the babies in their care. Babies received high quality care from dedicated and caring staff who were highly skilled in working with newborn babies and their families. There was a robust system in place for reporting and learning from incidents. The unit was visibly clean with a well-managed, clearly understood approach for maintaining a suitable environment. The standard of record keeping was good and both the nursing and medical staffing levels were appropriate to meet the needs of the babies in the unit. The multidisciplinary team worked well together. There were clear evidence-based guidelines to support practice. The service had achieved level 3 baby friendly status and there was focused work by staff to improve breastfeeding rates. Parents were active partners in the care of their babies, and communication with parents and families was good. Services were delivered by staff who were caring and considerate. Parents were universally positive about the care their babies had received and provided us with examples of when staff had 'gone the extra mile' to care for their babies and support them at the same time. Staff were proud to work in the unit and passionate about the service they provided. They were keen to receive feedback from families and the results were clearly displayed on a noticeboard. Feedback was used to support service developments. The

service received very few complaints but had dealt with the ones they had received in an appropriate manner. There was access to a translation service for parents and families, and information available in different languages. There was a transitional team and an outreach team that helped babies to be discharged home at the earliest opportunity. The services provided by the unit were well-led. There was strong medical and nurse leadership. Senior staff were positive role models for staff, and were visible and accessible. Staff were supported and encouraged to be innovative in their practice. There were robust governance systems in place. We saw good examples of a positive 'no-blame' culture and a well-developed approach to learning.

End of life care

Good

Patients who were considered to be in the last year of life were cared for in one of two specialist end of life suites on wards within the hospital (whenever possible). The Mulberry and Orchid suites were part of gynaecology ward 1 and provided patients with a private and calm environment where they could be cared for in an appropriate and tranquil setting. Patients and those close to them valued the environment and some patients had chosen the suites as their preferred place to die. The specialist palliative care team responded to the needs of patients in a timely way and were accessible to ward staff for support, advice and mentoring. There was good multidisciplinary working for the benefit of patients. Staff participated in regional and national networks to support service development and improvement. Staff were caring and compassionate and there was evidence of individualised, person-centred care. Processes for rapid discharge were in place to allow patients to return quickly to their preferred place of care. However, we did not see robust evidence of advanced care planning and 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions were not always made in a timely way so that patients could be involved in the decision making.

Summary of findings

Outpatients and diagnostic imaging

Good

There was good practice in the outpatient and diagnostic imaging departments to promote the safety of patients and staff. There was a clear process for reporting and investigating incidents. Learning from incidents was shared and there were examples of changes in practice in response to incidents. Cleanliness and hygiene in the department were of a good standard. Regular hand hygiene audits showed an appropriate level of compliance. Patient records were generally available for clinics although there were occasions when they were not. It was not possible to ascertain how widespread the issue was because incidents that related to the availability of patients' notes were not reported consistently and the availability of notes was not audited. Staff and managers could not tell us the percentage of notes that were unavailable. The issue was recorded on the risk register a week before the inspection started. Staff were aware of the policies and procedures to protect and safeguard children and adults, and training statistics showed that most staff had completed training in safeguarding for both children and adults. Other mandatory training courses were well attended and staff were positive about the training provided. They had also been trained in managing major incidents. Staffing was generally good; however, there were occasions when the foetal medicine unit was understaffed and managers were looking at ways to resolve this. The diagnostic imaging department used a private provider for sonography to address staff shortages. There was no evidence at the time of our inspection that this was having an impact on patient safety.

Liverpool Women's Hospital

Detailed findings

Services we looked at
Maternity (inpatient services); Maternity (community services); Surgery (gynaecology); Neonatal; Termination of Pregnancy; End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Liverpool Women's Hospital

Liverpool Women's Hospital is the main hospital site operated by Liverpool Women's NHS Foundation Trust, based in Toxteth, which serves more than 30,000 patients from Liverpool, the surrounding areas and across the UK.

The hospital is a major obstetrics, gynaecology and neonatology research hospital, one of only two specialist trusts in the UK, and the largest women's hospital of its kind in Europe.

Our inspection team

Our inspection team was led by:

Chair: Bronagh Scott, Deputy Chief Nurse, NHS England

Head of Hospital Inspections: Ann Ford, Care Quality Commission

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

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Liverpool Women's NHS Foundation Trust and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

Detailed findings

We held a listening event in Liverpool on 12 February 2015 when people shared their views and experiences of Liverpool Women's Hospital. Some people also shared their experiences by email or telephone.

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

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

We talked with patients and staff from all the ward areas and 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. We undertook an unannounced inspection of Liverpool Women's Hospital between 4pm and 7pm on 4 March 2015. During the unannounced inspection, we looked at maternity and surgical services.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Liverpool Women's Hospital.

Facts and data about Liverpool Women's Hospital

Liverpool Women's Hospital is the main hospital site providing services as part of Liverpool Women's NHS Foundation Trust. There are 157 beds on the site, which comprises of 39 for gynaecology, 70 for maternity and 48 for neonatal care. In 2013/14 there were 41,316 admissions, 41,429 discharges, 50,843 outpatient appointments and 11,305 emergency department attendances. There are over 1,300 staff employed.

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

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

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Maternity (inpatient services)

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

Information about the service

Maternity inpatient services were provided on a single site with approximately 8,000 deliveries each year. During our inspection, we visited the labour ward, emergency room, midwife-led unit, maternity assessment unit, Jeffcoate Ward, maternity base, induction suite and the Catharine Medical Centre.

We observed care, looked at care and medicine records for 9 people and spoke with 15 patients, 7 relatives and 33 staff across all disciplines.

Summary of findings

Overall we found that the inpatient maternity service was providing a good service to women and their babies.

There had been a significant improvement in the numbers of midwifery staff across the service, and this was having a positive impact on patient safety as there were more midwives to deliver care to women and their babies.

However, there were areas relating to safety that required improvement.

The maternity assessment unit did not have any equipment with which to resuscitate a newborn baby. Medicines were not always stored at the correct temperatures and an appropriate tracking system for keys to patient medication lockers was not in place.

The storage of formula milk was not well managed. Effective controls were not in place to prevent the abduction of infants from the labour ward and the Catharine Medical Centre.

Midwifery staffing levels were satisfactory across the service; however the number of hours of consultant cover (77 hours) were lower than the recommended minimum (98 hours) from the Royal College of Obstetrics and Gynaecology for a unit this size.

The ward and clinical areas were visibly clean and well maintained.

Maternity (inpatient services)

National guidelines were followed in treating patients and the outcomes for patients were comparable with other trusts nationally, although a small number of women were unable to access their chosen method of pain relief during labour. Patient care and treatment were delivered effectively by a multidisciplinary team 7 days a week both within and outside normal working hours. Midwives required to work in theatre recovery needed additional training. Integration between the hospital and community teams could be further developed.

Maternity services were delivered by caring and compassionate staff. Staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients.

The services were, in the main, responsive to patients' needs. They were planned and delivered to meet the needs of women; however, there were capacity issues within the induction of labour suite that sometimes meant low-risk patients waiting several hours for induction of labour. Timely advice and support via the telephone triage line was not always available.

Leadership within maternity inpatient services was good overall and staff spoke highly of managers with the exception of those in the labour ward. Midwives working in this area found it difficult to raise concerns because doing so was not always met with a positive response. In addition, staff working in this area reported that staff meetings felt punitive in nature and that staff who were involved or witnessed serious incidents were not always well supported.

Risks were managed satisfactorily and performance was monitored appropriately, but action was not always taken, or monitored, to address issues highlighted during audits.

Are Maternity (inpatient services) safe?

Requires improvement

There had been a significant improvement in the numbers of midwifery staff across the service, and this was having a positive impact on patient safety. However, there were areas relating to safety that required improvement.

The maternity assessment unit did not have any equipment with which to resuscitate a newborn baby. Medicines were not always stored at the correct temperatures and an appropriate tracking system for keys to patient medication lockers was not in place. The storage of formula milk was not well managed. Effective controls were not in place to prevent the abduction of infants from the labour ward and the Catharine Medical Centre.

Midwifery staffing levels were satisfactory across the service; however the number of hours of consultant cover (77 hours) were lower than the recommended minimum (98 hours) from the Royal College of Obstetrics and Gynaecology for a unit this size.

The ward and clinical areas were visibly clean and well maintained.

Incidents

- There were robust systems in place for reporting incidents and 'near misses'. Staff had received training and were confident in the use of the incident reporting system. Reporting of adverse clinical incidents, referred to as 'ACE reporting' was good, but staff told us that they were less likely to report non-clinical incidents.
- Feedback from incidents was found to be good for medical staff and midwives working within pre-natal and post-natal areas. Midwives working within the intra-partum areas reported a lack of feedback from incidents, unless they themselves actively sought this from managers
- A communication entitled 'Lesson of the week' was in place to disseminate learning from incidents to all staff.
- Perinatal mortality meetings were held weekly. These meetings discussed any perinatal deaths that had occurred within the hospital and any identified learning.
- Staff across all disciplines were aware of their responsibilities regarding the Duty of Candour legislation.

Maternity (inpatient services)

Cleanliness, infection control and hygiene

- The clinical areas we inspected were visibly clean and well maintained. There were cleaning schedules in place and levels of cleanliness were audited regularly.
- The cleaning monitoring audit between July and December 2014 showed compliance to be between 98% and 99%.
- Staff were aware of current infection prevention and control guidelines. They followed good hand hygiene practice in all the areas we visited.
- Hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand-washing sinks and hand gels.
- There were suitable arrangements for the safe disposal of waste. Used linen that presented an infection risk was segregated and managed appropriately. Clinical and domestic waste was segregated in colour-coded bags and managed appropriately. Sharps such as needles and blades were disposed of in approved receptacles.

Environment and equipment

- We checked the resuscitation equipment for women and babies, and the emergency equipment and drugs for the treatment of post-partum haemorrhage. Generally, we found this to be easily accessible and fully stocked, with all equipment in date. Records for the previous 3 months showed that the resuscitation equipment in all the areas we visited had been checked daily by a designated person.
- There was a delivery pack in the maternity assessment unit in case of an emergency delivery, but no resuscitation equipment for babies. Midwives told us they had requested neonatal resuscitation equipment but had been told that it was unnecessary. No risk assessment had been undertaken. Although it was unusual for a baby to be delivered in the maternity assessment unit, the nearest basic neonatal resuscitation equipment was kept in the induction of labour unit, located through fire doors and down a corridor. This equipment did not include a heater or its own oxygen supply. The absence of neonatal resuscitation equipment within the maternity assessment unit makes the chance of a successful resuscitation attempt less likely.
- We observed several pieces of portable electrical equipment that had not been tested for electrical safety since 2011, and others that had not been tested for over 2 years. There was no system in place, other than a visual check by midwifery staff before use, to regularly inspect the portable electrical equipment kept on the wards and establish that it was fit to use.

Medicines

- The drugs fridge on the maternity assessment unit had been broken for 2 weeks prior to our inspection. Drugs had been kept in the induction of labour examination room, which was unlocked. We highlighted this to the management team and the fridge had been repaired by the next day.
- Drugs for use throughout the hospital were stored in a room on the maternity base that had been above the maximum recommended temperature of 25°C. Temperatures of over 26°C had been recorded on 16 and 17 February 2015, but no action had been taken by staff. Drugs stored outside of the recommended temperatures may not be fit for use.
- The date on which over-the-counter medicines, such as cough medicine, had been opened was not recorded on bottles. This meant it was not possible to establish when the medicine should be discarded as no longer fit for use.
- There was no official handover or accurate record of which midwife was in possession of the keys to drug lockers in patient bays. It was impossible to establish the whereabouts of these keys from the record book, because an accurate and up-to-date record had not been kept.

Records

- We reviewed nine sets of patient records. Overall, midwifery care records were comprehensive, current, easy to navigate and contained all the information needed to support the delivery of safe care.
- Medical and allied health professional records were accurate, legible, signed and dated, easy to follow and gave a clear plan and record of a patient's care and treatment.
- Access to medical records for women admitted in an emergency was good. Medical records for maternity patients were stored on the premises and could be easily located within and outside normal working hours.
- Handheld records were used effectively. Women we spoke with understood the purpose of their own records and their baby's health and development review record, commonly known as the 'red book'.

Maternity (inpatient services)

Safeguarding

- There were detailed policies on safeguarding issues, which included infant security and the management of suspected or actual infant abduction. Electronic baby tags were not fitted to babies on the labour ward or in the Catharine Medical Centre; however, access to these areas was controlled with swipe card access. Neither of these areas were included in the trust's policy on infant abduction. An increased risk of infant abduction from these areas had been recognised and included in the organisation's risk register. Effective controls were being considered but were not in place at the time of our inspection, although minor improvements had been made and regular security drills were undertaken.
- There was a system in place for raising safeguarding concerns. Staff were aware of the process and demonstrated a good understanding of their role in safeguarding vulnerable adults and children. This process was supported by staff training.
- Safeguarding training formed part of the mandatory training programme. Training records showed that over 100% of medical staff providing maternity inpatient services had completed safeguarding adults training and level 2 or above safeguarding children training. It was not possible to establish the midwifery safeguarding training levels for maternity inpatient services because of the way in which data received from the trust was presented.
- The organisation was slow to review domestic abuse referrals from the police. Rates of review within 7 working days had fallen from 66% in October 2014 to 46% in December 2014.
- There were specialist clinics in place, supported by a Somali health link worker, to identify and address the needs of women who had experienced female genital mutilation (FGM).

Mandatory training

- The level of mandatory training across the hospital overall, at the end of January 2015, was 91% measured against the trust target of 95%. There were plans in place to achieve the target by the end of the financial year.

Assessing and responding to patient risk

- The maternal early obstetric warning system (MEOWS) was in use within the trust to manage the deteriorating patient. There were escalation policies in place for the acutely ill patient and monitoring systems to ensure that the scoring system was effective.
- There was a protocol in place for the rapid ambulance transfer of a deteriorating patient to the critical care unit of a neighbouring trust, which had been used (infrequently) and worked well.
- Risks related to the storage of formula milk on the post natal wards were not well managed. Fridge temperatures on Jeffcoate Ward had not been taken for over a week in December 2014 and 4 days in January 2015. Patients had been using the fridges to keep their soft drinks cool. There were no controls in place to prevent formula milk being tampered with. We discussed this with the matron who later that day produced a basic risk assessment that was in need of further development.
- The service had implemented 'five steps to safer surgery' procedures (Patient Safety First campaign) in the obstetric operating theatres.
- The World Health Organization (WHO) surgical safety checklist was used appropriately, with good communication and briefing sessions embedded in the service.
- An audit of compliance with the WHO checklist showed the checklist had been used in all cases reviewed in 2014 but there were some errors/omissions on the documentation noted and the trust had an action plan in place to address these.

Midwifery staffing

- The hospital had employed around 45 additional whole-time equivalent midwives during the past year. The midwifery vacancy rate, as at 16 February 2015, was 0%.
- Midwifery staffing levels had been reviewed throughout the maternity inpatient areas during 2014 and were due to be reviewed again. Staffing levels had been assessed using a validated acuity tool. There were minimum staffing levels set for all areas, and required and actual staffing numbers were displayed in every area we visited.
- We reviewed the duty rota's which showed that the staffing was at the required levels to meet the agreed staff establishment.

Maternity (inpatient services)

- Staffing levels were satisfactory, however due to the unpredictable nature of the work; there were times when areas such as the maternity assessment unit and labour ward were exceptionally busy. There was an escalation process, managed by the bleep holder, to address fluctuations in demand by redeploying midwives around the hospital when necessary. This process generally worked well. When extra staff were used, it was generally the services own staff working additional bank shifts.
- The cumulative year to date birth to midwife ratio was 1:30; however, in January 2015, the hospital were achieving a birth to midwife ratio of 1:28 against an England average of 1:28 in December 2014.
- The ratio of midwives able to provide one-to-one care to women in established labour had improved considerably from 71% in June 2014 to 95% in December 2014.
- Midwives throughout the maternity inpatient areas spoke very positively about the impact the increased midwifery staffing levels had made.
- Midwifery handovers took place during shift changeovers and were detailed and well structured.

Medical staffing

- There were 13 consultants, 11 of whom provided cover for 77 hours each week, made up of 13 hours on weekdays and 6 hours at weekends. This was less than the 98 hours recommended by the Royal College of Obstetrics and Gynaecology.
- We discussed the levels of consultant cover with junior and middle-grade doctors and midwives, all of whom told us that the consultants were often in the hospital for longer than their contracted hours. They also told us that advice and support from the consultants was easily accessible, both within and outside of normal working hours.
- A 'consultant of the week' system was in place, which ensured continuity throughout the week.
- An anaesthetist was available at all times in case of an emergency.
- Medical handovers were consultant led and took place at 8.30am and 8.30pm. The handovers were well structured, using some printed handover information, and there was always an anaesthetist present.

Major incident awareness and training

There were plans in place for the emergency closure of the maternity unit to new admissions. These plans had been implemented once during 2014 and had worked effectively. Senior midwives and medical staff we spoke with were aware of the protocols and how to access them, should it be necessary to do so.

Are Maternity (inpatient services) effective?

(for example, treatment is effective)

Good

Maternity inpatient services were effective. National guidelines were followed in treating patients and the outcomes for patients were comparable with other trusts nationally, although a small number of women were unable to access their chosen method of pain relief during labour. Patient care and treatment were delivered effectively by a multidisciplinary team 7 days a week both within and outside of normal working hours, although midwives required to work in theatre recovery needed additional training. Integration between the hospital and community teams was underdeveloped.

Evidence-based care and treatment

- Staff used a combination of guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges as a basis to determine the treatment they provided.
- Local practice followed these guidelines, although consideration should be given to the interpretation of the NICE clinical guideline 70 with regard to the artificial rupture of membranes. We spoke with a midwife who indicated that this procedure is attempted routinely at Liverpool Women's Hospital after the use of vaginal prostaglandins, with no regard to the Bishop score. The Bishop score is a series of measurements to ascertain the state of the cervix. Attempting to artificially rupture membranes when the cervix is unripe (i.e. with a Bishop score of less than 8) increases the likelihood that the induction will fail. This increases the risk that an emergency or unplanned caesarean section may be required. We discussed whether this was having an impact on failed induction of labour rates with the midwife, the labour ward shift leader and manager,

none of whom could tell us how many emergency caesarean sections were undertaken at the trust for failed induction of labour. Since the inspection, the trust have indicated that it always has regard to the Bishop score before the artificial rupture of membranes is attempted.
- Revisions to guidelines were made by the clinical group and ratified by the maternity risk group.
- Copies of policies and guidelines were available to all staff via the trust intranet.
- There were specific care pathways for certain conditions, such as sepsis, in order to standardise and improve the care for patients.
- A comprehensive programme of audit was undertaken annually throughout the maternity unit. However, follow-up from some of these audits in the form of a robust action plan and the subsequent monitoring did not always take place.

Pain relief

- Women were offered a choice of pain relief in labour that included epidurals and access to a birthing pool. Not all women (12% in November 2014 and 6% in December 2014) were able to access an epidural for non-clinical reasons. Suitable alternative pain relief had been given.
- There was only one birthing pool on the midwife-led unit. This meant that not all women who asked to use the birthing pool for pain relief could do so. The refurbishment of the unit, which was in progress at the time of our inspection, includes the introduction of two extra birthing pools. Midwives felt that this would be adequate to meet demand.
- The medication records we reviewed of postnatal patients showed that women were prescribed suitable pain relief and that it was administered as needed. Women we spoke with confirmed this.

Nutrition and hydration

- People were given a choice of suitable and nutritious food and drink, and we observed hot and cold drinks available throughout the day.
- Staff were able to tell us how they addressed people's religious and cultural needs regarding food. We saw that, whenever possible, there was a period during meal times when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to assist those patients who needed help.
- The hospital had a team of midwives, support workers and infant feeding advisers who helped support women to feed their babies. The hospital team was supported by Liverpool BAMBIS (Babies & Mums Breastfeeding Information and Support), a team of peer supporters who offer breastfeeding support and information to pregnant women, breastfeeding mothers and their families.

Patient outcomes

- Patient outcomes were monitored using a local maternity dashboard and Royal College of Obstetrics and Gynaecology indicators. These monitored key outcomes, such as methods of delivery, still-birth and neonatal death, epidural rates and the number of women receiving-one-to one care during labour. As there are only two specialist women's trusts in England, some of the outcomes had been benchmarked against the other specialist trust.
- The modes for delivery of a baby were similar to the England average across all areas.
- Outcomes for patients were generally in line with Royal College targets or those of other similar trusts, with the exception of the provision of one-to-one care in labour, emergency caesarean section rates and the rate for epidurals, which were marginally worse than the national target.
- Outcomes were monitored at the monthly Clinical Risk Committee, which was a sub-committee of the trust board.
- Analysis of Hospital Episode Statistics carried out by CQC found that women delivering at the hospital experienced significantly higher than expected rates of puerperal sepsis between March 2013 and April 2014. Puerperal sepsis is a severe infection of the genital tract that occurs up to 42 days after delivery and the trust were identified as an outlier for this condition. The maternity outliers we collate are part of a broader mortality and maternity outliers programme we use to monitor key indicators in relation to a range of clinical conditions. We are in active dialogue with the trust to identify any contributing factors and areas for improvement and we will review the trust's response to determine if and what further action we may need to take.

Competent staff

Maternity (inpatient services)

- There was a system in place throughout the trust to ensure that staff were registered with the General Medical Council and the Nursing and Midwifery Council and maintained active registration entitling them to practice.
- Approximately 80% of staff within maternity services had received an appraisal during the past year, measured against a trust target of 90%.
- All staff had been supported to complete additional training so that they could develop within their roles. Examples of this were healthcare assistants who were training to become midwives, and midwives supported to undertake courses in nurse prescribing and examination of the newborn.
- The ratio of supervisors of midwives (SOMs) to midwives was 1:18, compared with the Local Supervising Authority's recommendation of 1:15. All midwives we spoke with told us that access to their SOM was good. SOMs provide support, advice and guidance to individual midwives on practice issues, while ensuring that they practice within the standards set by the Nursing and Midwifery Council (NMC).
- Outside of normal working hours, midwives cared for women in the recovery area after emergency surgery. This was a specialist role for which they had not received any additional training. A consensus statement by the Royal College of Midwives and the College of Operating Department Practitioners (May 2009) recommends that minimum staffing of obstetric theatres should include a recovery practitioner who should be an 'Operating Department Practitioner or Registered Nurse (with a suitable recognised qualification in recovery practice).'
- Senior midwives were required to work as scrub nurses in theatres if an extra operating theatre had to be used in an emergency. Training had been given and competency assessed, but midwives told us they did not feel they carried out this role often enough for them to feel confident, particularly as the procedures were always emergencies.
- A large number of junior midwives had been employed within the trust during the past year. A comprehensive preceptorship programme was in place and recently employed midwives all spoke very positively about the support they had received since joining the trust.

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions with members of the MDT, we saw that staff across all disciplines genuinely respected and valued the work of colleagues within the team.
- Midwives working within the inpatient service identified a lack of integration between the community midwifery service and themselves.
- Opportunities for embedding multidisciplinary working by involving midwives in influencing decisions could be further developed.

Seven-day services

- The workload within maternity inpatient services was unpredictable and susceptible to peaks in activity. Liverpool Women's Hospital provided a full range of services, 7 days a week.
- There was a consultant presence on the maternity unit every day.
- Ultrasonography was available outside of normal working hours.
- Adequate emergency stocks of blood were kept on the premises, with access to laboratory services and further stocks from a neighbouring trust.

Access to information

- Medical and midwifery staff all reported information systems to be good, with timely access to results of investigations and test results.
- A telephone triage system was in operation to offer advice not only to patients and their families but also to other healthcare professionals, such as GPs and accident and emergency (A&E) departments in other hospitals. Advice was given throughout the UK and was not limited to the local area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. However, the consent was not always appropriately documented. A consent audit undertaken by the trust (there was no date recorded on the audit) found that only 33% of consent forms contained details of the anaesthetic that was to be given, and only 17% recorded whether the patient had accepted the top copy. Managers were working with staff to improve performance in this area.

Maternity (inpatient services)

- Training regarding the requirements of the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards, had been delivered to most of the band 7 midwives, and there was a rolling programme of training in place for the band 6 midwives and below.
- We observed staff obtaining verbal consent when helping patients with personal care.

Are Maternity (inpatient services) caring?

Good

Maternity inpatient services were caring. Services were delivered by caring and compassionate staff. We observed that staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients.

Compassionate care

- Care and treatment throughout the wards and departments providing care to maternity inpatients were delivered by caring and compassionate staff.
- We spoke with 15 patients and 7 relatives and everyone spoke very positively about the care that they, or their family member, had received.
- We received 25 online feedback forms giving very positive feedback from women about their experiences of the care and treatment they had received.
- We saw examples of ways in which people were encouraged to share their impressions of the hospital and how improvements could be made.
- The NHS Friends and Family Test showed a high level of satisfaction during the last quarter of 2014 of between 97% and 100%. However, it should be recognised that this data relates to small numbers analysed as a result of a low response rate.
- The responses to CQC's Survey of Women's Experiences of Maternity Service in 2013 were comparable to other trusts in England.

Understanding and involvement of patients and those close to them

- Women were involved in choices about their baby's birth both at booking and throughout the ante-natal period. Those we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.
- Midwives on the labour ward told us they were concerned about the level of pre-natal education/ information given to women by the community team during pregnancy. They reported women arriving in labour with little knowledge of childbirth and no birth plan or knowledge of the active management of the third stage of labour.

Emotional support

- Emotional support for women and families after stillbirth and perinatal death is described within the end of life section of this report.
- Staff were skilled at building trusting relationships with patients and their relatives within a short space of time. Patients and relatives told us that they received considerable emotional support from all members of the multidisciplinary team.

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

Good

Maternity inpatient services were generally responsive to patients' needs. Services were planned and delivered to meet the needs of women. However, there were capacity issues within the induction of labour suite that sometimes meant low-risk patients waiting several hours for induction of labour. Timely advice and support via the telephone triage line was not always available.

Service planning and delivery to meet the needs of local people

- All the women we spoke with had been given a named midwife and their contact details when they booked into the hospital.
- Induction of labour for all women was carried out at the hospital. There was no opportunity for low-risk women to begin the induction of their labour at home.
- Refurbishment of the midwife-led unit meant that the use of an extra two birthing pools would soon be available to women.
- The number of home births was low, with around 99% of births taking place within the hospital.

Meeting people's individual needs

Maternity (inpatient services)

- An outreach midwife with enhanced skills visited women with serious health conditions who had been transferred to another hospital for specialist treatment.
- Funding for a practice development lead in the high dependency unit had been approved and active recruitment to the post was due to begin.
- There were facilities for women to access a bed in a side room and for partners to stay overnight, for which there was a charge.
- If needed, staff could access an interpreter for patients whose first language was not English.
- There were midwives with specialist skills in conditions such as diabetes and substance misuse who were available to advise and support women.
- There was a midwife available to support people with disabilities.
- Access to information was good for patients and their families. We saw examples of comprehensive information for women regarding the management of their pregnancy and care of their newborn baby.
- There was a range of information leaflets in clinical areas on topics such as tests and screening, breastfeeding and other sources of support. Information was available in different languages if required.
- There were processes in place to support women with mental health concerns. A service level agreement was in place to access consultant psychiatric support from a neighbouring trust within normal working hours and from the mental health crisis team out of hours. .

Access and flow

- There were no spare appointments kept in the scheduling diary for induction of labour for patients who needed urgent induction because of concerns about their or their baby's condition. This meant that low-risk women, or those not at risk but due to be transferred from the ante-natal area, often had to wait up to 6 hours until a bed became available, although there were no reported delays longer than 6 hours.
- Breaches of the 4-hour waiting time in the emergency room were rare, with the last breach reported in December 2014.
- During times of peak demand, the telephone triage system was overwhelmed with calls that were picked up by the answerphone because there was no midwife available to answer them. This meant that women either had to wait for their call to be returned, or present themselves at the hospital because they were anxious about their condition and had been unable to contact anyone for reassurance in a timely manner.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff signposted patients to the Patient Advice and Liaison Service (PALS) team if they were unable to deal with concerns directly. Patients were advised to make a formal complaint if their concerns remained unresolved.
- Information on how to complain was displayed throughout the wards and corridors of the hospital on how to complain. We spoke with patients and relatives who knew how to raise concerns, make complaints and provide comments, should they wish to do so.
- Complaints and compliments were discussed at daily handovers, when relevant, to share learning within an individual ward or department. Occasionally, learning from complaints pertinent to the trust overall was included in the 'lesson of the month' communication.

Are Maternity (inpatient services) well-led?

Good

Most of the maternity in patient services were consultant led, with a midwife led unit delivering intra partum care to low risk women. They were supported in the delivery of care by matrons and individual service managers.

Staff were positive about the support they received from their line managers and felt comfortable and confident about raising concerns. The recruitment of extra staff had alleviated pressures on the service and staff morale had improved as a result. Midwives were positive about the service they provided, and they were proud of their work and the reputation of the hospital.

There were examples of good leadership by individual members of medical and midwifery staff that were positive role models for staff generally.

Staff spoke positively about the visibility of the executive team, particularly the director of nursing.

Junior and middle-grade medical staff were enthusiastic about the leadership provided by the senior medical team.

Maternity (inpatient services)

Leadership within maternity in-patient services overall was good with the exception of the labour ward.

Midwives working in this area found it difficult to raise concerns because doing so was not always met with a positive response. In addition, staff working in this area reported that staff meetings felt punitive in nature and that staff who were involved or witnessed serious incidents were not always well supported.

We raised these matters with the senior management team at the time of our inspection. The response was positive and senior managers made a commitment to invest in improving the culture within the labour ward as a priority.

Risks management and governance within the department had improved significantly since our last inspection. Risks were managed satisfactorily and performance was monitored appropriately.

Vision and strategy for this service

- There was a clear vision and strategy for the organisation that was apparent throughout the hospital and had been well communicated to staff.
- None of the midwifery staff below band 7 could tell us anything about the individual strategy for the development of the wards in which they worked, although staff on the post-natal wards felt that there was more enthusiasm and opportunity to participate in the future planning of services as the midwifery staffing levels had improved.
- In January 2015, supervisors of midwives had attended an 'away day' with the Local Supervision Authority's midwifery officer to discuss the development of their role and the plan for 2015/16.

Governance, risk management and quality measurement

- Since our last inspection, there was a tangible improvement in the way that risks were managed, how quality was measured and the overall governance within the department.
- The maternity dashboard had been further developed, which was a snapshot of important indicators that were being used to monitor performance, quality and safety against a set targets.
- There was a nominated consultant lead for the management of risk, with designated non-clinical time each week to manage risk within the maternity inpatient service.
- Supervisors of midwives were always involved in the investigation of serious incidents. There were plans to involve them in the debriefing sessions following perinatal mortality, although this had not been implemented at the time of our inspection.
- Risks within the service were discussed regularly at both ward and divisional level, and escalated when necessary.

Leadership of service

- We saw some examples of good leadership by individual members of the medical and midwifery staff who were positive role models for staff.
- Staff spoke positively about the visibility of the executive team, particularly the director of nursing.
- Junior and middle-grade medical staff were enthusiastic about the leadership provided by the senior medical team.
- Leadership within maternity inpatient services was good overall with the exception of the labour ward.
- Midwives working in this area found it difficult to raise concerns because doing so was not always met with a positive response. In addition, staff working in this area reported that staff meetings felt punitive in nature.
- Midwives working on the labour ward told us that their ideas and concerns were not always listened to or acted on, which left them feeling demoralised and demotivated at times.
- In addition, support for staff following serious incidents did not always follow trust policy. We spoke with six midwives and their colleagues who told us that psychological support after a recent incident, once the initial debrief had been completed, had been poor for some and non-existent for others.
- We raised these matters with the senior management team at the time of our inspection. The response was positive and senior managers made a commitment to invest in improving the culture within the labour ward as a priority.
- Staff on the wards providing post-natal care told us they attended regular staff meetings, which they found valuable, and that their immediate line managers were accessible and approachable.

Maternity (inpatient services)

Culture within the service

- All staff spoke enthusiastically about their work. They described how they enjoyed it, and how proud they were to work at the trust.
- Band 4 staff and below told us they did not feel they were respected by some of the matrons for the work they did.
- Four midwives described a reluctance to speak out about concerns because of a fear of repercussions from their immediate line managers.

Public and staff engagement

- The trust was represented on the local Maternity Services Liaison Committee, which had a growing lay membership. Discussions had taken place with the chair of this group to increase levels of engagement in the future.
- There were initiatives, such as 'team of the season' in place as incentives to staff.
- Staff spoke positively about the informal staff engagement sessions held to enable staff to speak openly to the executive team about their experiences of working within the hospital and the feedback on any concerns they raised.
- The service had featured on several television documentaries, including One Born Every Minute and Miracle Babies. Staff were extremely proud of this; they felt that the programmes had showcased their work and increased public confidence.
- There was a good use of volunteers within the hospital whose roles were clearly defined.

Innovation, improvement and sustainability

- Staff at the hospital participated in an extensive programme of local, national and internationally recognised research.
- The use of social media (e.g. Twitter etc.) as a vehicle to communicate with staff and patients was well developed and effective.
- A pilot project to provide online advice and support to women from midwives was in progress at the time of our inspection.

Maternity (community services)

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Community midwifery is part of Liverpool Women's Hospital's maternity service that delivers around 8,000 babies a year. The community team provide a comprehensive midwifery service that works in partnership with GPs, health visitors, family nurses, children's centres and lifestyle services. The service also makes provision for a home birth, although the home birth rate at the time of our inspection was less than 1%, which is lower than the average number of home births for a maternity unit nationally.

The team is managed by a matron, with the support of 4 whole-time equivalent (WTE) supervisory team leaders; 24-hour home birth and on-call arrangements are supported by 4 midwives at all times throughout the year.

In total, there are 63 WTE midwives within the community service, including 8 WTE maternity support workers delivering care from 75 community locations including GP practices and children's centres.

During this inspection, we visited the community midwives' office at Liverpool Women's Hospital and two clinics where midwifery activities took place. We spoke with 26 staff and 6 patients and relatives. We observed care and looked at care records. We looked at appropriate policies and procedures.

Summary of findings

Midwifery staffing levels were calculated using a recognised dependency tool and were sufficient to meet the needs of patients

There were systems in place for reporting actual and 'near miss' incidents in the community. The service monitored its risks and had local risk registers. However, we did not see evidence that identified risks had been addressed and mitigated. Staff also told us that they were not always comfortable raising concerns because of the punitive attitude of staff responsible for reviewing the incident forms.

Additional areas of concern related to equipment that was not regularly maintained and medicine stocks, carried by community midwives, which were out of date.

Staff had a good knowledge and understanding of the policies and procedures to promote the safeguarding of women and babies at risk of abuse and neglect.

Staff observed, understood and followed best practice infection control guidance.

Services were delivered by caring and compassionate staff. We observed that staff treated women with dignity and respect, and planned and delivered care in a way that took women's wishes into account. Emotional support was available for both mothers and their partners.

Most women were offered a choice of where to give birth and the service ran an on-call system for women

Maternity (community services)

choosing home birth. Caseloads were arranged by the number of women on their books each month and the ratio (midwife to woman) was 1:92, which was similar to the national average of 1:96.

At the time of our inspection, there was little integration between the community and hospital services; however, integration was a feature of the plans for the future reconfiguration of the community service.

Are Maternity (community services) safe?

Requires improvement

Safety in the community maternity services provided by Liverpool Women's Hospital required improvement. The main areas of concern were equipment that was not regularly maintained and that medicine stocks, carried by community midwives were out of date.

There were systems in place for reporting actual and 'near miss' incidents in the community. Staff knew how to report incidents and were able to describe how they would do so through the electronic system. However, only 49 incidents were reported in 2014; 16 of these related to communication. The number of incidents reported was low for a service of this size. Staff told us that they didn't always feel comfortable raising concerns because of the punitive attitude of staff responsible for reviewing the incident forms.

There had been 51 home births between August 2014 and February 2015; 15 of these were unplanned. We noted that only seven incidents reported related to births that had occurred before admission. We did not see any action plans arising from the outcome of any review of these incidents. This meant that opportunities for learning and prevention of recurrence may have been lost.

Midwives had access to anti-D immunoglobulin prophylaxis (anti-D immunoglobulin is a blood product given to women to prevent antibody formation in rhesus negative women), but they did not carry medication to treat an anaphylactic reaction. This was a risk to women who may suffer anaphylactic shock in response to anti-D immunoglobulin. This issue had been on the risk register since 2009.

Community staff carried security alarms to protect themselves as lone workers that were logged with an external provider. Monthly audit reports were provided to the community matron; however, we were told that the alarms frequently split from their attached name badge and were therefore not always used. This had been raised with management but staff had not yet received feedback.

We found that most record keeping was of a good standard. However, we identified one set of records with a loose leaf of paper without any patient identification details.

Maternity (community services)

Incidents

- Incidents were logged on the electronic reporting system and subsequently reviewed and investigated by the appropriate manager.
- Staff were informed about the outcomes of incidents they had reported via email and the outcome of investigations were provided in face-to-face meetings with their manager.
- Incident reporting was low for a service of this size, with only 49 incidents relating to the community service reported between 1 April 2014 and 19 February 2015. This was concerning because incident reporting and the subsequent investigation provides valuable opportunities for learning to prevent recurrence and promote patient safety.
- There were 15 unplanned home births in the community between August 2014 and February 2015. Only seven of these had been recorded as an incident and we did not see any evidence of audits or action plans in response to unplanned births at home.
- A number of front-line staff reported that they were not comfortable about raising concerns because of the punitive attitude of staff responsible for reviewing the incident forms.

Cleanliness, infection control and hygiene

- There was good use of personal protective equipment, and staff were observed to be wearing gloves or washing their hands between patients. Staff observed 'bare below the elbow' guidance. Midwives carried hand gel for use when hand washing facilities were not available.
- Audits carried out in community clinics indicated compliance with infection control practices.
- Staff were required to attend mandatory training for infection and prevention control.
- Birthing pools were rented to women who chose to give birth at home. Appropriate advice was provided to women about storing, using and cleaning the birthing pools.

Environment and equipment

- Emergency alarms and equipment for treating adverse events such as maternal collapse were not available in the two clinics we visited; although emergency equipment was available in an adjacent walk-in centre at one of the clinics. In the other centre, staff had to make an emergency telephone call in the case of an emergency.
- It was unclear if there was a system to monitor equipment that required servicing. We found that one set of baby scales that was due for servicing in February 2015 but there was no appointment scheduled for this at the time. The trust have since provided evidence that it was serviced later in February as required.
- We found a sonicaid (a device to listen to a baby's heartbeat) that did not have a service sticker on, and the midwife did not know when it was due for servicing.
- There was a checklist for home birth equipment. However, there were no episiotomy scissors in their home birth packs. This could present a risk to women who needed an episiotomy to expedite the birth of a baby at home.
- Community staff carried security alarms that were logged with an external provider who gave monthly audit reports to the community matron. We were told that the alarms frequently split from their attached name badge and were therefore not always used. This had been raised with management but staff had not yet received feedback.

Medicines

- We found that midwives' medicine stocks were out of date. Pre-prepared packs are provided for midwives from pharmacy containing syntometrine, ergotmetrine and Vitamin K (for the baby). We saw packs that had expired in July 2014.
- Midwives carried syntometrine (a drug that helps to speed up delivery of the placenta and reduce the risk of heavy bleeding).Syntometrine must be stored between at temperatures of between 2° and 8°C for prolonged periods and protected from light. Syntometrine may be stored up to 25°C for 2 months when protected from light, but it must then be discarded. We were not assured that there was a process in place to store, monitor and dispose of this drug in line with the requirements.
- Entonox® cylinders were stored in midwives' cars in specifically designed bags. One midwife had not received any guidance on storing entonox, and we were not assured that it was stored appropriately or at the right temperatures in line with guidance.

- Midwives stored their equipment, including medicines, in their homes when not on duty and we did not see any risk assessments for individual midwives to show what risks there were and how they would be mitigated. We were not provided with evidence that there was appropriate documentation in place to show if the medicines and equipment were stored correctly. There was no facility for them to store their equipment or medicines in the community midwives' office.
- Midwives had access to anti-D immunoglobulin prophylaxis (anti-D immunoglobulin is a blood product given to women to prevent antibody formation in rhesus negative women), but they did not carry medication to treat an anaphylactic reaction. This was a risk to women who may have had anaphylactic shock in response to anti-D immunoglobulin. This issue had been on the risk register since 2009 and the action on the risk register was to develop a guideline and that it would be ready by February 2015.

Records

- The trust used paper based patient records and these were securely stored in each area we inspected.
- Documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. Risk assessments were in place and reviewed throughout a woman's pregnancy. Care plans contained clear accounts of actions taken to reduce and manage risks to patient safety.
- We identified one set of patient records that had a loose leaf of paper stored inside without any patient identification details which presents a risk that it may not relate to the correct patient and it could be lost easily.
- Records were transported appropriately and returned promptly to the community midwives office for collation with hospital records. An audit system was in place to ensure all records were returned in order to support ongoing care and multidisciplinary team working.
- A 'child health record' ('red book') was issued to mothers on discharge from hospital and used appropriately to transfer a record of the child's health, growth and development to the health visiting service.
- Midwives arranged 'mini-bookings' for women having their babies with other providers so that they had basic information available.

Safeguarding

- Staff had a good knowledge and understanding of the policies and procedures in place to promote the safeguarding of women and babies at risk of abuse and neglect. Safeguarding training was mandatory for all clinical staff, and training records confirmed that the service was on target to achieve 95% compliance by March 2015.
- Community midwives received quarterly safeguarding supervision.
- The enhanced team (an externally funded team of midwives) provided care for the most vulnerable women in the community.
- The maternity service made prompt and timely referrals for patients and babies that were identified as vulnerable and there was evidence that the trust worked closely with the Local Authority and Police where necessary.

Mandatory training

- The service had developed a robust training needs analysis to ensure that training was in line with the national recommendations for all professionals working in maternity services.
- There was a good system in place to check that all staff who worked in the community completed the mandatory training. Records showed that the community service was in line to meet the target of 95% by the deadline in March 2015.

Assessing and responding to patient risk

- Community midwives carried out initial risk assessments and revisited these throughout a pregnancy. There was evidence of completed histories and risk assessments being added to handheld notes. This enabled all health professionals involved in a woman's care to be aware of identified risks and care planning.
- There was evidence of appropriate care plans for women with high-risk pregnancies who chose to give birth at home.
- All midwives in the hospital and community teams were required to undertake annual newborn life support training as part of combined clinical study days. However, community midwives did not attend advanced this training. This should be considered in the event of a home birth.

Maternity (community services)

- The maternity service had an escalation policy whereby on-call community midwives were required to provide additional staffing to the hospital. The policy had been used twice in the past year; however, services to women in the community had not been affected.
- Emergency alarms and equipment for treating adverse events such as maternal collapse were not available in the two clinics we visited; although emergency equipment was available in an adjacent walk-in centre at one of the clinics. In the other centre, staff had to make an emergency telephone call in the case of an emergency.

Midwifery staffing

- Community midwifery staffing levels were calculated using a recognised dependency tool. Staff were aware that this tool had been used but were unaware of the recommendations made as a result.
- Recruitment of midwifery staff to funded posts had been successful since our last visit and the community service was now up to full establishment.
- Active recruitment was ongoing for a consultant midwife. This was identified as a key role necessary for the further development of the community service.
- The sickness rate at the time of our inspection was 4.6%, which is in line with the national average. It was mostly due to long-term sickness.
- The service did not use agency midwives. Substantive staff and bank staff covered any absence or leave and staff turnover rates had improved since our last visit.
- There were 16 active supervisors of midwives (SoMs) giving a ratio of SoMs to midwives of 1:17. SoMs' caseloads covered both the community and the hospital midwives, this was normal practice.
- Caseloads were arranged by the number of women on their books each month and the ratio (midwife to woman) was 1:92, which is similar to the national average of 1:96.
- One woman told us that she would not consider having a home birth because the community midwives were "too busy" and she felt she "would not be looked after properly".

Medical staffing

- Community midwives had access to advice from medical obstetric colleagues either in person or by referral to an antenatal clinic. They could also refer women to GPs.
- Staff could access the triage system. However, on occasions, midwives were unable to get through to the maternity assessment unit and messages were not returned. This meant that women could be at risk of harm due to delay in their being seen at the hospital.

Are Maternity (community services) effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Policies and practice were based on national guidance. There were guidelines for staff on the trust's intranet site to use for things such as home birth and water birth.

There was limited evidence of audit being used to benchmark performance and support improved practice within the service. This had been recognised by the trust and remedial actions were being taken at the time of our inspection

Community midwifery appraisal completion levels for 2014 were 100%.

Access to medical support was available 7 days a week.

Evidence-based care and treatment

- The service used a combination of National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidance to determine the treatment provided. The trust provided current guidelines for the majority of situations such as guidance for staff when supporting a home or water birth.
- We saw that NICE guidance was not always adhered to in the delivery of antenatal and postnatal care. We saw evidence that five out of eight women received postnatal visits that were not based on clinical need. Staff told us, "We are nicer than NICE." One patient told us that her midwife would have visited her every day in the postnatal period if she had wanted her to.
- The service did not demonstrate a positive and proactive approach to auditing practice or reviewing the effectiveness of service delivery. The trust acknowledged that the approach to audit in this service was underdeveloped and told us that future audits of community care would be managed by the Maternity

Risk Committee. There would be a planned schedule of audit in the future and results would be reported, disseminated and used to support ongoing service improvement.
- Babies requiring paediatric review were referred to another provider locally. The community maternity service was notified of admissions and discharges. However, the admission rates and such information was not used or audited to change or (potentially) improve practice.

Pain relief

- Discussion on options for pain relief formed part of the birth plan discussion at 36 weeks.
- Community midwives carried entonox for women who gave birth at home.
- Women needing pethidine for use in labour had to ask their GP to prescribe it for them; alternatively, a consultant obstetrician prescribed the medicine and the woman collected it from the hospital pharmacy.

Nutrition and hydration

- Women were supported to feed their babies using their preferred method. The trust had been awarded the baby friendly stage 3 accreditation from UNICEF. 'Baby friendly' focuses on staff knowledge and skills to support families with their infant feeding choices. The breastfeeding rate was 52%, which was below the national average.

Patient outcomes

- We found that data on specific patient outcomes was not collected (for example, the admission rates of babies to another provider). Such information could show the performance of the service in regards to neonatal jaundice or poor weight gain.
- Liverpool Women's Hospital monitored its clinical outcomes through the maternity dashboard. Four categories were used: clinical activity, workforce, clinical outcomes and risk incidents, complaints and patient satisfaction surveys. The performance information was fed back to the community midwifery teams by the team leaders.

Competent staff

- Appraisals were undertaken for all staff in 2014 and the staff we spoke with were positive about the process.
- All midwifery staff were subject to an annual professional registration check and were supported to maintain their professional development.
- The service shared a wide range of training opportunities with the hospital based staff to ensure that they had the skills and knowledge to carry out their job roles. We found that skills and drills training was tailored to the needs of community staff.
- Some community midwives were trained in 'examination of the newborn'. One team had five midwives qualified to carry out this examination and this meant that women did not have to take their babies to hospital for their first examination.
- All midwives had an annual supervisory review by their nominated supervisor. Midwives had access to a supervisor of midwives (SoM) 24 hours a day, 7 days a week. The SoM was a source of professional advice on all midwifery matters and was accountable to the Local Supervising Authority's midwifery officer for all supervisory activities.
- The maternity skills study day used community-based scenarios. These provided community midwives with the opportunity to practise emergency skills and drills in settings appropriate to their area of practice.

Multidisciplinary working

- Staff told us they had support from GPs and social services. However, communication with health visitors was variable because they were not attached to GP practices and this hindered direct communication.
- The discharge procedure from the hospital maternity team was efficient, and communication with GPs during this time was well organised.
- There were links between the community and hospital midwifery teams. Team leaders attended a weekly meeting and information was cascaded to midwives via email.
- There was good multidisciplinary working across all the maternity services that facilitated easy and timely referral.
- There was evidence of good communication when women chose to transfer their care to another local provider.

Seven-day services

- Services were available 7 days a week. Patients had access to a 24-hour triage unit with medical and

midwifery staff. However, during times of peak demand, the telephone triage system was overwhelmed with calls that were picked up by the answerphone because there was no midwife available to answer them.
- Postnatal services were available in the community (women were transferred home to the care of the community midwives until at least the tenth day after delivery).
- An on-call rota was in operation to cover home birth.

Access to information

- Staff could access information such as policies and procedures from the trust's intranet when in the community midwives' office in the hospital.
- A telephone triage system was in operation to offer advice not only to patients and their familes but also to other healthcare professionals, such as GPs and accident and emergency (A&E) departments in other hospitals. Advice was given throughout the UK and was not limited to the local area.
- Midwives felt that it was often difficult to obtain patient information such as blood results because of the lack of IT equipment in the community. At the time of our inspection, 20 new 4G devices which were linked to the hospitals information management system had been rolled out as part of a phased approach and the full planned roll out was expected to be completed by June 2015 which would address this issue.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff showed the appropriate skills and knowledge in seeking consent from patients. They were clear about how they should seek verbal informed consent or written consent before providing care or treatment.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). They were aware of their duties and professional obligations relating to the Act.

Are Maternity (community services) caring?

Good

Services were delivered by caring and compassionate staff. Staff treated women and their relatives with dignity and respect, and planned and delivered care in a way that took women's wishes into account. Emotional support was available for both women and those close to them. It was provided with sensitivity and compassion.

Compassionate care

- The community maternity service was delivered by committed and compassionate staff. Patients were treated with dignity and respect.
- Maternity services were added to the NHS Friends and Family Test (FFT) in October 2013. The postnatal care in the community question was related to the community service. The December 2014 FFT scored 100% on the question 'How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment?'; however, it is important to note that the response rate was low.
- Most patients were positive about the care they had received. One patient said "On an individual basis they are good and friendly but the maternity service is disorganised and no outline of care is given." Another told us, "My midwife talked me through the notes."

Understanding and involvement of patients and those close to them

- Patients and those close to them were included when deciding on their care and treatment plans.
- Women were active partners in their care and their wishes where taken in account by staff providing the service.

Emotional support

- Arrangements were in place to provide emotional support to patients and their families when required. Emotional support was offered to families who had suffered a pregnancy loss or stillbirth. The patient's named midwife provided support at home to those who had suffered pregnancy loss. This was done in a sensitive and compassionate way.
- Patients were referred to appropriate counselling support when needed.

Are Maternity (community services) responsive to people's needs?

(for example, to feedback?)

Maternity (community services)

Good

Maternity community services were responsive to patients' needs. Services were planned and delivered to meet the diverse needs of the women using the service.

Managers recognised that community maternity services were an integral part of the trust's 5-year plan, and that community midwifery services would need reconfiguration to meet future service challenges. A project board had been established to take this work forward.

Timely advice and support via the telephone triage line was not always available.

There were plans to involve local people through the Maternity Services Liaison Committee (MSLC) to ensure that safe pathways of care were in place to meet the needs of mothers and their babies in the community.

Service planning and delivery to meet the needs of local people

- The service had implemented a named midwife model of care. Women confirmed that they had a named midwife and valued the continuity of care that this provided.
- A range of services and clinics had been developed to meet the diverse needs of women using the community midwifery service. As an example, Urgent Care 24 was a clinic led by a community midwife which was set up for women who were not registered with a GP. An average of five women were seen each week at this clinic.
- The trust had an enhanced team in place, which were a group of six whole-time equivalent externally funded midwives who were employed by the trust to care for women with complex social needs.
- Scans were offered in community clinics. Women valued this service because they did not have to go to the hospital and could access the service closer to home.
- The trust was working on a reconfiguration of the community service at the time of our inspection. Meetings had been held and were planned to continue fortnightly. There was an intention to involve local people in the planning through the Maternity Services Liaison Committee to ensure that safe pathways of care were in place to meet the needs of mothers and their babies during pregnancy.

Access and flow

- Women were able to self-refer to an easy-access clinic via an online form. An appointment was made for the booking visit with a named midwife in a local clinic. This was the first meeting with a midwife where a medical history was taken, risks were assessed, scans arranged and plans made for the pregnancy.
- There was an absence of postnatal clinics (which are frequently offered in maternity services). The community manager told us that these would be included as part of the community service reconfiguration.
- An on-call system was in operation to cover home births over a 24-hour period, 7 days a week.
- Two women told us that they had not seen their named midwife because of staff sickness. Women were provided with contact numbers for their named midwife and the community midwives' office. One woman had tried to contact her midwife and noted that there was no voicemail message. She felt that it was impossible to contact her midwife outside of an appointment time. Another woman told us that she would not consider having a home birth because the community midwives were "too busy" and she felt she "would not be looked after properly".
- During times of peak demand, the telephone triage system was overwhelmed with calls that were picked up by the answerphone because there was no midwife available to answer them. This meant that women either had to wait for their call to be returned, or present themselves at the hospital because they were anxious about their condition and had been unable to contact anyone for reassurance in a timely manner.

Meeting people's individual needs

- A range of specific clinics were in operation to meet people's individual needs. For example, a link booking clinic was held at Liverpool Women's Hospital for women whose first language was not English. The Birth Choices Clinic provided support throughout pregnancy to women with tokophobia (fear of childbirth) and a vaginal birth after caesarean section (VBAC) clinic was also available.
- There were newly produced information leaflets available in large print and other languages.

Maternity (community services)

- Staff had received training in managing people with complex needs, and also in supporting women who had undergone female genital mutilation (FGM).
- There were clear pathways in place to support pregnant women who were obese or engaging in drug or alcohol abuse.
- We spoke with women who had different accounts of the information (including choice of place of birth) given to them by midwives. One woman told us that she hadn't received a lot of advice and information and that options for birth were not discussed. Another told us that the midwife was "really good" and answered all her questions. A new package had been produced to standardise information given to women, and that this was available from February 2015.

Learning from complaints and concerns

- Patients were aware of how to complain and felt that they would be confident to do so if they had any concerns. There were low numbers of complaints for this service.
- Complaints were handled in accordance with trust policy. Staff signposted patients to the Patient Advice and Liaison Service (PALS) team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained unresolved.

Are Maternity (community services) well-led?

Requires improvement

The community maternity service did not have robust governance and quality systems in place. Data collection and audit activity were insufficiently robust to inform service improvements.

The trust provided a maternity and imaging risk register but we did not see evidence of local monitoring of risk within the community midwifery service.

Senior staff told us of the service's vision for community redesign. This included integration into the midwifery-led unit, an increase in the home birth rate, assessment of early labour at home and the creation of a freestanding birth centre. The head of midwifery confirmed that a working party had been established and that the vacant consultant midwife post was due to be advertised. However, many front-line staff were unaware of the future plans for the service.

Most staff felt part of Liverpool Women's Hospital. Some felt that their community colleagues were not always aware of what was going on in the hospital and that there was sometimes a feeling of "them and us". Staff felt that the community service was "dragging behind" the hospital service.

Staff told us that they felt well supported by their local team leaders and peers, and worked in a good team environment.

Several midwives told us that they were "in the best place that I had been in for a long time". One said, "Over the past year, I feel I can shape service and I am listened to and respected."

There was evidence of good local leadership with individual managers providing support to their team. However front-line staff felt disconnected from the senior management team and some were unaware of the plans for the future of the service or their role in service reconfiguration.

Vision and strategy for this service

- There was no formalised strategy for this service, although it was understood that it needed reconfiguration and integration to meet future service demands.
- Progress of the project was linked to the appointment of a consultant midwife. This role was to be advertised within a month of our inspection.
- Staff were aware that there were plans for the community service in the future but were not sure what these were or what they would mean. They said that they were committed to embracing improvements in the community maternity service once they understood how and when these would happen.

Governance, risk management and quality measurement

- The community maternity service did not have robust governance and quality systems in place. We were given the maternity and imaging risk register, but this covered the whole of maternity and did not separate out risks that related to the community element of the service.

Maternity (community services)

- We did not find evidence of local action plans to address and mitigate identified risks within the community service.
- The analysis of data collected was insufficiently robust to properly inform service and quality improvements. Examples included admissions of babies for neonatal jaundice or poor weight gain.

Leadership of service

- There were examples of team leaders displaying excellent leadership and professionalism across the community services. There were plans to integrate the community and hospital service as part of the reconfiguration of the community.
- Staff told us they felt well supported by their team leaders and manager.

Culture within the service

- There was a mixed culture in the service. Staff spoke positively about the service they provided for patients. They worked well together locally and felt that they would and could continue to develop and improve services in the future.
- Although most staff felt part of the trust, some felt that the community service was not always aware of what was going on in the hospital and that there was a feeling of "them and us". Staff felt that the community service was "dragging behind" the hospital service and these issues had an impact on relationships and collaborative working.

Public and staff engagement

- Staff told us that they had regular communication with team leaders. Regular community team meetings did not take place. Team leaders had 'regular catch-ups' with the matron for community. Community and hospital team leaders attended a weekly quality meeting. However, we were not provided with minutes of any meetings.
- There was no evidence of formal meetings to engage with members of the public about the community maternity services, although we were told that plans to do this would be included in the service reconfiguration project.

Innovation, improvement and sustainability

- Plans to improve the service with the roll out of new computer equipment to improve communication across the community services. It was anticipated this would take place in May 2015.
- The unit had a lower than national average home birth rate. The clinical lead outlined that the service was planning to increase the home birth rate in the future.

Surgery (gynaecology)

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

Information about the service

Gynaecology and surgical services are provided to women in the Liverpool area, with some specialist services such as gynaecology oncology being offered to those from a wider geographic area. A total of 10,700 gynaecology procedures were performed between 1 April 2014 and 31 January 2015. This did not include urogynaecology and oncology procedures.

As part of the surgery core service, we inspected all areas where surgical procedures were or could be a part of the treatment provided. These included:

- a unique gynaecology emergency department where patients could be referred by their GP or make a self-referral;
- two gynaecology wards where patients were accommodated pre and postoperatively; one of these wards specialised in gynaecology oncology;
- a high dependency unit (HDU) with 2 beds situated on one of the gynaecology wards to accommodate patients in need of one-to-one care after surgery;
- a preoperative clinic situated within the outpatients department where patients had their health needs assessed before surgery; patients attended this clinic from both Liverpool Women's Hospital and Liverpool Women's at Aintree;
- a day case unit which provided accommodation where patients could prepare for surgical procedures and recover before returning home the same day;
- five operating theatres for use by the gynaecology surgery team, including for emergency surgery if required;
- the Catharine Medical Centre, which is a private surgical ward, situated on the second floor of the hospital; because of the nature of the service, patients were seen by consultants who worked on a sessional basis. At the time of the inspection, there were no patients on this ward. We were told that this area has been used as an escalation area for NHS patients when required and appropriate to do so.

Throughout this report, the terms 'surgery' or 'surgical services' will be used as collective terms for all the above services, although, if a comment relates to a particular area this will be clearly stated.

Surgical services were led by a consultant (as the clinical lead) and a lead nurse, with an operations manager providing business support.

During our visit we spoke with 11 patients, 8 doctors, 22 nurses (between bands 5 and 7), 2 student nurses, 4 operating theatre personnel and 2 ward managers. We observed care and looked at care and treatment records of 8 patients. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Surgery (gynaecology)

Summary of findings

Surgical services at Liverpool Women's Hospital were caring, effective, responsive and well-led. There were some concerns about the comprehensiveness of patient records, medical handovers, medicines management and storage, safeguarding practices and levels of staff training, which meant that safety required improvement.

There were processes and procedures used in practice both preoperatively and postoperatively to ensure that people received good care and treatment that resulted in a short hospital stay. There were systems in place to monitor the quality and performance of the various wards and areas, and these resulted in actions to improve care when necessary. Staff had access to the information they needed to deliver care to their patients.

Patients reported that staff were kind and patient, protecting their privacy and dignity while providing a high level of care and support.

The gynaecology service responded to the needs of the local population by providing services where gaps had been identified. Joint working with other organisations had also resulted in improved access to services for patients.

Staff were proud of working at the trust and described a culture of openness where they could discuss concerns or ideas with the managers.

Are Surgery (gynaecology) services safe?

Requires improvement

While most of surgical services were operating safely, there were some concerns about the comprehensiveness of patient records, medical handovers, medicines management and storage, safeguarding practices and levels of staff training, which meant that safety overall required improvement.

There was no formalised or recorded gynaecology handover for medical staff from one shift to another.

Training for the safeguarding of vulnerable adults had recently been introduced. However, the knowledge of the staff, as well as their understanding of the impact of safeguarding on their practice, needed further development. We identified one occasion when an issue regarding potential financial abuse should have been referred to the local authority safeguarding team for investigation, but this did not happen. This was raised with trust management at the time of our inspection, and a review of the case undertaken to ensure that the issue was appropriately managed.

Records were securely stored and well kept, including those for the assessment of a patient's health during and after surgery. However, when we reviewed the patient records of three potentially vulnerable adults, we found that the notes lacked depth and did not fully explain how some decisions had been made.

Emergency medicines in the high dependency unit (HDU) were left in an unlocked removable box on top of a cupboard. The HDU was not always occupied by patients or staff, which meant that the medicines contained within may have been accessible to the public.

We found two occasions when the twice-daily check of controlled drugs had only been checked once in the 9 days prior to the inspection. We also found that, when checking the controlled drugs stock, two staff from the same shift would carry out the check together, which meant that staff on the opposite shift might only identify a discrepancy up to 12 hours later when they carried out their own check. This could delay the follow-up of any discrepancy and potentially make it less likely to track missing medication.

Surgery (gynaecology)

Not all staff had completed up-to-date mandatory training including safeguarding vulnerable adults and basic life support.

While there were sufficient medical and nursing staff to deliver the care and treatment required, there was a reliance on locum medical staff and agency operating department personnel.

Patient safety was monitored and incidents were investigated to assist learning and improve care. There was an open culture to support the reporting of incidents. The ward areas were visibly clean and tidy and infection control measures were adhered to. Appropriate equipment was available and well maintained.

Incidents

- There were 152 incidents reported in the gynaecology and surgical services from October to December 2014. This was a reduction of 8.4% compared with the figures for the previous 3 months.
- Staff were aware of the process for reporting any identified risks to staff, patients or visitors. All incidents, accidents and 'near misses' were logged on the trust-wide electronic incident reporting system. Staff felt that the electronic reporting process had been simplified and was easy to use.
- There was evidence that incidents were investigated and action plans implemented to improve patient care and prevent avoidable harm. An example of this was the introduction of electronic blood tracking and traceability after a 'never event' in 2013. ('Never events' are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken). The introduction of this had a positive impact and the trust was still monitoring the improvements.
- Incidents within the surgical services were discussed and reviewed as part of the Gynaecology Divisional Risk Committee monthly meetings. This committee included medical and nursing staff and managers. Any trends identified were discussed, with actions agreed and reviewed at each meeting.
- A proforma had been created by the trust to provide feedback for staff following serious incidents. This was displayed in staff areas in all departments within the surgical services and used as part of the safety briefing. It included actions that had been taken to reduce the risk of recurrence.
- Nursing and medical staff said they were informed of the outcome of investigations into incidents via the feedback forms, communication at ward or department meetings and handovers, and a newsletter they received with the divisional 'lessons of the month'.
- Mortality and morbidity meetings took place on a 3-monthly basis and staff felt that this was sufficient for the levels of activity. These were multi-disciplinary meetings open to all grades of doctor, senior nurses, and ward or area managers. Individual patient cases were reviewed and lessons learned discussed.

Safety thermometer

- A safety thermometer was displayed at the entrance to each gynaecology ward. These included the incidences of falls, pressure sores, urinary tract infections and venous thromboembolism. The information showed 100% compliance with these safety indicators on the gynaecology wards in the previous month.

Cleanliness, infection control and hygiene

- All areas were visibly clean and tidy. Cleaning regimes and schedules were in place.
- Hand gel was available at the entrance to each clinical area. Staff encouraged people entering to use it. Personal protective equipment was also available at the entrance to all ward areas.
- Monthly audits of hand hygiene were carried out and compliance for December 2014 was 96%, which was within the trust's target.
- Patients were screened preoperatively for MRSA.
- There had been no incidences of MRSA but there had been one incident of Clostridium Difficile (C.diff) in the surgical service in the past 6 months.
- When infection control audits highlighted areas of concern, an action plan was developed and actions monitored for completion.

Environment and equipment

- Staff in all areas including operating theatres had access to the equipment they needed and any issues with equipment were quickly resolved.
- Routine maintenance checks had been recorded within the past 12 months.
- Emergency resuscitation equipment was available in the ward areas and theatres. Daily checks of the equipment were recorded.

Surgery (gynaecology)

- There was no resuscitation equipment in the emergency department, which was a risk to patient safety. The nearest equipment was in the outpatients department, which was through four sets of double doors, some with security access, and across a busy thoroughfare in the hospital. This meant that staff would have to leave the area to access emergency equipment, resulting in a possible delay in treatment.
- There were five operating theatres for surgical procedures. One theatre was latex free and used to treat patients with a latex allergy. All theatres were visibly clean and tidy and contained all the appropriate well-maintained equipment.
- Specialist equipment was available if required. This included bariatric equipment. The need for this would be identified during preoperative assessment and planned before the procedure.
- Equipment for surgical procedures carried out in the Catharine Medical Centre was provided in spacious treatment rooms. Equipment needed for the safety and comfort of patients using this area after surgery in the theatres of the main hospital was provided in individual en-suite rooms.

Medicines

- Medicines in the operating theatres, day case ward and Catharine Medical Centre were safely stored, and stock (including controlled drugs) had been checked in line with appropriate procedures.
- The portable medicine administration trolleys on the gynaecology wards had integrated computers. These trolleys could not be used because the temperatures of the computers could not be adequately controlled for the safe storage of medicines. This resulted in two separate trolleys being used for medicine administration, one containing a computer for the records and the second contained the medicines. Therefore, two staff members were needed to administer the medicines, which they felt was not an efficient use of their time. Staff were unaware of any actions in place to manage this issue.
- A new record book for the twice-daily check of the stock of controlled drugs on the gynaecology wards had been started 9 days before the inspection. However, on two of those days, the medication stock check was recorded once only. The shift leader was unaware of this and that the expected procedure was not being followed.
- The checking of the stock of controlled drugs for the two gynaecology wards was carried out by two staff members from the same shift. This meant that the staff on the opposite shift would not be aware if a check had been omitted until they carried out their own count up to 12 hours later. This could delay the follow-up of any discrepancy and potentially make it less likely to track missing medication.
- In the HDU on the gynaecology ward, there was an unlocked box containing emergency medicines situated on top of a cupboard. This area was not secured and could be left unattended if there were no patients on the unit. This meant that the medication was potentially accessible to patients and the general public. Although this was raised with the ward manager on the announced inspection, the box was still in the same place when we returned for the unannounced inspection.
- All staff in theatres and 95% of staff working in surgical services had completed medicines management training.
- There were piped medical gases available in the operating theatres and wards. Portable cylinders were available as a contingency should the supply fail.

Records

- The areas we inspected used a combination of paper records, which were stored securely, and computerised medical records that were password protected.
- There were occasions when handwritten records on the gynaecology wards were not comprehensive. We saw examples of two patients who had been involved with the trust's safeguarding team. The handwritten notes lacked depth in relation to the incidents that had occurred and how decisions had been made. We were told by senior staff at the trust that some of the information not held on the handwritten files was held electronically, but it was not clear which records should be held electronically and which should be held in a handwritten file. This presented a risk that those responsible for the care of patients might not have all the information they needed to be able to treat them effectively.
- Most handwritten records were legible, signed and dated. Records in the emergency room were securely

stored, legible and current. A specific template had been devised for use in the emergency area for telephone triage records and these were used when required.
- Preoperative assessments were carried out in a specialist clinic before admission. The assessment results were then attached to the medical notes and transferred to the ward on the day of surgery.

Safeguarding

- Two staff members had a lead role in safeguarding adults and provided support to staff with safeguarding issues, including outside their own working hours. This was not sustainable in the long term and we were told it would be reviewed when staff were more knowledgeable and familiar with procedures.
- Staff were more aware of some specific areas of concern, such as domestic violence, than they were of other forms of potential abuse. They were able to ask the safeguarding leads for advice; however, we did identify an occasion when a safeguarding concern regarding potential financial abuse on a gynaecology ward should have been referred to the local authority for investigation but this did not happen. This was raised with trust management at the time of our inspection and action was taken to address and learn from the incident.
- The trust target of 95% of staff having completed safeguarding adults training was not met in all areas. While 100% of nursing staff had completed this training, on one gynaecology ward only 65% of medical staff had done so. This meant that not all staff were up to date with current guidance on how to safeguard vulnerable adults from potential harm. We were aware that the trust had been undertaking a significant amount of training with staff at the time of our inspection and development was ongoing in this area.
- In the emergency department, the triage assessment included a prompt for safeguarding concerns, such as domestic violence. This would alert the nurse to contact the local safeguarding team at social services and staff had done so when required.
- Staff told us that there was no training regarding female genital mutilation (FGM) included in the safeguarding training, which meant there was a risk that this might not be identified or managed appropriately. Should staff have any concerns in this regard, they would contact the safeguarding leads for the hospital.

Mandatory training

- Information provided by the trust showed that 87% of staff in surgical services had completed mandatory training by the end of January 2015. This did not meet the trust's target of 95% and meant that some staff might not have up-to-date knowledge and skills.
- Staff told us that mandatory training was available and accessible for them. They were reminded when it was due for renewal and could usually attend, but it may be delayed if there were too few remaining staff to allow them to leave the ward or department.
- The staff who worked in the HDU had completed critical care training to the level appropriate for the acuity of the patients accommodated on the unit.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could have an impact on patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and the divisional matrons to address these risks.
- On admission to the surgical wards and before undergoing surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and infection control. Patients at high risk could be booked into the HDU or placed on care pathways with care plans to ensure that they received the right level of care.
- The assessment of a patient's condition after surgery or admission to a ward was recorded on an observation chart. This included escalation procedures if their condition deteriorated. These were completed within the agreed frequency.
- The HDU was situated in a bay on gynaecology ward 1. This could accommodate two patients and was used on a risk basis after surgical procedures or in an emergency. This meant that patients at risk of deteriorating, or whose observations had already identified a deterioration in their condition, were managed in an appropriate setting.
- Nursing and medical staff in the gynaecology theatres and wards were not up to date with basic life support (BLS) training. Only 70% of medical staff and 80% of staff on one gynaecology ward had received up to date BLS

training at the time of our inspection. This presented a risk that not all relevant staff had the up-to-date skills and knowledge to respond as required in an emergency situation.

- General health checks were carried out in the preoperative clinic, such as weight and blood pressure. Further investigations would be completed on a risk assessment basis (for example, if the patient had an underlying medical condition).
- In the operating theatres, the World Health Organization (WHO) surgical checklist was completed in a detailed, unhurried and inclusive way. Should an issue that could lead to non-compliance be identified, this was recorded and actions taken to address it.
- An audit of compliance with the WHO checklist showed the checklist had been used in all cases reviewed in 2014 but there were some errors/omissions on the documentation noted. Managers had an action plan to address these.
- Staff told us that patients who become unwell in the Catharine Medical Centre would use the medical services available in the hospital, including the HDU if necessary. The risks of complications after surgery were assessed preoperatively and postoperatively.

Nursing staffing

- There were enough staff to meet the needs of the patients. Records on the wards showed that the actual numbers of staff met the planned numbers during the inspection.
- There had been 11 new qualified nurses on the gynaecology wards in the past few months. They worked alongside a more experienced nurse until they were deemed competent to work alone.
- There was some flexibility in the staffing between the two gynaecology wards and the HDU if one area was busier than the other. This meant that the workload could be assessed on an ongoing basis throughout the day and the available staff used to ensure that patients' needs were met.
- Should patients who had been admitted to the day case area need to stay overnight, the need for additional staff at short notice could be assessed and accommodated between the two wards quickly.
- On one of the gynaecology wards, the shift leader was not always supernumerary, which meant that they were unable to supervise and support the ward staff as intended. This had been raised with managers; however, staff shortages meant that this was an ongoing issue. There were plans for further recruitment that would enable more supernumerary time. In the meantime, if the ward manager was available, they would assist in the day-to-day management of the ward in the absence of the shift leader.
- Staff in all surgical areas described a good team atmosphere in which they supported each other and worked well together for the benefit of patients.
- Staff numbers in the emergency department were adequate to care for patients in a timely manner.
- There were specific qualified nurses working in the Catharine Medical Centre. Because patients were booked in advance, the workload was planned and staff from other areas were not expected to work in the centre at short notice.
- There was a formal recorded handover at each shift change on the gynaecology wards and in the emergency department and theatres. There was opportunity to discuss in depth the care required by a patient with the staff member who had been responsible for their care on the outgoing shift.

Medical staffing

- One consultant had the responsibility for new patient admissions on a weekly basis. This rotated between the consultants and it meant any patients admitted because of an emergency were more likely to be under the care of the same consultant throughout their stay.
- Doctors of all grades told us that they were well supported by consultants and felt comfortable asking for advice or assistance should they need it.
- There were five oncologists employed by the trust to ensure comprehensive cover and support to the gynaecology oncology service.
- The medical on-call rota meant consultant cover was available at all times including out of hours. Consultants attended for at least 6 hours on a Saturday and Sunday, again with on-call cover being provided out of hours.
- Doctors visited the wards on Saturdays and Sundays. Discharges could be facilitated if this was required. A senior registrar was on duty at other times to provide emergency treatment during on-call hours. However, staff said consultants would usually attend to perform emergency surgery out of hours. Junior doctors found this supportive.

Surgery (gynaecology)

- Locums accounted for 25% of the surgical cover because of sickness and absence among the permanent staff. Locum doctors were aware of the processes and practices within the hospital. Senior medical staff said they were investigating options as to how to reduce the use of locums in the service. Medical staff reported that there were enough doctors on duty both day and night.
- There was a high number of agency staff used in the operating department; this could be as high as 50% of the workforce. Whenever possible, the service used regular agency staff who were familiar with the department's procedures.
- There had been a review of the activity and workforce requirements in the operating theatres. This had resulted in changes in role and salary bands for some operating department assistants. There were mixed views as to the likely impact of this on the working procedures in the theatres.
- Doctors told us that there was no formalised or recorded gynaecology handover from one shift to another. The doctor who had been working through the night passed information to the doctor working during the day. They would give information about any emergency admissions that had taken place. The consultant working as the duty doctor for the day would visit the wards and discuss patients' treatment in an informal way with the doctor who had been on duty during the night. This meant there was no formal or recorded mechanism for sharing information between shifts.
- In the Catharine Medical Centre, individual doctors had contracts to use the facilities to carry out cosmetic surgery procedures. This was done on a booked sessional basis.

Major incident awareness and training

- Senior staff members were aware of their role in a major incident. Some other staff were not aware and had not been part of any formal practice for these procedures.

Are Surgery (gynaecology) services effective?

(for example, treatment is effective)

Good

Surgical services provided evidence-based care and treatment. Policies and procedures were based on the relevant guidelines. The trust took part in local and national audits and measured its performance in order to identify areas for improvement. Patients had a low incidence of surgical site infection and a short hospital stay compared with other trusts in England.

The assessment, management and detailed record keeping for patients who lacked the mental capacity to make some or all of their own decisions required improvement. This included consent to care and treatment. While some staff had completed training provided by the trust that had increased their knowledge and awareness about these issues, the practices, procedures and documentation to ensure safe management of such patients needed further development.

There was recognition by medical staff that the services to provide chronic pain management to patients required development.

Measures were in place to assess the competence of staff and monitor their performance. There was effective multidisciplinary working between staff off all grades and most necessary services were available 7 days a week. Staff had access to the information they needed to deliver care to their patients.

Evidence-based care and treatment

- Policies and procedures were developed in line with current guidance including those issued by the National Institute for Health and Care Excellence (NICE) and Royal Colleges.
- We saw examples of where guidelines had been developed in line with NICE guidance such as the 'guideline for physiological monitoring and medical early warning scores'. Guidelines were reviewed by the gynaecology and surgical services policy, audit and patient information group to ensure that they were kept up to date.

Surgery (gynaecology)

- A report had been circulated to the surgical services in February 2015. This gave outcomes of audits that had been completed within the hospital to monitor performance and compliance with NICE guidance. It included an audit of midurethral tapes for urinary stress incontinence against NICE clinical guideline 171. The outcomes of the audit and resulting recommendations included the development of new departmental guidance for preoperative investigations.
- There was a clinical network group that developed guidance for the gynaecology oncology service. Staff said there was a trust-wide guidelines group in the past. However, this became too large because of the diversity required. Smaller groups had since been developed. The development of policies to meet guidance was now the responsibility of each clinical specialty.
- Senior staff took part in national and local audits to ensure that they were providing care in line with recognised standards. These included the national menorrhagia audit and a local audit to investigate the recurrence rate of infections with Bartholin's gland surgery. The results were comparable with other similar organisations.
- Surgical site infection rates were compared with a peer trust for the 12-month period up to December 2014; the trust was better than or equal to the peer trust on all but one type of infection. There were no instances of surgical site infection recorded from July 2014 to December 2014.
- Clinical pathways had been developed to guide practice in surgical services. These included the 'Enhanced recovery integrated care pathway for laporoscopic gynaecological surgery 24–36 hour clinical pathway'. This meant that there was clear guidance for staff, based on nationally recognised guidelines, for the care and treatment of patients having surgical procedures.
- A sepsis care pathway had been implemented to reduce the risk of sepsis after a surgical procedure. Staff in the HDU had attended specialist training in sepsis and cascaded this knowledge to other nurses on the ward.

Pain relief

- Procedures were in place to ensure that patients received pain relief as soon as they needed it after surgical procedures. These included pre-assessment discussions with the patients and prescribing pain relief preoperatively to prevent delays postoperatively.
- Assessments of pain were recorded as part of the nursing observation of patients in the theatre recovery areas and on the gynaecology wards. Patients told us that their pain had been well managed.
- There was no identified staff member with a lead role in pain management within the trust. Senior staff said this meant that individual anaesthetists were consulted regarding pain management for patients. However, no-one had overall responsibility for ensuring a consistent approach or developing pain management protocols in the trust.
- Senior staff told us that the management of chronic pain required development, which included appointing specialists and developing procedures for pain management. However, there was a protocol for the referral of patients with chronic pain to specialist clinics at Liverpool Royal Hospital or Walton Neurological Centre.

Nutrition and hydration

- Staff communicated at handover if a patient was to have nothing to eat or drink before surgery and they also checked with the nurse in charge before offering refreshments.
- A nurse on the gynaecology ward had developed a documented protocol for the management of fluid intake to reduce the risk of dehydration in patients. This included the addition of fluid intake and output charts on the general observation charts, and incorporated guidance as to how much fluid each container held. A water symbol was also placed by the bed of people who were at risk of dehydration.
- An enhanced recovery pathway was in use that included encouraging high carbohydrate drinks preoperatively and giving nutritional food and drink as soon as possible postoperatively. This had a positive impact on recovery times and reduced the length of stay for patients.
- A selection of hot and cold food was provided on the wards at meal times. Staff assisted patients who needed support with eating and drinking, and did so in a dignified and sensitive manner.

Patient outcomes

- Liverpool Women's Hospital is one of only two specialist hospitals in the country that provide services specifically

for women and, as a result, it uses information from the other specialist hospital to benchmark its performance and measure the effectiveness of its interventions with patients.
- The incidence of patients having a hospital-acquired infection after a surgical procedure was 0.3%, which was lower than the 0.4% that the peer trust used for benchmarking.
- The average length of stay for patients after surgery was lower than the England average. For elective surgery, it was 1.2 days, which was better than the England average of 3.3. For non-elective surgery, it was 1 day, which was better than the England average of 5.2; however it is difficult to compare this equally given the specialist nature of the trust and the service it offers. This meant that patients were able to leave hospital as soon as possible to recover at home without their discharge being delayed.
- A comparison with a peer trust showed that between January and December 2014, 2.7% of inpatients (gynaecology only) were re-admitted to the trust. This was better than the peer trust's 8.1%, which was used for benchmarking. This level of performance suggested that the discharge procedures were well developed and that the enhanced recovery pathway was effective in supporting early discharge.

Competent staff

- Newly qualified nurses had a 3-month supernumerary induction to the surgical services. This included rotation between the various wards and departments, such as the gynaecology wards, emergency department and day case ward. This meant staff could develop their knowledge and skills while not being included as part of the ward staff team.
- Competence assessments were included as part of the training systems within the hospital. These included the use of equipment and medicine administration. This meant that staff were observed to be competent before carrying out procedures or using equipment alone.
- Information provided by the trust showed that staff were up to date with their personal development reviews that resulted from their annual appraisals. Staff said they had formal and informal opportunities to discuss their learning needs, and could attend extra training if there was funding available to do so.
- There were opportunities for staff to develop their knowledge and skills based on their own interests. As an example, one nurse had recently become the link nurse for nutrition, which included working with dieticians and helping to develop practice and procedures on the wards.

Multidisciplinary working

- A multidisciplinary clinic was held weekly. This was specifically designed to include the attendance of specialist clinicians (as required) to provide care to patients with complex medical needs that might require the input of more than one specialist, such as a cardiologist or other health professionals including dieticians or physiotherapists.
- Staff in the preoperative clinic gave examples of when other health professionals had been part of the planning for a surgical procedure, such as for a patient with learning disabilities. This case had included staff from the outpatients department, operating personnel, anaesthetists and medical, nursing and ancillary staff.
- Nursing staff could refer directly to a health professional if this was required, and they were aware of the referral procedures.
- Some of the department meetings, such as those on mortality and morbidity, were open to medical and nursing staff to support information sharing and learning.
- Medical, nursing and ancillary staff all described good multidisciplinary working, saying the team work was good and everyone communicated well across the various disciplines.
- In all surgical services, staff could make referrals to outside agencies if they deemed this necessary. This included social services if they felt a patient needed this type of support.
- On all wards, staff gave examples of how they would include families and carers in a patient's care both at the planning stage and after surgery, if appropriate.

Seven-day services

- Planned surgery took place between Monday and Friday. Two extra slots had been made available to deal with patients who needed surgery in a shorter time frame to improve the likely outcomes. Outside these hours, sufficient staff were available, either in the hospital or on call, to carry out emergency procedures as required.

- The medical on-call rota meant that consultant cover was available at all times. Doctors completed visits to the wards on both Saturdays and Sundays, and supported timely discharge.
- The Catharine Medical Centre was open Monday to Friday. There were no treatments planned over the weekend but the area could be used for escalation if required.

Access to information

- Medical records were handwritten and not held electronically. In all areas, they were centrally stored and doctors had easy access to them. Records were made available quickly if staff needed to access historical medical notes (for example, in the emergency department).
- Preoperative records were handwritten and accompanied the patient's medical notes. Staff told us they were easily accessible when needed and they had not experienced difficulties due to records being unavailable.
- Nursing records on the gynaecology wards were electronically stored. Staff had one computer on each ward that they shared to obtain and record relevant information. There were times when they had to wait in order to access the records, and this could lead to a delay; however, the delay was brief and did not result in adverse outcomes for patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A consent audit undertaken by the trust (which was not dated) in gynaecology showed that, while everyone selected in the sample had a signed consent form, not all of the completed forms contained the correct information. In the audit sample, 40% did not list all the alternative procedures (including the option not to treat) and 30% did not record details of the anaesthetic.
- There was no recognised approach to the assessment of a patient's understanding of potential surgical procedures in the preoperative clinic. Some staff said they would carry out such an assessment by asking general questions to assess memory. Others said they would check the understanding of the person when explaining a procedure. This meant there was no formal, agreed assessment to ensure that a patient fully understood and could question the choices available to them.
- A programme of safeguarding training, which included information about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards for the nursing and medical staff, had begun in December 2014. Staff who had attended felt it had helped their understanding of how this had an impact on their work. Because the introduction was in its infancy, not all staff understood what changes to their practice were required, such as needing to assess a person's mental capacity to consent to investigations or taking medicines. As a result, there was a risk that not all practical means to carry out care in the best interests of the person were explored and recorded.
- Where there were identified issues relating to mental capacity, the procedures for obtaining valid consent for a surgical procedure did not always ensure that the person's capacity to consent had been assessed at every stage to determine if capacity was still absent or if it had returned.
- There was a lack of information in two patient records regarding the ongoing assessment of their mental capacity to consent to specific decisions about their care or discharge. In both cases, capacity assessments were not documented on every occasion to show how professionals had arrived at a particular decision. The trust acknowledged some of the errors made in these cases and indicated that they would use them both to learn and improve.
- There was no specific assessment or plan of care on the meditech system (a computerised system which includes care plans for people with specific conditions) for patients without mental capacity to make decisions. This meant that there was no plan or record of how patients had their mental capacity assessed, how choices were offered and what necessary support was put in place with regard to their day-to-day care on the wards.
- Staff said they had approximately four patients a month who lacked capacity. No audits of the number or management of these patients had taken place.
- Staff said they had never applied for a Deprivation of Liberty Safeguard, but the recent training had helped them understand when this might be required.
- There was one example of when the Mental Health Act 1983 had been used to detain a patient after surgery.

The trust was not registered to use these powers of detention (although the trust had applied for registration and was awaiting the outcome at the time of our inspection).

- The records regarding this detention were incomplete in that actions taken beforehand were not clearly documented. It was unclear from the notes if a less restrictive option had been considered or could have been used.
- A leaflet had been developed by a nurse on the gynaecology ward as a guide for staff regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They had done this because there was no official easy guide available and staff found it very helpful.

Are Surgery (gynaecology) services caring?

Good

Patients reported that staff were kind and patient, protecting their privacy and dignity while providing a high level of care and support. They were helped to recover quickly after surgery, which resulted in them having a short hospital stay.

Informal carers could be involved in the care and support of patients should this be required, and patients were given the information they needed to make choices that were respected.

Compassionate care

- Patients told us that nursing staff were kind and patient. They said they were well cared for in a sensitive manner.
- They said staff understood their need for privacy, and door signs were in use to indicate when a room was occupied. Privacy curtains were used on the wards and in clinic areas.
- Patients told us that nurses understood their need for rest and it was quiet at night times.
- We observed staff speaking respectfully to patients and protecting their dignity when preparing them for transfer to theatres.
- Patients told us that their call bells were answered quickly.
- Of those patients who completed the NHS Friends and Family Test in January 2015, 100% said they would recommend the unit to others.
- Overall, the Friends and Family Test scores for the emergency room had been better than the national average by 20% or more since October 2013.

Understanding and involvement of patients and those close to them

- Staff said that, if a patient required a relative to be with them because of, anxiety or any other need, they would facilitate this if possible.
- At the preoperative stage, patients were included in their care and treatment as far as possible. This included discussions regarding their treatment options (including not having surgery if this was their choice) and pain relief after surgery.

Emotional support

- Staff discussed how they would offer support to a patient and their family should they need to deliver worrying or bad news. They understood the sensitive nature of this.
- In the wards and departments, a room had been set aside for private discussions to deliver worrying or difficult messages.
- Staff knew there were other agencies they could use when appropriate, or which could provide information for patients who might require ongoing support.
- Staff discussed how the emotional or social needs of a patient would be assessed as part of their preoperative care, and how the results would form part of their care plan postoperatively.

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

Good

The gynaecology service responded to the needs of the local population by providing services where gaps had been identified. Joint working with other organisations had also resulted in improved access to services for patients.

Complaints were managed in a timely way, and lessons were learned and shared.

Surgery (gynaecology)

Provision was made for patients with complex physical or mental health needs and those for whom English was not their first language.

Service planning and delivery to meet the needs of local people

- The gynaecology services at the hospital were provided for women living in the Merseyside area local to the hospital. Specialist gynaecology surgery services, such as urogynaecology and oncology, were provided for women who could be referred to the hospital from a wider geographical area. This increased the diversity of patients who might attend the hospital and this was considered when planning the service.
- The gynaecology emergency service was unique in that it allowed patients to refer themselves to a specific unit for assessment and treatment of gynaecological emergencies.
- Around 900 patients a month were expected to attend the emergency unit, but this was normally exceeded by approximately 100 because the service had been re-located to a more accessible area. Senior managers were continuously reviewing the resources they had in order to provide a high level of service. This proactive approach was supported by the recent relocation and refurbishment of the emergency department to increase capacity.
- An ambulatory gynaecology service was introduced to reduce the need for patients to be admitted to theatre or as an inpatient. To date, this had not reduced the theatre activity; however, it did provide a prompt and accessible service for patients who did not need to stay in hospital overnight.
- The preoperative service provided a choice of a walk-in service or booked appointments. This meant that patients could choose the best option for them when they needed a preoperative assessment. The service was available for patients who were seen in specific outpatient clinics.
- Gaps in service provision for local people were considered in the planning of services at the trust. An example of this included the development of a specialist endometriosis clinic that gave women with this condition an opportunity to see multidisciplinary specialists locally.
- Joint working with other trusts in the area took place to increase the services offered. This included a grant for the development of a transitional adolescent gynaecology clinic in conjunction with a local children's hospital.

Access and flow

- Patients could attend the emergency department by referring themselves, via their GP or as an emergency.
- The Department of Health target for emergency departments is to admit, transfer or discharge patients within 4 hours of arrival. For the period March 2013 to November 2014, this target was achieved for 99% of patients.
- The percentage of emergency admissions via accident and emergency (A&E) waiting 4–12 hours from the decision to admit until being admitted had been reported by the trust as zero for the period March 2013 to November 2014.
- Bed occupancy on the gynaecology wards varied throughout the week with midweek being the busiest at around 95% occupancy, reducing to 40–50% at other times. Staff said they could always access a bed on a ward should they need to, and beds in the private Catharine Medical Centre could be used if the gynaecology wards were full.
- Patients were transferred from the operating recovery rooms to the wards without delay.
- Recognising that the trust provided specialist services for women, a multidisciplinary clinic was specifically introduced to include the attendance of specialist clinicians (as required) to provide care to patients with complex medical needs that might require the input of more than one specialist, such as a cardiologist or other health professionals including dieticians or physiotherapists.
- Staff told us about occasions when surgery is planned and carried out by surgical services staff at the premises of other providers to ensure that the right level of support was available to patients who might deteriorate quickly or needed other specialist surgery that required joint working.
- Theatre sessions for unplanned procedures had increased from 1 to 2 half-days a week. This was designed to ensure that there was extra capacity available for surgery to take place at short notice, rather than being added to the end of a day's operating list.

Surgery (gynaecology)

Meeting people's individual needs

- There was no lead nurse with responsibility for practice development with regard to patients with complex needs such as dementia or learning disabilities. This was the responsibility of the nurse with a lead role in supporting vulnerable adults; however, this post was vacant. The trust had plans to recruit to this role in the near future.
- The new trust-wide lead for the safeguarding of vulnerable adults told us that they were involved at the planning stage when a patient with complex mental or physical health needs was to be admitted for surgery. This was to ensure that services able to meet their needs were in place before admission.
- There were services available for patients whose first language was not English. These included interpreters and the use of a telephone interpretation service. We found examples of when this had been used successfully. However, there were occasions when relatives were used to aid communication, which is not considered in line with best practice guidance.
- There were no signs or leaflets on display in any format other than written English. Staff told us they thought they could order leaflets in other languages but were unsure of the process. This meant that people who could not use the written word (such as those with visual impairments) or English to communicate did not always have ready access to the information they needed.
- When information was displayed for ease of access, care was taken to protect the identity of patients (for example, by using a screen to cover a patient's name on a whiteboard.

Learning from complaints and concerns

- Information was displayed in the department for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS) service.
- Complaints regarding surgical services were discussed during the governance meetings. The outcomes were shared with gynaecology service managers who cascaded any learning to their staff.
- Staff received feedback regarding complaints during their informal ward meetings and via newsletters.
- Patients had the opportunity to speak to staff if they were not happy, and felt comfortable about doing so.

Are Maternity (community services) well-led?

Good

Surgical services overall were well-led. Staff at all levels were supported by the leadership team; senior colleagues were approachable and made them feel included both in day-to-day decisions and in the future development of the trust.

There were systems in place to assess risks, develop actions to reduce them and monitor progress. The quality of the service was monitored and feedback was provided to the trust board monthly.

There was an open culture and staff felt that they were able to discuss any concerns, they would be heard and appropriate actions would be taken. When changes had been made, this had been communicated to staff effectively.

There were some good examples of inclusion of the local population in the development of the service. There was evidence of the development of innovative practice that had had an impact on the clinical advancement of gynaecology services.

However, there was an occasion when a patient on a gynaecology ward had been detained under the Mental Health Act 1983, a regulated activity that the trust was not registered for. An application was submitted before the patient was detained but the outcome had not been determined before the service acted. We raised this matter with managers after our unannounced inspection. The senior management team committed to refraining from detaining patients until registered to do so.

Managers were also taking appropriate remedial actions in relation to informing the patient of this incident and its aftermath.

Vision and strategy for this service

- Senior staff discussed how the gynaecology services at the trust were part of the wider discussions regarding the future development of the hospital. Some staff said they were part of these discussions while some consultants said they did not feel their opinions were either sought or respected.

Surgery (gynaecology)

- Staff at all levels were aware that the vision for the gynaecology services was to continue with the specialist services they offered, such as gynaecology oncology and urogynaecology, in order to provide a unique service to the local and wider population. They were also looking to develop extra specialist services to expand the current provision, such as the multidisciplinary endometriosis clinic.
- Staff at all levels were proud to work in a specialist trust and saw the service they offered as unique. They conveyed a wish to provide high levels of care and treatment, and to develop and improve the service.

Governance, risk management and quality measurement

- Information on the trust's risk register for gynaecology and surgical services showed that there were four risks identified with a review that was overdue. In the past 4 months, this had been the case 50% of the time. This showed that the system for ensuring risks were reviewed within agreed timescales was not always achieved.
- There were governance arrangements in the surgical services that ensured performance was measured, results discussed and actions put in place to improve. Targets were set and progress was monitored on a monthly basis. For example, meetings were held to discuss the data on the service's clinical and quality dashboard. Monthly reports on the quality of the service were presented to the trust board.
- The risk register for surgical services had a robust action plan with regular review dates and monitoring systems in relation to all the risks on the register. When actions had been taken, they continued to be monitored for compliance.
- Not all of the risks identified by CQC had been recorded on the risk register; however, where concerns were raised with the trust an internal review was undertaken and an action plan was put in place.
- A monthly meeting was held to discuss the risks within the gynaecology and surgery services. These included senior nursing staff, anaesthetists, medical personnel and any individual involved in a specific risk issue. The risks, and actions to mitigate them, were discussed. The senior nurses then disseminated the information to the other staff in their department, both verbally and in writing, so that all staff were aware of the outcomes of the meeting.

Leadership of service

- Staff in all areas of the surgical services felt they could approach their senior colleagues and were well supported by them. They spoke highly of the leadership of the service and told us that they felt included and valued.
- There were examples of when change had been introduced that had led to positive improvements in the service. In the theatres, a recent change had not been accepted well by all staff; however, its purpose was clear and the process had been open and transparent.
- Staff in surgical services said that the members of the trust's executive management team were visible and approachable.

Culture within the service

- Staff said the culture was one of openness and transparency in which they could discuss any issues or concerns and would be listened to.
- Staff were encouraged and supported to report any issues in relation to patient care or any adverse incidents that occurred.
- In all areas, staff told us that the care, welfare and experience of the patient was paramount, and this approach was well supported by managers.
- Staff were involved in decision making as far as practicable with regards to their area of the service. This included suggestions for changes to records, inclusion of information for patients and extra staff training to expand the service provision.

Public and staff engagement

- Staff were included in discussions about the gynaecology and surgery services. They had informal and formal ward meetings, email communications and notices displayed around staff areas. They had opportunities through meetings and informal sessions with area managers to put forward their ideas.
- Two meetings had been held with the council of governors for the trust and partnership organisations. There had been discussions about how the trust could work more closely with local women's organisations to "ensure its services were as accessible as possible and the best they could be". The outcomes had included direct referral access to voluntary services from the emergency department.

Surgery (gynaecology)

Innovation, improvement and sustainability

- As a major specialist hospital in gynaecology, the trust had been innovative in several areas of clinical practice. These included ambulatory gynaecology and laparoscopic procedures. The hospital was a specialist regional centre for gynaecology oncology, attracting referrals from a wide geographical area.
- There were innovative joint working projects with other trusts to develop services to help the local population. These included adolescent gynaecology clinics held in conjunction with a nearby children's hospital to aid the transition from child to adult care.
- Consultants working at the hospital held senior posts in professional organisations such as the Royal College of Obstetrics and Gynaecology. This meant that the profile of the hospital was raised within these organisations and through its publications.
- Staff at all levels said there was a culture of continual improvement, which meant there was ongoing development work in which they could be involved if they wished. This included groups set up to investigate specific areas of work, such as infection after surgery, which had resulted in changes in practice to improve the experience of patients.
- Senior staff told us that there were open discussions, with staff at all levels, about the future of the gynaecology services at the trust. These discussions included the challenges within the local area that had an impact on the services provided at the hospital, and possibilities for future joint working with other organisations.

Termination of pregnancy

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

Information about the service

Termination of pregnancy services at Liverpool Women's Hospital are mainly provided at the nurse-led outpatient and day care facilities within the Bedford Centre. The service undertakes approximately 3,000 medical and 800 surgical terminations of pregnancy a year and provides sexual health advice, contraceptive services and chlamydia testing for women under 25 years old.

Terminations are carried out for patients that are up to 12 weeks pregnant; however, in some acute situations, terminations are carried out after 12 weeks but this is not routine.

We visited the Bedford Centre during our inspection. We observed care, looked at records for 14 people and spoke with 4 patients, 2 relatives and 12 staff across all disciplines, including doctors, nurses and members of the management team.

Summary of findings

There were robust systems for the reporting of incidents and the management of risk within the termination of pregnancy service. The centre was visibly clean, medicines were safely stored and well managed, and the standard of record keeping was good. There were sufficient well-trained nurses to provide safe and effective care.

The multi-disciplinary team worked well together, using national guidelines to treat patients. Access to information was good and there were robust processes in place to gain consent.

Services were delivered by caring and compassionate staff who treated patients with dignity and respect. Care and treatment were planned and delivered in a way that took into account the wishes of the patient.

Access to treatment, advice and information was good both during procedures and after discharge. Complaints were well managed.

The trust's vision and values for the organisation had been well communicated to staff.

There was a 'no blame' culture that gave staff confidence to report incidents and 'near misses'. We saw individual members of medical and nursing staff who displayed good leadership skills and were positive role models for staff generally.

Termination of pregnancy

Are termination of pregnancy services safe?

Good

There were robust systems for the reporting of incidents and the management of risk within the Bedford Centre. The centre was visibly clean, medicines were safely stored and well managed, and the standard of record keeping was good. There were sufficient numbers of well-trained staff to provide appropriate care.

- There were robust systems in place for reporting incidents and 'near misses'. Staff had received training and were confident in the use of the incident reporting system. We spoke with a new member of nursing staff who had not yet had to report an incident but could demonstrate the procedure to us.
- Nurses met together at the beginning of the working day for a 'huddle and a cuddle', which included dissemination of any relevant safety information, feedback from incidents, and actions after complaints or incidents. This meeting also provided a forum for staff to raise any safety issues or highlight any practical or emotional support they might need that day.
- An annual mortality and morbidity meeting had been initiated with the other major local provider of termination of pregnancy services to review any complex cases and share ideas. Staff from the Bedford Centre told us they could feed information and suggestions into this meeting, and that they received feedback on the discussions that took place.

Cleanliness, infection control and hygiene

- The Bedford Centre was visibly clean. There were cleaning schedules in place and levels of cleanliness were monitored by the nurse manager and audited regularly.
- Staff were aware of current infection prevention and control guidelines. They consistently followed hand hygiene practice and 'bare below the elbow' guidance.
- There were sufficient hand-washing sinks and hand gels. Hand towels and soap dispensers were adequately stocked. There were suitable arrangements for the safe disposal of waste. We saw that used linen that presented an infection risk was segregated in line with best practice guidance and managed appropriately. Clinical and domestic waste was also segregated in colour-coded bags, and sharps (such as needles and blades) were disposed of in approved receptacles.
- Pregnancy remains were handled in line with Human Tissue Authority guidelines.

Environment and equipment

- Staff told us that equipment was readily available and any faulty equipment was either replaced or repaired promptly.
- We observed one piece of portable electrical equipment that had not been tested for electrical safety since 2007, and others that had not been tested for over 2 years. There was no system in place, other than a visual check by nursing staff before use, to regularly inspect and establish that the portable electrical equipment was fit to use. This issue was not recorded as a risk on either the trust or departmental risk register.
- We checked the resuscitation equipment and found it to be easily accessible and fully stocked, with all equipment in date. Records for the previous 3 months showed that it had been checked daily by a designated nurse.

Medicines

- We looked at the prescribing and medicine administration records for nine patients. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- Medicines, including those requiring cool storage, were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.
- Controlled drugs were stored and managed appropriately**.** Some drugs used in the termination of pregnancy were kept and administered as controlled drugs. While this was not a legislative requirement, it was a practice that had been put in place as an extra control given the nature of the drugs.

Records

- During our inspection, we reviewed 14 sets of patient records. Each record contained up-to-date

documentation, completed by nursing and medical staff, that was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment.
- Organisations that carry out a termination of pregnancy are legally required to report them to the Department of Health. We reviewed completed copies of the required documentation and found that all had been done correctly and within the required timescales.
- There was good practice in documenting the reasons for the termination of pregnancy. Required documentation was signed appropriately by two doctors in accordance with the legislative requirements. We found no evidence of pre-signing documentation.

Safeguarding

- There was an effective system in place for raising safeguarding concerns. Staff were aware of the process and could explain in detail their role with regard to vulnerable adults and children. They had frequent contact with the hospital safeguarding team and described them as "very responsive".
- The safeguarding process was supported by staff training. All nursing staff had received up-to-date level 3 safeguarding training.

Mandatory training

- Levels of mandatory training, which included domestic violence training, were very good for staff at the Bedford Centre and were in line with the trust target of 95%.
- Mandatory training records were clearly displayed in the staff rest room for each staff member, which meant they could easily see at a glance if any training was outstanding.

Assessing and responding to patient risk

- Staff within the Bedford Centre monitored and assessed patient risk appropriately. There were processes in place to identify patients at risk of deteriorating and those who required an urgent review.
- We found that the response provided by medical staff to a patient whose condition was deteriorating was timely and effective.
- We visited a theatre that was used for the surgical termination of pregnancies. The service had implemented 'five steps to safer surgery' procedures (Patient Safety First campaign) in the operating theatres used for the termination of pregnancies.
- We observed that the World Health Organization (WHO) surgical safety checklist was used appropriately, with good communication and briefing sessions embedded in the service.
- An audit of compliance with the WHO checklist showed the checklist had been used in all cases reviewed in 2014 but there were some errors/omissions on the documentation noted. Managers had plans in place to address this issue.

Nursing staffing

- Nursing staffing levels were reviewed twice yearly throughout the hospital, which included the Bedford Centre. Staffing levels had been assessed using a validated acuity tool and were due to be reviewed again in March 2015.
- We reviewed copies of duty rotas and found that nursing staffing levels, established by using the acuity tool, were satisfactory. This was confirmed by nurses who told us that, although they were busy, there were sufficient staff to provide a safe and effective service to the women they cared for.
- Gaps in rotas were filled by current staff undertaking extra hours or shifts. The continuity provided by the use of nursing staff with knowledge of the specialised systems and processes in the Bedford Centre enabled the consistent delivery of safe, high-quality care and treatment to women.

Medical staffing

- The termination of pregnancy service is nurse-delivered.
- Medical terminations were generally carried out by nursing staff; however, there was good access to medical staff, including consultants, when required.
- For surgical terminations, there were specified theatres sessions with sufficient medical and theatre staff with the appropriate knowledge and skills to carry out the role.

Termination of pregnancy

Are termination of pregnancy services effective?

(for example, treatment is effective)

Good

National guidelines for termination of pregnancy were used to treat patients, access to information was good and the multidisciplinary team of competent staff worked well together. Patients had access to pain relief when required and they were asked to give consent to procedures appropriately and correctly.

Evidence-based care and treatment

- Staff used a combination of guidelines from the National Institute for Health and Care Excellence (NICE) and Royal Colleges' as a basis to determine the treatment they provided. Local policies were written in line with these and had been updated periodically, as required.
- Policies and guidelines were available to all staff and printed copies were stored in the staff room. Staff could also access this information via the trust's intranet or a shared drive on the trust's IT network. Any changes to a policy or national guideline were discussed at weekly staff meetings.
- There were specific care pathways for termination of pregnancy using various methods and at various stages of the pregnancy, in order to standardise and improve the care for patients.
- Chlamydia screening was offered to women under 25 years old. It was necessary to signpost women over 25 years to the local genito-urinary medicine (GUM) service. This was because contact tracing for the younger women was provided as part of a local initiative for the under 25s only. The management team told us they recognised the provision of GUM services in general as a gap in the service provided to patients who present for a termination of pregnancy. They were keen to explore the development of a GUM service to women attending the Bedford Centre in the future.
- Most forms of contraception were available to women following a termination of pregnancy. If their preferred method (such as contraceptive implants) could not be provided, they were referred to the local family planning service. Staff usually made appointments on the patient's behalf to increase the likelihood of attendance.
- Women who requested access to a counsellor were given a choice of two local organisations providing counselling services.

Pain relief

- Pain relief was prescribed and obtained in advance of procedures taking place, and it was always available for patients if needed.
- Appropriate advice on the use of 'over-the-counter' medicines was given before discharge.

Nutrition and hydration

- People were given a choice of suitable and nutritious food and drink that was appropriate for their religious, cultural and dietary needs.
- We observed that hot and cold drinks were available to patients throughout the day.

Patient outcomes

- Audits of the service given to women attending the Bedford Centre were undertaken locally and informed services development; however, it was not possible to reliably compare data with other NHS organisations that provided a similar service. The Bedford Centre treated women from throughout the UK, Republic of Ireland (ROI) and abroad. Women from ROI and abroad generally returned home soon after the procedure; therefore, any resulting complications or outcomes would not always be made known to the Bedford Centre from which to draw conclusions.
- Patients were occasionally transferred to the hospital from another provider for further treatment following complications, usually after a late surgical termination of pregnancy. There were four women transferred to Liverpool Women's Hospital in 2014. Medical staff had initiated an annual meeting with the provider concerned to discuss these cases and any actions necessary to prevent avoidable harm to women in the future.

Competent staff

Termination of pregnancy

- There was a system in place throughout the trust to ensure that staff were registered with the appropriate professional body (GMC, NMC, HPC etc.) and that they maintained active registration entitling them to practice.
- All nursing staff working within the Bedford Centre had received an appraisal, which included a training needs analysis, during the past year. The NHS Staff Survey 2013 showed that the trust as a whole was comparable to the England average for staff reporting that their appraisal was well structured.
- Nursing staff had been offered extra training opportunities, such as mentorship courses, to develop within their roles. Such opportunities were also displayed on a noticeboard in the staff rest room.

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions, it was clear that staff across all disciplines genuinely respected and valued the work of other members of their team.
- The nursing team at the Bedford Centre worked very closely with the safeguarding team to provide a safe service for women and young people.

Seven-day services

- The Bedford Centre was open 6 days each week, and occasionally on a Sunday in response to peaks in demand.
- All services necessary to provide a safe and effective termination of pregnancy service were available during the hours that the Bedford Centre was open.
- Women could access telephone advice from the Bedford Centre during opening hours, and out of hours via the hospital's emergency room helpline.

Access to information

- Staff had access to appropriate national and local guidance for patients attending for terminations.
- Protocols and procedures were available on the trust's intranet site.
- Scans were carried out in advance of terminations and the results were available to ensure effective treatment.
- GP letters were optional, but encouraged by staff and usually sent within 24 hours of the procedure, with the patient's consent.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Patients were asked for their consent to procedures appropriately and correctly.
- Staff could explain how the Gillick competencies and Fraser guidelines were used when consent was gained from young people.
- Consent documentation had been audited throughout the trust and the Bedford Centre had scored 100% in all areas except for the documentation of the top copy being given to patients, which only scored 20%.

Are termination of pregnancy services caring?

Good

The termination of pregnancy services was delivered by caring and compassionate staff who treated patients with dignity and respect. Care and treatment were planned and delivered in a way that took into account the wishes of the patients.

Patients told us they had felt well supported to make the right decision for themselves and their families, and had been given sufficient time to consider all the options available to them.

Compassionate care

- Care and treatment throughout the Bedford Centre was delivered by caring and compassionate staff.
- We observed that staff were skilled in establishing rapport with patients in a short time frame. We spoke with four patients and two relatives who all spoke positively about the care and treatment that they, or their family member, had received.
- The NHS Friends and Family Test for the Bedford Centre showed a 100% satisfaction rate with the service over the previous 3 months, which was very positive; however the response rates were low.
- We were also informed that a poster requesting egg donors had been removed by staff from the corridor near the Bedford Centre because it was considered insensitive to the women attending for termination of pregnancy.

Termination of pregnancy

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with said they had felt involved in their care. They understood the treatment options available to them and had made an informed decision after discussions with staff and family, when appropriate.
- Patients told us they had felt supported to make the right decision for themselves and had been given sufficient time to consider all the options.

Emotional support

- Staff showed considerable skill in providing emotional support for both women and their families in a way that was not seen to be judgemental. This was confirmed by patients and relatives whom we spoke with.
- Patients could be accompanied for termination of pregnancy by a partner, friend or family member to support them throughout the procedure. Staff welcomed them and also provided them with emotional support as required.

Are termination of pregnancy services responsive to people's needs?
(for example, to feedback?)

Good

Access to treatment, advice and information was good, both during procedures and after discharge. Complaints were well managed within the Bedford Centre and we saw evidence that the service had learned from complaints.

Service planning and delivery to meet the needs of local people

- We were told how local people had previously been required to provide a referral letter from their GP to access termination of pregnancy services, whereas people who did not live locally were able to refer themselves. After discussions with the local clinical commissioning group (CCG), a contract variation was agreed so that all women were able to refer themselves for this service.

Meeting people's individual needs

- An interpreter could be provided for patients whose first language was not English. The same interpreters were used on a regular basis and were familiar with the procedures undertaken at the Bedford Centre. Female interpreters were usually provided and patients were consulted in advance if only a male interpreter was available.
- Women were always seen alone for part of their initial assessment. This was to give them an opportunity to disclose abuse or coercion to staff.
- We saw a series of comprehensive information leaflets given to patients, depending on the procedure they had undergone. All leaflets we saw were in English.
- Interpreters were available to anyone whose first language was not English.
- Discharge information was given to patients in advance of the procedure so that they had time to read it thoroughly and ask any questions when they attended.

Access and flow

- Accessing the service was done via self-referral but all calls to arrange them were handled by a third party provider who managed the access and also provided terminations of pregnancy locally.
- Timescales for access to assessment and treatment were closely monitored and in line with those recommended by the Royal College of Obstetricians and Gynaecologists. Extra capacity was introduced by opening the Bedford Centre on a Sunday, when necessary, so that women always received timely assessment and treatment.
- Staff had identified a lack of privacy for women while at the reception desk due to the layout of the Bedford Centre. Adjustments had been made to the patient flow through this area in order to protect women's privacy until planned re-modelling of the area could take place.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff signposted patients to the Patient Advice and Liaison Service (PALS) team if they were unable to deal with concerns directly. Patients were advised to make a formal complaint if their concerns remained unresolved.
- There was information displayed throughout the Bedford Centre about how to complain. We spoke with patients and relatives who knew how to raise concerns, make complaints and provide comments, should they wish to do so.

Termination of pregnancy

- Staff explained how the complaints leaflet had been re-designed with a more sensitive logo than the standard one used throughout the hospital, which showed a family with a baby.
- Although the Bedford Centre received very few complaints, we saw strong evidence of learning from comments and complaints through discussion at staff 'huddles' and the weekly team meetings. There was evidence that complaints were regarded as a positive learning opportunity in order to improve the patient experience.

Are termination of pregnancy services well-led?

Good

The trust had a vision and values for the organisation that had been well communicated to staff in the Bedford Centre.

There was a 'no blame' culture within the centre that gave staff the confidence to report incidents and 'near misses'. We saw individual members of medical and nursing staff throughout the Bedford Centre who displayed good leadership skills and were positive role models for staff generally.

Vision and strategy for this service

- The trust had a vision and values for the organisation that had been well communicated to staff in the Bedford Centre. We saw examples of staff activity and initiatives that had been linked to the trust's values but remained relevant to the work undertaken by the centre's front-line staff.
- A strategy had been developed to take the termination of pregnancy service forward, and this included re-modelling the Bedford Centre. A decision on this strategy had not been made by the trust at the time of the inspection.

Governance, risk management and quality measurement

- Risks within the Bedford Centre were discussed regularly at both local and managerial level, and escalated appropriately as required.
- The trust maintained a detailed quality dashboard for each service and clinical area, including the Bedford Centre. This showed performance against quality and performance targets and the results were presented monthly at clinical risk meetings.
- There was a robust system in place to communicate risks and changes in practice to nursing staff. In addition to the morning 'huddles', risks, incidents and complaints were discussed weekly at team meetings.
- All areas of the trust, including the Bedford Centre, were participating in the NHS-wide 'Sign up to Safety' campaign, which had a 3-year objective to reduce avoidable harm by 50%.

Leadership of service

We saw individual members of medical and nursing staff throughout the Bedford Centre who displayed good leadership skills and were positive role models for staff. Staff were well managed and well led by knowledgeable and supportive managers.

- Staff recognised and appreciated the strong and effective leadership and told us that their immediate line managers were accessible and approachable. They also said they had previously felt disconnected from the executive team, but that within the past year members of that team had become much more visible, particularly the director of nursing who often visited the Bedford Centre.

Culture within the service

- Several staff members talked of an open, 'no blame' culture within the Bedford Centre, which gave them the confidence to report incidents and 'near misses'.
- All staff spoke enthusiastically about their work. They described how they enjoyed their individual roles within the team and how proud they were to work at the trust but, in particular, within the Bedford Centre.

Public and staff engagement

- Staff felt that, historically, the termination of pregnancy service had had a low profile within the organisation and the staff had felt isolated. The management team addressed this in a number of ways that included rebranding and the development of a dedicated website, in addition to the information about the Bedford Centre available on the Liverpool Women's

Hospital's website. The service also now had a full page within the hospital's directory of services. These actions had been successful in raising the profile of the Bedford Centre within the trust.

- There were no non-executive directors with specific responsibility for the Bedford Centre.
- Staff meetings were held weekly and each year the unit was closed for a day for team-building and education. Staff at all levels told us they felt "listened to" and empowered to effect changes.

Innovation, improvement and sustainability

- Manual vacuum aspiration, a method of pregnancy termination normally performed under anaesthetic, was due to be introduced as an ambulatory procedure.

Neonatal services

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

Information about the service

The neonatal unit has three intensive care rooms with capacity for five babies in each of the rooms. There are three high dependency rooms, each with space for six babies. There is also a low dependency room that can accommodate 15 babies. Neonatal surgery is not undertaken at this site. Babies who require surgery are transferred to a nearby specialist children's hospital.

The trust hosts the neonatal transport service for Cheshire and Merseyside and provider staff to support babies during transfer to other providers.

We visited all areas of the neonatal unit as part of our inspection. We observed patient care, looked at patient records, both paper records and those on the Badger system. This system is a live patient data management system that operates as a hosted managed service throughout the UK. Patient records are held centrally within secure hosted data centres, and each distinct record can be accessed on a controlled basis by all healthcare professionals.

We spoke with 12 sets of parents in the unit and several members of staff including nurses, doctors, consultant obstetricians, domestic personnel, administrative staff, and members of the management team.

Summary of findings

We found that, overall; the neonatal services provided were of a very high standard. There was a palpable sense of pride in the service and staff were very committed to providing high-quality services. Neonatal nurses and doctors worked well together to achieve the best outcomes for the babies in their care. Babies received outstanding care from dedicated and caring staff who were highly skilled in working with newborn babies and their families.

There was a robust system in place for reporting and learning from incidents. The unit was visibly clean with a well-managed, clearly understood approach for maintaining a suitable environment.

The standard of record keeping was good, and both the nursing and medical staffing levels were appropriate to meet the needs of the babies in the unit.

The multidisciplinary team worked very well together. There were clear evidence-based guidelines to support practice.

The service had achieved level 3 baby friendly status from UNICEF and there was focused work by staff to improve breastfeeding rates. Parents were active partners in the care of their babies and communication with parents and families was good.

Neonatal services

Services were delivered by staff who were caring and considerate. Parents were universally positive about the care their babies had received and provided us with examples of when staff had 'gone the extra mile' to care for their babies and support them at the same time.

Staff were very proud to work in the unit and passionate about the service they provided. They were keen to receive feedback from families and the results were clearly displayed on a noticeboard. Feedback was used to support service developments.

The service received very few complaints but had dealt with the ones they had received in an appropriate manner.

There was access to a translation service for parents and families, and information available in different languages. There was a transitional team and an outreach team that helped babies to be discharged home at the earliest opportunity.

The services provided by the unit were well-led. There was strong medical and nurse leadership. Senior staff were positive role models for staff, and were visible, knowledgeable and accessible. Staff were supported and encouraged to be innovative in their practice. There were robust governance systems in place. We saw good examples of a positive 'no-blame' culture and a well-developed approach to learning.

Are neonatal services safe?

Good

There were good systems and processes in place to prevent avoidable patient harm. There was a robust system for reporting and learning from incidents. The unit was visibly clean with a well-managed, clearly understood approach for maintaining a suitable environment.

There was a good system in place for monitoring and assessing patient's risks. The Neonatal Early Warning Score (NEWS) was used in the unit to alert clinicians to infants whose condition was deteriorating.

Medication 'data sheets' which are used to calculate the correct dosage of medication had not been checked for several years. They are currently only updated when the lead consultant identifies a change in the administration of a particular medicine but it would be best practice to review them on a regular basis, to confirm if there has been a change or not.

The standard of record keeping was good.

Both the nursing and medical staffing levels were appropriate to meet the needs of the babies in the unit.

Incidents

- There was a robust incident reporting system in place, and staff were competent and confident in recording and reporting incidents. They were well supported when raising concerns.
- Staff were involved with investigating incidents that were relevant to them. Feedback was emailed to staff that identified areas for improvement. The application of learning from incidents was monitored.
- Lessons learned were shared with all members of the team. They were also shared widely within the organisation to support improvement in other areas. This was considered good practice.

Safety thermometer

- There was no national safety thermometer for neonatal services.
- The neonatal unit used its own assessment tool, which included relevant risk elements (such as tissue viability and catheters) for avoiding patient harm.

- Staff were positive about the tool in supporting harm-free care.

Cleanliness, infection control and hygiene

- There was a high standard of cleanliness throughout the unit.
- The neonatal room was cleaned twice daily and domestic staff followed the appropriate guidance. Each cot area and associated equipment were cleaned by the nurse in charge twice daily.
- Cleaning activity was recorded and audited.
- Incubators were regularly cleaned and deep-cleaned fortnightly (or when the cot was no longer in use).
- Hand hygiene was exemplary and staff were active in ensuring that all visitors adhered to the hand-washing policy.
- Hand-washing audits were completed for the unit with high levels of compliance reported.
- Hand-sanitising gel was available at every incubator. Each room had a sufficient number of sinks and hand towels/soap dispensers were adequately stocked.
- Performance monitoring led to changes in practice to improve infection rates. Examples included the appointment of an infection control nurse and practice changes for cannula insertion.

Environment and equipment

- Resuscitation equipment was checked and found to be fully stocked and ready for use.
- Equipment had been tested for electrical safety (portable appliance testing [PAT]).
- Medical equipment was serviced on site and there was a database of all equipment.
- Space was limited on the unit considering the complexity of the care provided and the equipment needed at each bed space. There was a lot of large equipment left in corridors due to limited storage facilities.
- Staff did not always having more basic equipment however, such as cotton wool. This was due to a change in ordering processes and the issue had since been resolved.

Medicines

- A sample of prescription charts was checked and all were fully completed, signed and countersigned in accordance with good practice.
- There was a good system in place for labelling intravenous medication. All medications that were checked were found to be labelled correctly.
- New doctors on the unit had to be signed as competent before prescribing medicines.
- There was good support from the pharmacist who visited the unit daily and reviewed all prescriptions.
- In each neonatal room, a folder was kept that contained medication 'data sheets' which were used to calculate the correct dosages of medication that they administer. Many of these data sheets had not been checked for several years. They are currently only updated when the lead consultant identifies a change in the administration of a particular medicine.
- Staff identified that they were only updated when there was a change in the administration of the medicine. This was confirmed by the lead consultant and the head pharmacist for the service.

Records

- The unit used the nationally recognised Badger system for medical records. The records on the system were well written and accurately reflected care and treatment. They were full contemporaneous records that were well structured and included specialist advice.
- Each baby also had paper medical records, some of which were not dated or timed.
- Staff informed us that it was rare for the Badger system to fail, but confirmed that a contingency plan was in place if there was any disruption to the electronic system.

Safeguarding

- There was a robust system in place for safeguarding. Staff were familiar with the safeguarding policy and procedures.
- Safeguarding practice was supported by staff training and the trust had close links with the local authority and police.
- All relevant staff had completed level 3 safeguarding training.
- Two sets of case notes were reviewed in relation to safeguarding and found to be thorough. There was also good multidisciplinary working in relation to safeguarding issues that was clearly documented.

Mandatory training

Neonatal services

- All staff had received mandatory training and yearly updates. All staff were informed about their mandatory training compliance and allowed adequate time to complete their mandatory training when required.
- All new neonatal nurses had completed a 6-month role-specific induction training. Approximately 18 months after the induction, staff were supported to complete Qualification in Speciality (QIS). Within the induction period, newly appointed nurses were given supernumerary status.

Assessing and responding to patient risk

- There was a good system in place for monitoring and assessing patient's risks. The Neonatal Early Warning Score (NEWS) was used in the unit to alert clinicians to infants whose condition was deteriorating.
- The service was the first in the country to implement the HeRo system. The system originates from the USA and was designed to monitor the heart's beat-to-beat variability and the information was used to detect early signs of infection and other problems. This allowed staff to respond to babies' needs and start treatment much earlier (sometimes up to 24 hours) than previous. It was estimated that it would save between five and seven lives a year. The HeRo system was evident on all monitors and all staff had received satisfactory training in its use.
- The trust host the neonatal transport network for Cheshire and Merseyside which is used to transport babies that may require surgery or transfer to another specialist provider.
- There was a policy and standard operating procedures for babies who were unwell. This was comprehensive and had been recently updated.

Nursing staffing

- Staff in the unit raised concerns around staffing levels, which they felt were not at the recommended levels. The unit was not yet up to the British Association of Perinatal Medicine (BAPM) standards, but it was in the process of recruiting 10 additional qualified nurses. At the time of the inspection, the staffing shortages were covered by current neonatal staff working extra hours.
- There was a good skill mix evident in the unit where new staff worked with more experienced colleagues. Staff also rotated around the unit to ensure that they maintained their skills within each of the clinical areas.
- The advanced neonatal nurse practitioners (ANNPs) on the unit reported that they did not feel part of either the medical or the nursing team. They were often not consulted about policy changes or asked to use their expertise in terms of training.
- The senior management team on the unit was aware of this matter and acknowledged that further work was needed to integrate the ANNPs more effectively. Plans were being developed to take this forward.

Medical staffing

- There was sufficient number of medical staff to provide appropriate care and treatment.
- Consultant ward rounds took place twice a day, 7 days a week and they were on call out of hours.
- A consultant or a registrar was available on the unit at all times.
- Medical staff reported feeling well supported by the consultants on the unit.
- The tier 1/middle-grade staffing levels were acceptable in terms of establishment but frequently the unit operated with fewer than the establishment. However, the development of the ANNP role would help support junior doctors and practice in the unit.

Major incident awareness and training

- There was a business continuity plan in place.
- There was a continuity plan for the Badger system if the system should fail. There were assessment tools and paper notes available for each of the babies on the unit to support their continuing care and treatment.

Are neonatal services effective?

Good 

The service used a combination of guidelines from National Institute for Health and Care Excellence (NICE), British Association of Perinatal Medicine (BAPM) and Royal Colleges' to determine the care and treatment provided.

The service benchmarked patient outcomes against similar units in the UK and the USA. Outcomes compared well with other neonatal services. There was also benchmarking against similar units for mortality and morbidity rates.

Neonatal services

There was evidence that mortality rates were within acceptable ranges and were continuing to decline. Infection rates had also declined and compared well to similar units.

There was effective working within the multi-disciplinary teams and with medical specialties.

Evidence-based care and treatment

- The service used a combination of National Institute for Health and Care Excellence (NICE), British Association of Perinatal Medicine (BAPM) and Royal Colleges' guidelines to determine the care and treatment provided.
- There was evidence that all guidelines relating to use of the Badger system were available to staff. All guidelines were signed and dated, and had a review date. All but one were in date for review.
- There was a medical teaching session 4 days a week. We observed one of these sessions in addition we reviewed reports relating to the neonatal unit's benchmarking of its practice and outcomes against other units in the UK and the USA.
- There was clear evidence of communication with staff to inform them of updated NICE guidance and changes to the previous guidance.
- There was also evidence of benchmarking for morbidity outcomes.

Pain relief

- The assessment and management of pain was undertaken using the Echelle Douleur Inconfort Nouveau-Né (EDIN) assessment tool. This was completed at the beginning of every shift. If the score changed, staff repeated the process an hour later to monitor changes.

Nutrition and hydration

- The unit had achieved level 3 baby friendly status. There was a clear understanding among the staff of the importance of the neonates receiving breast milk.
- Parents could borrow breast pumps from the unit. However, there had been some difficulties in the unit about ensuring these were returned when they were no longer needed. The unit had recognised this and were looking at plans to address it. However, it always had enough pumps to fulfil demand.
- There was a breastfeeding advisor on the unit and who worked closely with the infant feeding team.
- Staff on the unit received regular training in infant feeding.
- Information on a baby's feeding and the frequency of feeds was handed over well at staff change overs and to parents.

Patient outcomes

- The Vermont Oxford Network (VON) was the main benchmarking process that the Neonatal Unit used to compare outcomes for babies. The VON is a database that contains data relating to preterm babies (< 30w, < 1500g). Data from the trust was benchmarked against the rest of the VON collaboration network, and against the other 29 VON UK centres. The network contains data from approximately 55000 preterm babies admitted to 850 centres across the world (predominantly from North American units).
- Mortality rates for the unit were well within the Inter Quartile Range (IQR) and declining.
- Neonatal necrotizing enterocolitis mortality rates were within an acceptable range. (NEC) (is now the most common gastrointestinal emergency occurring in neonates. [It mainly affects premature infants who, having survived a difficult neonatal period, then confront a disease with high morbidity and mortality).
- The clinical area that the VON benchmarking process had the greatest impact on was infection rates; Following the Infection results from VON in 2007 the service instigated the Neonatal Infection Project. At the start of this project 50% of preterm babies admitted below 30 weeks' gestation developed a late-onset, hospital-acquired bloodstream infection. Over the last 4 years (2009-2012), as a result of the measures put in place had resulted in a fall in infection rates. In 2011, only 19% developed a nosocomial infection. This reduction meant that, for every 100 preterm babies admitted to the unit there are approximately 31 fewer babies acquiring an infection now compared with 2007.
- Neonatal mortality was also benchmarked against England and Wales as a whole using the Office for National Statistics (ONS) data. The service used this information to underpin actions to improve mortality rates. In response the service had increased the number of hours per week with a neonatal consultant on site and carried out a prospective review of all deaths and prioritised a reduction in nosocomial infection.

Neonatal services

- The service also participated in the National Neonatal Audit Programme (NNAP)
- However, national audit data is collected using the National Badger system and the service did not enter data directly into the National Badger System. It had a stand-alone Badger 3 system. This system is not fully compatible with the national system. Attempts to match data items captured by the two systems had been made but were unsuccessful. As a result senior clinicians reported that the national audit outcome data was inaccurate for some key national indicators. The service provided locally held data showed the performance of the unit was within or above acceptable ranges against most of the 10 standards. The only area of concern identified in the local data was the rate of preterm babies who were receiving breast milk at discharge. This is considerably lower than the national average. This had already been recognised by the unit and work is in progress to improve performance in this area. The breast feeding rate was improving as a result.
- The unit was in the process of migrating from the "Badger 3 and would be fully compliant with the National Badger system
- The service also submitted data to the NHS England Quality Dashboards. The results for the first three quarters of 2014/15 showed that Retinopathy of Prematurity (ROP) screening the Trust is better than the national picture; blood stream infection rates and admission temperatures are within the expected range based on the national picture.
- Internal benchmarking is carried out against previous trust performance using a neonatal databook. Benchmarking in this way allowed the trust to review practice and make improvements to term admissions and the proportion of preterm babies receiving breast milk at discharge.

Competent staff

- All medical and nursing staff had received an annual appraisal.
- There were role-specific training programmes for all newly qualified staff, including a thorough induction programme.
- Staff were given time to complete any training required.
- The medical team was committed to teaching, and provided a formal teaching session every week.
- Feedback from the doctors was that the teaching sessions were very valuable.
- The ANNPs were not represented by the education team in line with other professionals, and had no protected time to allow them to contribute to the training programme.
- Plans to fully support the ANNPs were being discussed and developed at the time of our inspection.

Multidisciplinary working

- There was excellent multidisciplinary working and a genuine respect for each discipline's role in providing individualised care for patients.
- Multidisciplinary team meetings were held weekly for treatment and discharge planning.
- Good team working and positive working relationships were evident throughout the service.
- Transfers between sites (from or to other hospitals) followed perinatal network guidelines (Cheshire and Merseyside neonatal network) and care pathways.

Seven-day services

- Consultants are on site 7 days a week and carry out two ward rounds a day.
- Out-of-hours cover was provided by a specialist registrar and junior doctor with consultants available on call.
- Out of hours there was an on-call pharmacist available. The pharmacy hours at the weekend were 9.30am to 4pm.

Access to information

- Around 50 parent information leaflets were viewed on the Badger system. This showed that information leaflets were readily available for parents when required.
- Parents were invited to ward rounds and involved in their baby's care.
- Information boards around the unit provided useful information for parents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Parents were very involved in the care of their babies and the decisions that were being made about them. Consent was sought appropriately.

Neonatal services

Are neonatal services caring?

Good

There was a strong, visible, family-centred culture in the service. Staff were highly motivated and offered care that was kind, sensitive and supportive. We observed many interactions throughout our inspection that showed how dedicated the staff were.

Staff recognised and respected the babies' and their family's needs. We found that parents' personal, cultural and religious needs were always taken into account when discussing the care and treatment of their baby.

Staff offered parents emotional support and recognised that having a baby cared for in the unit was a worrying and anxious time for them. There was a range of options for people to talk about their anxieties, including access to chaplains and a counselling service. The counselling service was readily available and well publicised. It was also available to staff members.

Senior staff were aware that at times they had to deliver difficult messages to parents about their baby's condition and prognosis, and they took pride in making sure that this was done in a sensitive and compassionate way.

Compassionate care

- There was a strong, visible, family-centred culture in the service. Staff were highly motivated and offered care that was kind, sensitive and supportive. We observed many interactions throughout our inspection that showed how dedicated the staff were.
- The trust participated in the 2014 Neonatal Picker survey, the results of which were comparable with other similar organisations.
- We spoke with 12 parents and all but one were overwhelming in their praise of the care and devotion shown to the babies being looked after on the unit. They felt that staff always 'went the extra mile' for them and their babies.
- Parents comments included, "You would think they were looking after their own babies", and "the care is fantastic".

Understanding and involvement of patients and those close to them

- Each of the parents we spoke to felt that they had been involved in the care of their baby.
- There was evidence in the clinical notes that parents were involved in making decisions about care and treatment.
- All the families felt that they were truly respected and valued as individuals. All but one felt empowered and engaged in the care of their babies.

Emotional support

- Staff offered parents emotional support and recognised that having a baby cared for in the unit was a worrying and anxious time for them.
- There was a range of options for people to talk about their anxieties, including access to chaplains and a counselling service. The counselling service was readily available and well publicised. It was also available to staff members.

Are neonatal services responsive?

Good

Services provided were planned to meet local need. The service was active in considering future requirements and the staff were working with managers regarding service development.

There were discussions and plans underway to improve the physical environment and secure more space on the unit. In addition, the service was working with its partners regarding transfer arrangements for babies who required admission or transfer to another local trust for surgery.

There was a parent survey in use on the unit and the results were displayed on a noticeboard. The feedback from the surveys was very positive and used to secure service improvement.

Staff were able to provide an interpreting service for parents whose first language was not English.

The service had access to three flats close to the hospital for parents and families to stay in. However, it was acknowledged that, given the size of the unit and the large geographical area covered, there was a need for more parent accommodation. The hospital had recognised this as a need and developed a plan to address it in the near future.

Neonatal services

Parents we spoke with told us that discharge planning was discussed with them and that discussions included follow up care arrangements. There was a transitional team and an outreach team that facilitated babies being discharged home safely at the earliest opportunity.

There were few complaints received about the unit, but parents had an understanding of the complaints process. Information about the procedure was displayed for parents to see.

Service planning and delivery to meet the needs of local people

- Services provided were planned to meet local need. The service was active in considering future requirements and the staff were working with managers regarding service development.
- There were discussions and plans underway to improve the physical environment and secure more space on the unit. In addition, the service was working with its partners regarding transfer arrangements for babies who required admission or transfer to another local trust for surgery.
- There was a parent survey in use on the unit and the results were displayed on a noticeboard. The feedback from the surveys was very positive and used to support service development and improvement.
- It was evident that that staff considered the needs of families and were flexible and adaptable in meeting those needs. Examples included amending the visiting policy for specific groups of families, including teenage parents, single parents or parents who had a learning difficulty. The unit allowed these parents to nominate a named person to visit with them for support, or instead of them if the parent was not able to visit themselves.
- There was a translation service if required. However, there was a family on the unit during the inspection who did not speak English as their first language and they were not offered the translation facility. The father did not speak any English and the mother had only limited use. The family had used the translation facility during the pregnancy. They were also not offered any literature in their first language.

Access and flow

- The neonatal unit rarely had to send babies outside the hospital as a result of demand pressures. Staff reported that they could always accept babies onto the ITU.
- There were good multidisciplinary discharge planning arrangements
- There were clear discharge criteria for babies that were well understood and rigorously applied by staff.
- The service had a transitional team that provided intensive medical cover for babies discharged home. The team was unable to provide the administration of intravenous antibiotics at home; however we were told that this was being considered as part the trust's planned expansion of community services.
- The service also had an outreach team for babies that were discharged but required support at home and this service was available 4 days a week. It was identified that this could delay the discharge home of some babies because of the limited working hours of the team.

Meeting people's individual needs

- Parents were invited to ward rounds and meetings in which their baby's care and treatment were being discussed.
- Skin-to-skin contact was offered to all parents on the unit, as the baby's condition allowed. Parents valued the arrangements for physical contact with their babies.
- Breastfeeding support was offered to all parents as required.

Learning from complaints and concerns

- There were few complaints about the service. Only 3 were received within a 12-month period. These were all handled in an appropriate and timely manner.
- Posters were displayed on the unit about how parents could raise any concerns or complaints. These posters were also displayed around the hospital, including in the lifts.

Are neonatal services well-led?

Good

There was a strong leadership team in place, led by the clinical director and matron. The neonatal team were passionate about the service they provided and staff were clear about the opportunities and challenges in relation to the service. Leaders were visible, accessible and very knowledgeable about their field of practice. The service was dynamic and leaders were constantly looking at ways

to improve the service provided to babies and those close to them. The leadership style of the senior team fostered close working relationships between doctors and nurses for the benefit of patients.

There were good examples on innovation including the implementation of the HeRo System and ongoing engagement with wider networks to support service design and delivery.

All staff were able to clearly articulate the trust's vision and strategic direction. They were engaged and informed regarding the future of the service and the hospital.

Governance systems were well understood and used to manage and monitor performance.

The risk register for the service was up to date, well managed and regularly reviewed.

Staff were enthusiastic and passionate about the work they did. There was a sense of pride in the service and in the hospital.

The service had featured on several television documentaries, including One Born Every Minute and Miracle Babies. Staff were extremely proud of this; they felt that the programmes had showcased their work and increased public confidence.

Vision and strategy for this service

- The trust had a clear vision and set of values that had been well communicated to staff in the service.
- The service had developed plans for further development of neonatal services which were under consideration by the board.
- All staff were able to articulate the trust's vision and strategic direction.
- Staff were engaged and informed regarding the future of the service and the hospital.

Governance, risk management and quality measurement

- All staff were clear about their own role and responsibilities within the unit.
- Governance systems were robust and well understood. They were used to manage and monitor quality and performance with the ultimate aim of improving outcomes for babies in their care.
- The risk register for the service was up to date, well managed and regularly reviewed with risk assessments and action plans in place where appropriate.
- There were regular risk management meetings on the unit in addition to those at directorate and trust levels.

Leadership of service

- There was strong and visible medical and nursing leadership within the service that strived for continuous improvement.
- The leadership style of the senior management team fostered close working relationships between doctors and nurses for the benefit of their patients.
- Doctors were well-led and supported by the clinical lead.
- The nursing team was cohesive and members were supportive of each other; staff had worked together for a long time and had built up strong working relationships that helped the unit to function well.

Culture within the service

- Several staff confirmed the service was extremely positive and open with a 'no-blame' culture within the unit.
- Staff were overwhelmingly enthusiastic and passionate about the work they did.
- There was a palpable sense of pride from staff in the service they provided and in the hospital.

Public and staff engagement

- The service had featured on several television documentaries, including One Born Every Minute and Miracle Babies. Staff were extremely proud of this; they felt that the programmes had showcased their work and increased public confidence
- The unit had a parent questionnaire in use that every parent was asked to complete when their baby was discharged home. The results of this were clearly displayed on the noticeboard at the entrance to the unit.
- Staff felt listened to and involved in activities on the unit.

Innovation, improvement and sustainability

Neonatal services

- The service was forward thinking and innovative in its approach to the care and treatment provided. Examples included the implementation of the HeRo system, with the service being the first in the country to introduce this.
- Staff were keen to continually improve the quality of care that was provided, and they became involved nationally and internationally to benchmark outcomes and support this ambition.
- The work that has been undertaken by the neonatal project team has been presented locally, regionally and nationally to support wider learning and service improvement.

End of life care

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

Information about the service

The trust is a tertiary referral centre for women presenting with gynaecological malignancy. End of life services are provided on site at Liverpool Women's Hospital and the trust has local network links with other hospitals and hospices. The trust participates in the local clinical strategic network, and palliative and end of life meetings for the region. It also provides bereavement services for relatives and parents who have lost their babies.

Patients who are considered to be in the last year of life are identified and cared for in one of two specialist end of life suites on ward areas within the hospital (whenever possible). The Mulberry and Orchid suites are part of gynaecology ward 1. Ward staff are responsible for the care of patients in the end of life suites with input from specialist palliative care team (SPCT). The SPCT in operation at the trust consists of a palliative care consultant who is employed for 1 day a week (0.2 whole-time equivalent [WTE]) and 2.4 WTE specialist nurses who are gynaecology oncology and palliative care specialists. In 2013/14, there were 43 people who had died at Liverpool Women's Hospital, 29 of which were neonatal, 8 for gynaecology and 6 for gynaecological malignancies. From April 2014 until October 2014, there had been 36 deaths at Liverpool Women's Hospital, 26 of which were neonatal, 4 gynaecology and 6 gynaecological malignancies.

All patients who require end of life care have access to the SPCT. During this inspection, we visited two gynaecology wards where end of life services were being provided, the emergency department, the Honeysuckle midwifery bereavement suite and the outpatient clinic, and we observed a multidisciplinary team meeting. We spoke with two patients and one relative, and a range of staff including members of the SPCT, chaplaincy staff, junior doctors, ward managers, nursing staff and members of the midwifery bereavement team. In total we spoke with 14 staff. We observed care and looked at care records. We looked at appropriate policies and procedures. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

End of life care

Summary of findings

Patients who were considered to be in the last year of life were cared for in one of two specialist end of life suites on ward areas within the hospital (whenever possible). The Mulberry and Orchid suites were part of gynaecology ward 1 and provided patients with a private and calm environment where they could be cared for in an appropriate and tranquil setting. Patients and those close to them valued the environment and some patients had chosen the suites as their preferred place to die.

The specialist palliative care team (SPCT) responded to the needs of patients in a timely way and were accessible to ward staff for support, advice and mentoring. There was good multidisciplinary working for the benefit of patients. Staff participated in regional and national networks to support service development and improvement.

They were caring and compassionate and there was evidence of individualised, person-centred care. Processes for rapid discharge were in place to allow patients to return quickly to their preferred place of care.

However, we did not see robust evidence of advanced care planning and 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions were not always made in a timely way so that patients could be involved in the decision making.

Are end of life care services safe?

Good

End of life care was provided to meet the individualised needs of patients and those close to them. Patients at the end of life were cared for in the gynaecological wards and whenever possible in the Mulberry and Orchid suites. The suites provided patients with a calm, dignified and tranquil environment where they could spend time with those close to them in private.

Patients and those close to them valued the Mulberry and Orchid areas and some patients had chosen the suites as their preferred place to die.

There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for.

There were adult safeguarding procedures in place, supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect or abuse.

There were systems for reporting actual and 'near miss' incidents across the hospital.

There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.

'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were appropriately completed. However, there were examples of when DNACPR decisions were not made in a timely way so that patients could be involved in the decision making.

Incidents

- There were robust systems in place for reporting incidents and 'near misses'. Staff had received training and were confident in the use of the incident reporting system.
- Medication errors were reported and investigated in line with trust policy. We saw that an error relating to end of life care medicines had been analysed and the root cause identified. There had been an emphasis on learning for staff involved, including the need to minimise distractions when administering medicines.

End of life care

- Ward managers told us they could add risks to the risk register, although we saw an incident relating to the shared clinical room between ward 1 and ward 2 had not been added.
- Nurses met at the beginning of the shift for a 'safety huddle'. This included dissemination of safety alerts, feedback from mortality and morbidity meetings, and actions from complaints and incidents. These 'huddles' were not specific to end of life care but this could be discussed if appropriate.
- Members of the specialist palliative care team (SPCT) held meetings at ward level to discuss end of life care incidents to share learning and support service improvements.

Medicines

- The trust used the Cheshire and Merseyside palliative care network audit group standards and guidelines for prescribing medicines at the end of life. Copies of the guidelines were available to staff on the wards and in the clinical areas.
- We observed SPCT nurses working closely with medical staff to support the prescription of medicines to manage symptoms and promote comfort at the end of life.
- There was guidance for the use of anticipatory medicines for the five key end of life symptoms to ensure that there was no delay in medication for patients who developed end of life symptoms quickly. However, medical staff told us they were not routinely asked to prescribe anticipatory medicines; rather, they would be asked by the specialist nurses to prescribe medicines at the time when the patients showed relevant symptoms. At the time of our inspection, we did not see any evidence that this was having an impact on patients approaching the end of life, but there was no consensus among staff as to the use of anticipatory medicines and this needed to be addressed.
- Controlled drugs were stored, administered and recorded in line with trust policy and controlled drugs legislation. Medicines for anticipatory prescribing were in date and accessible.
- Access to syringe drivers for people needing continuous pain relief was available. Staff were aware of how to use these effectively. We saw that checks relating to the safe administration of medicines via this route were recorded every 4 hours in line with trust policy.

Records

- During our inspection, we reviewed three sets of patient records. In all three, documentation by nursing and medical staff was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment.
- Both paper and electronic records were in use. An electronic care planning system was used, ensuring a standardised approach while enabling nursing staff to develop individualised plans of care for each patient.
- Care records we viewed were generally up to date, signed and dated.
- We reviewed an audit of DNACPR documents and saw that the trust had identified the use of abbreviations as being an area it needed to improve on. One ward manager told us they were monitoring the use of abbreviations closely and addressing this with individuals to ensure learning.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect.
- Safeguarding practice was supported by mandatory training and an internal safeguarding team that offered support and guidance.

Mandatory training

- End of life care planning was incorporated into the medical induction training for doctors working at the hospital.
- At the time of our inspection, 71% of ward nurses and healthcare assistants had attended end of life care study days.
- The palliative care consultant participated in the delivery of communication training for medical students, including delivering difficult messages to patients about their prognosis.
- Members of the palliative care team attended mandatory training including safeguarding and basic life support.
- Ward-based nurses on the gynaecology wards took part in a mentoring programme provided by the specialist palliative care nurses.

Assessing and responding to patient risk

End of life care

- Patients identified as being at the end of life were cared for using guidance that included areas such as communication, ongoing medicines and symptom management, interventions, nutrition and hydration, skin care and hygiene.
- An individualised plan of care was put in place and developed for all needs identified through the risk assessment of the patient.
- Part of the care planning included the care of those people close to the patient.
- We saw two situations in which patients had not been able to be involved in discussions about the DNACPR decision because it was made at a time when their condition had deteriorated. Neither patient had an advanced care plan in place, nor did we see evidence in their records of advance care planning being discussed at an earlier date.
- The specialist palliative care nurses told us the Cheshire and Merseyside end of life care network was developing regional guidance about advanced care planning, and that the trust would be participating in the project.

Nursing staffing

- There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for.
- There were 2.4 whole-time equivalent specialist care nurses specialising in gynaecology and palliative care based at the hospital.
- Specialist palliative care nurses were available from 9am to 5pm Monday to Friday. There was no on-call specialist palliative nursing rota for out of hours, but there were informal arrangements whereby ward staff could contact the lead nurse out of hours for advice. Staff also had access to a 24-hour Marie Curie advice line out of hours.
- Nursing staff on the wards felt they had sufficient staffing to prioritise good-quality end of life care and that there were processes in place to escalate staffing concerns should they arise.
- Ward-based nurses on the gynaecology wards took part in a mentoring programme provided by the specialist palliative care nurses which ensured that nursing staff had support from specialised staff when delivering care to patients approaching the end of life.

Medical staffing

- There was one 0.2 whole-time equivalent palliative care consultant employed by the trust. They were based at the hospital 1 day a week.
- The palliative care consultant would review patients on the wards and in the outpatient clinic.
- The SPCT was available for specialist advice as needed.
- There was no direct out-of-hours specialist palliative care medical cover in place, but staff could access the 24-hour Marie Curie advice line.

Major incident awareness and training

- We reviewed a business continuity plan for the Honeysuckle suite (midwifery bereavement). The plan included sensitive transfer arrangements for babies should an incident require an evacuation.

Are end of life care services effective?

Good

Care for end of life patients was based on the National Institute for Health and Care Excellence (NICE) guidance. The trust had reviewed its own processes in response to the national review of the Liverpool Care Pathway and produced end of life care guidance for staff. The guidance included the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Care Strategy and the Francis Report – Mid Staffordshire NHS Foundation Trust Public Inquiry.

National audits were adapted to measure patient outcomes in a way that was relevant to a specialist hospital.

The hospital had developed 'Do not attempt resuscitation' (DNAR) guidelines in line with national guidance for 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) that complied with the guidance issued by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. However, we found that DNACPR decisions were not always discussed in a timely way.

Patients received specialist support from a multidisciplinary team that included specialist palliative care nurses and a palliative care consultant.

Evidence-based care and treatment

- Care for end of life patients was based on NICE quality standards. The trust had reviewed its own processes in

response to the national review of the Liverpool Care Pathway and produced end of life care guidance for staff. The guidance included the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Care Strategy and the Francis Report – Mid Staffordshire NHS Foundation Trust Public Inquiry.
- National audits were adapted to measure patient outcomes in a way that was relevant to a specialist hospital.

Pain relief

- Patients were assessed using pain scores and these were also used to evaluate the efficacy of pain relief.
- The specialist palliative care nurses supported this process and provided ward-based staff with guidance and support to manage patients' pain appropriately.
- Stocks of medicines used in end of life care were kept on the ward, including those used for the five key symptoms most commonly experienced at the end of life.
- Patients were able to access appropriate pain relief in a timely way.

Nutrition and hydration

- Care plans for patients at the end of life included a section on nutrition and hydration.
- Patients were provided with a choice of suitable and nutritious food and drink that was appropriate for their religious, cultural and dietary needs.
- Patients were supported to take food and fluids for as long as possible or for as long as they wished to.
- We saw that a 'red tray' system was available to identify patients who needed help and support to eat and drink.
- Patients told us they were encouraged to make nutritional choices for themselves and that staff would support them to eat the foods they enjoyed whenever possible.

Patient outcomes

- The trust did not participate in the National Care of the Dying Audit for Hospitals (NCDAH) because of the low numbers of patients who had died at the hospital (11 in 2014).
- The specialist palliative care team (SPCT) undertook its own care of the dying audit from April to – December 2014.
- This audit involved a retrospective review of case notes and care plans relating to 11 adult deaths over a 9-month period, and we saw plans in place to develop this into a prospective audit.
- The audit showed that most patients who had died at the hospital had done so in their preferred place of death; they had been asked about their spiritual needs and had been prescribed end of life care medication appropriately.
- A template had been designed, based on the Cheshire and Merseyside cancer network review of care of the dying, to support development and improvements in areas such as communication, hydration and nutrition.

Competent staff

- Members of the SPCT had been trained at Master's level with a focus on pain and symptom management; communication; women's health; counselling; and death, dying and bereavement.
- Training records confirmed that most ward-based staff had attended a 1 day end of life care course run by a specialist palliative care educator at a local NHS provider.
- A pilot of the advisory mentoring in gynaecology oncology service (AMIGOS) was run as a project from April 2013 to April 2014. The aim of this project was to increase the confidence of staff in gynaecology oncology and palliative care knowledge, and to involve staff more in the planning of care for patients.
- The AMIGOS project was based on a group of ward-based staff being mentored by a member of the SPCT. The structure of this included the delivery of ward-based training and support as well as information and guidance geared towards improving end of life care.
- Each clinical nurse specialist was mentor to a group of 12 staff on the wards, and we saw the use of flash cards that had been developed by the specialist nurses in a number of areas. We saw flash cards around the priorities of care at the end of life, drug compatibilities in syringe drivers and medicines used in symptom control.
- All members of the SPCT were trained in communication skills and had attended a 3-day national Advanced Communication Skills Training (ACST) course.

Multidisciplinary working

End of life care

- A specialist palliative care multidisciplinary team (MDT) was in operation at Liverpool Women's Hospital.
- Specialist joint gynaecology oncology and SPCT MDT meetings were held on a weekly basis. The meetings were attended by specialist oncology and palliative care staff as well as junior doctors and other relevant staff.
- We saw that target attendance by core members of the specialist palliative care service was 66% and that all members had attended between 78% and 84% of the meetings.
- We observed an MDT meeting where aspects of holistic care for patients were discussed. Examples included discussions around safeguarding issues, symptom management and practice updates.

Seven-day services

- The SPCT provided a 5-day 9am to 5pm face-to-face service with availability between 9am and 5pm at weekends via an informal telephone system. Specialist nurses told us that, although they did not have a formal on-call system, a specialist nurse could be contacted to assess a patient if needed.
- There was an out-of-hours advice telephone line available via the Marie Curie Hospice where staff could escalate concerns to an on-call palliative care consultant if necessary.
- The lead cancer nurse had compiled an algorithm of how patients were to be assessed before a weekend and this was clarified within individual patients' case notes. It also gave staff advice about when to contact the Marie Curie out-of-hours service.
- The chaplaincy service was available for spiritual support out of hours via their switchboard.

Access to information

- Specialist palliative care was provided alongside gynaecology oncology services with some of the staff having a dual role in this regard. This enabled staff to provide a seamless transition for patients who moved from active treatment into palliative care. Access to all the information about their care was readily available and continuity of care was maintained.
- An electronic care planning system was in use that gave staff access to information and guidance for patients with specific conditions such as dementia. This allowed staff to ensure that a defined care plan was followed but it also gave them the flexibility to adapt it to a patient's individual needs.
- We viewed the records of three patients who were considered to be coming to the end of life. In all three, we saw that the patients had been assessed, care plans were in place and records were accessible.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A unified DNACPR form was in use when a decision had been made that a patient would not be resuscitated in the event of a cardiac arrest.
- We reviewed three DNACPR forms and found that all had been completed appropriately.
- We reviewed one DNACPR form in which a patient had been identified as lacking the mental capacity to be involved in the decision. In this situation, the safeguarding team had been involved and an Independent Mental Capacity Advocate (IMCA) had been appointed. Because the patient was identified as having fluctuating capacity, the decision was later discussed with them.
- We also reviewed an audit of DNACPR forms which showed that they were well managed; however, the trust had identified the use of abbreviations as being an area that needed improvement. One ward manager told us they were monitoring the use of abbreviations closely and addressing this with individuals to ensure learning and improvement.

Are end of life care services caring?

Good

The palliative care team, the chaplaincy and nurses in the wards and departments provided patients with a caring and compassionate service. Patients and those close to them were very positive about the care and emotional support provided.

Patients were active partners in their care and there were excellent examples of staff going out of their way to assist patients in carrying out their wishes.

Staff were skilled in providing patients and those close to them with emotional support.

An annual service of remembrance was held at the hospital for babies and patients who had died during the year.

Compassionate care

End of life care

- Nursing and medical staff treated patients and their relatives with kindness, dignity and respect.
- As a specialist trust, Liverpool Women's Hospital are not included in the VOICES end of life and bereavement survey. Specialist palliative care nurses confirmed that there was a local care of the dying evaluation tool being developed for use across the local network. However, a request to be a part of this had been declined because of the small number of deaths occurring at the trust. As a result, the trust had adapted and developed its own version of the VOICES survey.
- The survey had been sent out to families of patients who had died at Liverpool Women's Hospital in 2014. The survey was sent out at the beginning of February 2015 and the trust were awaiting the outcome at the time of our inspection. Questions asked included those related to respect and dignity, relatives' ability and opportunity to discuss worries and fears, the level of support and caring around symptom management, and the information given.

Understanding and involvement of patients and those close to them

- A patient focus group had been developed within the trust. This had been set up by the nurse specialists to involve patients in improving the patient experience. Patients had been involved in the development of information leaflets and the design of the end of life suite in the hospital.
- Learning from patient feedback had led to service improvements (for example, the addition of information in letters sent to patients that they were able to bring a friend or relative with them to appointments).
- Patients and relatives we spoke with told us they felt involved in choices about their care.
- Patients were actively supported in making their own choices at the end of life. There were excellent examples of staff going out of their way to assist patients to carry out their wishes (for example, in a very short time period, the service had arranged for one patient who was coming to the end of life to be married at the hospital).

Emotional support

- An annual service of remembrance was held at the hospital for babies and patients who had died during the year.
- A bereavement service was provided by the specialist nurses in line with the Cheshire and Merseyside cancer network 'Bereavement support guideline' 2010.
- One patient told us they had experienced some concern in the way information had been given to them at the point of their diagnosis. This had been escalated to the lead cancer nurse who was reviewing the incident in relation to delivering difficult messages to patients appropriately and sensitively.
- The chaplaincy service was accessible via the hospital switchboard if patients needed it.

Are end of life care services responsive?

Good

Patients' needs were assessed, and care and treatment was planned and delivered in an individualised and person-centred way.

The development of the Mulberry and Orchid suites provided suitable environments for patients to receive end of life care in a dignified and respectful way. Patients and those close to them appreciated the privacy afforded by the suites, which allowed them to have sensitive and confidential conversations without being overheard.

There were appropriate provisions of care for the deceased and those close to them that met their personal or religious wishes.

There was good evidence of learning from complaints and concerns, and staff were committed and enthusiastic in their endeavours to improve services for patients.

Service planning and delivery to meet the needs of local people

- An audit of end of life care in 2014 showed that 91% of patients had died in their preferred place of death.
- Staff were committed to service improvement and meeting the needs of patients and those close to them.
- A number of audits and projects had been designed or were in development at the time of our inspection that were focused on reviewing and improving patient experience.

End of life care

- A recent bereaved relatives survey included the question, 'Do you think your relative had enough choice about where they died?' However, the survey results had not yet been returned by the time of our inspection.
- The specialist palliative care team (SPCT) told us of plans to develop a proactive audit and that they were in the process of designing a template for this work.
- Because the hospital specialised in the care and treatment of women, the clinical nurse specialists in the hospital were trained in gynaecology, oncology and specialist palliative care. This helped to ensure that the ethos of palliative care was incorporated into the patient's gynaecological cancer journey.
- Two end of life care suites had been developed and were in use on the gynaecology oncology ward. The suites provided private space for the care of patients in the last year of life. The space enabled family and friends to stay and support their loved one for extended periods of time.

Meeting people's individual needs

- Once a patient had been identified as being at the end of life, staff used a care planning document that incorporated guidance and prompts for staff to address patient symptoms, spiritual needs, communication needs, nutrition and hydration needs, and other nursing care needs.
- Risk assessments and care plans were in place for patients at the end of life. However, the care plans did not always meet all the patient's identified needs. For example, we saw three patients who had been identified as being anxious, tearful or confused, but there was no care plan to reflect this or specify how they were to be supported. In addition, care plans were not in use for a patient who had been identified as having mobility problems, or another who had a urinary catheter fitted. This meant that staff did not always have access to up-to-date relevant care plans when caring for people at the end of life.
- Patients with complex needs would be referred to the SPCT for extra support, particularly when there were issues around managing their symptoms effectively.
- There was an electronic care planning system that could be adapted to meet the specific needs of individual patients.
- Welcome packs were available on the wards for patients who needed them. They included toothbrushes, socks and toiletries.
- General ward staff we spoke with told us they had not received training in care for patients living with dementia or delirium.
- There was examples of patient information leaflets in Welsh and we were told that others were available for patients whose first language was not English.
- Chaplaincy and ward staff had access to information about different cultural, religious and spiritual needs and beliefs, and so were able to respond to the individual spiritual needs of patients and those close to them.

Access and flow

- Ward staff knew how to make prompt referrals to the SPCT and said that the team was responsive to the needs of patients.
- The specialist palliative care nurses attended the ward on a daily basis to provide advice, guidance and support for patients and staff. The specialist nurses would see patients at weekends if patients needed specialist assessment or support.
- Advice from the SPCT was recorded in a patient's notes and easily accessible to ward staff. The team was actively involved in care planning for patients at the end of life.
- We viewed records that included space for staff to record conversations with patients about their preferred place of death and discharge in the last days of life. The SPCT were developing a rapid (sometimes within 4 hours) discharge pathway and we saw this included in the multidisciplinary work plan for the team.

Learning from complaints and concerns

- Staff attended daily 'safety huddles' where they identified issues or concerns relating to patient safety. In addition, regular staff meetings were held that included discussions about complaints and incidents so that lessons learned could be shared and applied.

End of life care

Are end of life care services well-led?

Good

There was a draft vision and strategy in development that was led by the specialist palliative care team (SPCT). In developing this strategy, staff had used national guidance, feedback from patients and those close to them, as well as feedback from staff working in the hospital.

There was good local leadership at ward and department level, as well as good leadership from the SPCT. There was a culture of good-quality end of life care within the trust, coupled with good examples of patient and public engagement in the development of end of life services.

Vision and strategy for this service

- Although there was no non-executive lead for end of life care, staff were clear that the board and executive team were committed to the delivery and development of the service.
- An end of life care strategy was being developed at the time of our inspection and we saw the draft version. The vision was focused on the timely identification of patients at the end of life and the involvement of patients and those close to them in making decisions about care and service provision.
- The specialist palliative care consultant and the lead cancer nurse were active participants in the regional strategic network for palliative and end of life care.

Governance, risk management and quality measurement

- As a specialist trust, it was not always appropriate for the service to contribute to national patient surveys and audits. When this was the case, the service developed its own key performance indicators and measured patient experience and service performance accordingly. Recent results indicated that the service was performing well.
- The service was in the process of adopting the use of the End of Life Care Quality Assessment Tool (ELCQuA). The ELCQuA is a tool that tracks progress in delivering end of life care services.
- Staff were positive about the changes in governance structures that had led to improved communication and better engagement opportunities. One example was that ward managers felt they had better control over local risks through the use of the risk register.
- Changes to the risk management policy had improved communication and provided an emphasis on learning. Clinical areas had adopted a 'lessons of the month' approach to communicating with staff. Managers told us they felt empowered to deliver and be more innovative with practices on the wards.

Leadership of service

- There was good evidence of local leadership within the palliative care and midwifery bereavement teams, and on the gynaecology wards.
- Staff were positive about their line managers and the support they received from the SPCT. The team was visible, accessible and very supportive.

Culture within the service

- There was a positive culture within the service. Staff were proud of the work they did and worked well together for the benefit of patients and those close to them.
- There was a strong and visible commitment to continuous improvement that was supported and encouraged by managers.
- The development of an education and advisory support model for ward staff had raised awareness regarding good-quality end of life care and helped to support staff to deliver a good-quality service.

Public and staff engagement

- Staff were made aware of feedback about patient experiences, including feedback from the Patient Advice and Liaison Service (PALS) and from discharge questionnaires.
- We saw information displayed on boards in ward areas that summarised themes identified through feedback.
- A patient focus group was in operation and had been involved in the design and décor of the end of life care suites on the gynaecology wards. The group had also been involved in the development of patient information literature.

Innovation, improvement and sustainability

End of life care

- There were good examples of how lessons learned were used to improve services, particularly in terms of the development of the midwifery bereavement suite.
- The SPCT was focused on continually improving the quality of care and we observed a commitment to this at ward level.
- The development of the AMIGOS mentoring project had helped to raise awareness of end of life care and develop the service further.
- There was good use of national guidance in the development of services and that the SPCT was involved in developing the strategy for the service.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

A range of outpatient services are provided by Liverpool Women's NHS Foundation Trust at Liverpool Women's Hospital and Liverpool Women's at Aintree. The main outpatient department at Liverpool Women's Hospital is located on the ground floor. In 2013/14, there were 50,843 outpatient appointments on this site.

The outpatient department offers specialist clinics for gynaecology, urogynaecology, colposcopy, miscarriage and foetal medicine. Liverpool Women's Hospital is the specialist regional centre for women's cancer services, known as gynaecology oncology.

The diagnostic imaging department provides a comprehensive range of diagnostic services to the patients of Liverpool Women's Hospital including general x-ray, DEXA scanning, non-obstetric and obstetric ultrasound, and fluoroscopy. Portable machines are available in the neonatal unit.

We visited the outpatient and diagnostic imaging departments on 18 and 19 February 2015 and spoke with 13 patients, 3 senior managers, 2 doctors, 4 clinic/ department managers, 7 nurses, a sonographer, imaging staff and 2 healthcare assistants.

Summary of findings

The quality of service in the outpatient and diagnostic imaging departments was good. Staff were aware of how to report incidents and could clearly show how and when incidents had been reported. Lessons were learned from incidents locally, and staff felt confident about raising incidents through the reporting system.

There were appropriate protocols for safeguarding vulnerable adults and children, and staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.

Staffing levels and skill mix were planned to ensure the delivery of outpatient diagnostic services at all times. There were shortages in some services, but the trust was aware of these and there were plans to address them. Any staff shortages were responded to quickly and adequately at the time.

Risks to people who used the services were assessed and managed appropriately. There were clear protocols for providing care to people with specialised conditions, including the need to monitor for any deterioration in a patient's condition. Staff were trained in medical emergencies and could show through past events that their skills were used appropriately and promptly.

The outpatient and diagnostic imaging service did not have a major incident or business continuity plan. At the time of our inspection, the service was experiencing difficulty in securing pathology test results in a timely

Outpatients and diagnostic imaging

way. Staff managed the disruption locally to ensure that patients' test results were available for their consultations, but there was no formal and tested plan to address this issue.

Are outpatient and diagnostic imaging services safe?

Good

There was good practice in the outpatient and diagnostic imaging departments to promote the safety of patients and staff. There was a clear process for reporting and investigating incidents. Learning from incidents was shared and there were examples of changes in practice in response to incidents.

Cleanliness and hygiene in the department were of a good standard. Regular hand hygiene audits showed high levels of compliance.

Patient records were mostly available for clinics although there were occasions when they were not. It was not possible to ascertain how widespread the issue was because incidents that related to the availability of patients' notes were not reported consistently and the availability of notes was not audited. Staff and managers could not tell us the percentage of notes that were unavailable. This issue was recorded on the risk register a week before our inspection started.

Staff were aware of the policies and procedures to protect and safeguard children and adults, and training statistics showed that most staff had completed training in safeguarding for both children and adults. Other mandatory training courses were well attended and staff were positive about the training provided.

Staffing levels were appropriate to meet the needs of patients, however, there were occasions when the foetal medicine unit was understaffed and managers were looking at ways to resolve this. The diagnostic imaging department used a private provider for sonography to support staff shortages.

Incidents

- An investigation relating to one serious incident in the diagnostic and imaging department had been closed in August 2014. There was evidence that the incident had been investigated, actions taken to prevent recurrence and learning disseminated throughout the trust via the trust-wide 'lesson of the week' communications to all staff.

Outpatients and diagnostic imaging

- Staff were familiar with, and encouraged to use, the electronic system to report incidents within the department. There was evidence of shared learning from incidents, supported by staff training to reduce the risk of recurrence. Staff were aware that the governance team analysed incidents and reported findings on the intranet.
- Information provided by the trust showed that some incidents were reported inconsistently. For example, when case notes were not available, some staff recorded an incident for every set of notes but in other cases they logged one incident per clinic, which could include several sets of missing notes. This was not helpful to the service in determining if the availability of case notes was an issue.
- The diagnostic imaging department was only able to access information about incidents reported when a particular person was available. This meant that information was not available within the department if that person was on leave or absent from work.
- Managers used incidents positively to underpin service improvement and risk management within the service.

Cleanliness, infection control and hygiene

- The outpatient department was visibly clean throughout. Staff followed good practice guidance in relation to the control and prevention of infection. This included the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned.
- Diagnostic imaging rooms were cleaned every morning and evening, and extra cleaning was carried out at weekends.
- Monthly infection control audits were carried out regularly and covered topics such as the World Health Organization (WHO)'s '5 Moments for Hand Hygiene' and cleanliness generally. The results of the audits were fed back to staff and actions for any required improvements were set and monitored.
- Patient-led assessments of the care environment (PLACE) showed that the diagnostic imaging department scored above the national average for cleanliness.
- Infection control training had been completed by 97% of staff, which was above the trust's target of 95%.

Environment and equipment

- The diagnostic imaging rooms were spacious and had en-suite facilities.
- Although the outpatient department waiting areas were sometimes crowded, baby changing and toilet facilities were available. There were also water fountains, vending machines and a tea bar for refreshments.
- Maintenance contracts were in place to ensure that specialist equipment in the outpatient and imaging departments was serviced regularly and faults repaired quickly.
- Resuscitation trolleys were visibly clean and in good order, with all the required equipment available. However, we found that the resuscitation workstation number 2 in outpatients was not checked daily.
- Staff confirmed that they had never been asked to use equipment they had not been trained to use.
- Some of the equipment in outpatients had not undergone portable appliance testing (PAT) since 2012. The outpatients' manager told us this issue would be recorded on the risk register.
- The foetal medicine unit lacked the space. Charitable funds were currently being considered to improve the environment and provide an extra counselling room.
- Monthly audits of the patient environment and equipment were undertaken. The results of these audits were fed back to staff and actions for improvements were set and monitored.
- There was suitable and safe access for patients using a wheelchair.

Medicines

- There were robust systems in place for managing and dispensing medication to patients who attended the outpatient and diagnostic departments.
- A limited amount of medication was appropriately stored within the department; however, patients were usually issued with a prescription that could be dispensed at the hospital pharmacy when attending appointments in outpatients.

Records

- Patient records were stored securely with due regard to privacy and confidentiality.
- There were occasions when records were not available for an appointment. In such cases, staff prepared a temporary file for the patient that included

correspondence and diagnostic and test results so that their appointment could go ahead. Staff acknowledged that this was not ideal; however, it meant that the patient did not have to reschedule their appointment.
- The availability of records was not routinely monitored and no audits had been carried out to identify whether this was a widespread concern.
- Information provided by the trust showed that 32 incidents had been reported relating to non-availability of records across both the trust sites in the period January 2013 to November 2014.
- The lack of availability of records was recorded as a risk on the risk register the week before our inspection began.

Safeguarding

- Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Training statistics provided by the trust showed that 91% of staff had completed the required safeguarding adults training, which was below the trust's 95% target and 88% had completed safeguarding children level 3; however, 97% had completed level 1 and all staff who were required to had completed level 2.
- In the diagnostic imaging department, 69% of staff had completed the required safeguarding adults training and 92% had completed safeguarding children training level 1 against a trust target of 95%; however, all staff had completed levels 2 and 3 who were required to.
- A new safeguarding lead had been appointed to the trust. Safeguarding and training about the Mental Capacity Act 2005 were identified as priorities for the outpatient department, and future training and information were planned in these areas.
- Relevant policies and procedures were available electronically on the trust intranet for staff to refer to.
- Managers supported staff in escalating concerns in a timely and appropriate way.

Mandatory training

- Staff were given mandatory training on a rolling annual programme. They were able to access online courses as well as face-to-face training.
- The mandatory training was in areas such as infection prevention and control, moving and handling, and domestic violence.
- Training statistics for outpatient staff showed that 93% of staff had completed their mandatory training, which was marginally below the 95% trust target.
- Only 89% of staff in the imaging department had completed their mandatory training against a trust target of 95%.
- A member of staff who had been employed through an agency told us they were able to access the same training as permanent staff.
- Staff were positive about the content and quality of the training they had received.

Assessing and responding to patient risk

- Staff had clear guidance to follow should a patient's condition deteriorate while they were in the outpatient department.
- Resuscitation equipment was available in the department and ready for use.
- Risk assessments were completed for patients who needed extra care during a procedure. Multidisciplinary team meetings were held where appropriate.
- There was a clear process to check the identity of patients in the outpatient and diagnostic imaging departments. This included patients who were unable to confirm their own identity.
- Policies and procedures were in place for the range of outpatient and diagnostic imaging services.

Nursing staffing

- Nurse staffing levels had been determined using a recognised management tool.
- British Society for Colposcopy and Cervical Pathology (BSCCP) requirements for staffing were always met. This meant that there was always one staff nurse to support colposcopists and one healthcare assistant available as a chaperone.
- Departmental staffing risk indicators highlighted several risk factors, including levels of staff sickness, the orientation and induction of new staff. Extra training was being arranged for staff and a more robust induction planned to address the risks identified.
- Staff worked closely with the outpatient team on the Liverpool Women's at Aintree site. They were used flexibly across both sites to maintain staffing numbers and the availability of chaperones.
- The foetal medicine unit identified risks related to staffing issues. The manager was currently looking at

ways to address these, including seeking secondment opportunities. The manager gave us an example of how these risks were managed (for example, by postponing training to ensure that the unit was properly staffed).

Medical staffing

- Medical consultants and other specialists arranged outpatient clinics directly with the outpatient department to meet the needs of their specialty.
- The diagnostic and imaging department used a private provider for sonography to support staffing issues. To address this, the trust was providing training and had trained two sonographers in the past 2 years. Discussions were also being held with another provider regarding partnership training and the sharing expertise.
- Senior managers had identified that succession planning needed further development because some specialised services were managed by only one or two skilled people.

Major incident awareness and training

- Staff were trained and able to describe their role and responsibilities should a major incident occur.
- Staff were used flexibly across both sites when there were staffing issues or incidents that required additional staff support.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients attending the outpatient and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance. Staff worked well together in a multidisciplinary environment to meet patients' needs. Medical staff were well supported by specialist nurses.

Information relating to a patient's health and treatment was obtained from relevant sources before a clinic appointment. After the appointment, information was shared with a patient's GP and other relevant agencies to ensure continuity of care for the patient.

Evidence-based care and treatment

- Care and treatment followed appropriate national guidance. Guidance from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges, and other best practice guidelines, were available to staff via the intranet.
- Staff were given regular updates if and when guidance was reviewed or practice changed. They told us they were given updates during preparation for outpatient clinics.
- Staff worked across all clinics on a rota basis, so they received all updates.

Pain relief

- Staff could access appropriate pain relief for patients within clinics and diagnostic settings.
- Staff told us that pain was managed by both nursing and medical staff. When it was identified that a patient was in pain, a doctor would assess and prescribe treatment as appropriate.
- Patients were given information about ambulatory procedures (minor procedures that can be performed in a clinic setting without the need for admission to a ward). They were offered a choice of pain relief for the procedure and appropriately supported with any symptoms afterwards.

Patient outcomes

- Treatment in the colposcopy service was given in line with the Liverpool and Sefton Cervical Screening working group guidelines, and outcomes for patients were monitored against the agreed criteria.
- The trust compared outcomes for patients against the other specialist women's hospital. These included re-admissions after procedures.
- An electronic patient questionnaire (EPAQ) was used to ask questions about a patient's lifestyle before treatment and then after physiotherapy or surgery. This enabled patients to see the results of the treatment and the improvements in their quality of life.

Competent staff

- Staff were trained in core subjects such as infection control, safeguarding, and health and safety. They were also given training relevant to their specialty (for example, some healthcare assistants were trained in scanning).

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- Competency frameworks were in place. These meant that staff undertook training and were assessed in practice; managers would then verify that the member of staff was competent.
- All staff held the required professional registration and received notice as to when it was due to expire.
- Only 77% of outpatient and 82% of imaging staff had completed their performance development review in January 2015; this was below the trust target of 95%.

Multidisciplinary working

- There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together for the benefit of patients.
- Letters were sent out by the outpatient department to patients' GPs to provide a summary of the consultation and any recommendations for treatment in a timely way. Patients were provided with a copy of the letter sent to their GP.
- The outpatient department operated a multidisciplinary gynaecology oncology clinic every Wednesday in conjunction with a local specialist NHS cancer provider. In these clinics, patients had access to a wide range of specialists and there was evidence of a multidisciplinary approach to meet the (sometimes) complex needs of the patients who attended these clinics. The intention was that patients could come to one appointment and see arrange of specialists with returning for further appointments.

Seven-day services

- The outpatient clinics ran Monday to Friday. An emergency service was available so that patients with concerns or problems outside normal clinic hours could access support. A phone number was available for patients who were experiencing difficult or who were worried; nurses contacted the patients within 24 hours and they were invited to attend a clinic the next day.
- The diagnostic imaging department provided some services such as x-ray and scanning at weekends.

Access to information

- The imaging department used a system that allowed staff to view images and reports from other hospitals; this aided prompt diagnosis and reduced the need for repeat imaging.
- Imaging and test results were stored in a patient's records and available to staff during a consultation or when giving treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were confident and competent in seeking consent from patients; however, they did not always understand how mental capacity should be assessed.
- To ensure that patients were dealt with correctly, staff would seek advice and guidance from their line manager if a patient lacked capacity to advise them regarding the processes for making decisions about their care or treatment.
- Staff were given a small booklet with information about mental capacity as a quick reference guide.
- A specific maternity clinic was provided for patients with a history of mental health issues. The team that operated this clinic included a consultant psychiatrist and two psychiatric nurses who dealt with any concerns about capacity appropriately.

Are outpatient and diagnostic imaging services caring?

Good

Outpatient services were delivered by caring, committed and compassionate staff who treated people with dignity and respect. Care was planned and delivered in a way that took patients' wishes into account. Their confidentiality and privacy were respected and promoted whenever possible.

Staff actively involved patients and those close to them in all aspects of their care and treatment. Patients were positive about the way staff had looked after them.

Compassionate care

- Throughout our inspection, we witnessed patients being treated with dignity and respect. Staff listened to patients and responded positively to questions and requests for information. We observed a member of staff providing a hot drink for an elderly relative of a patient.

Outpatients and diagnostic imaging

- Patients spoke positively about the care provided by staff. One patient said, “fabulous service” and another said, “staff are very caring and knowledgeable”. Other patients told us, “The service is superb, fantastic; wish I had the words to do it justice.”
- Chaperones were available to support patients during procedures if needed. Policies regarding chaperones were available on the intranet and in the office. Staff had received training for the role and further suggestions had been made for future training. One patient said, “It was no problem getting a chaperone; they arranged it quickly.”

Understanding and involvement of patients and those close to them

- We spoke with eight patients about the information they had received in relation to their care and treatment.
- Patients said that staff had explained their treatment options to them clearly and they had been involved in decisions regarding their care. They told us they were pleased with the information they had received. One patient said, “Staff gave very good explanations.”
- Patients said that staff were good at communicating with them, and that the range of information leaflets available was good.
- After treatment, leaflets and contact details were given to patients. They were also able to contact the reception at Liverpool Women’s Hospital 24 hours a day, 7 days a week, if they had any concerns.

Emotional support

- Staff were sensitive to the needs of patients who were anxious or distressed about their appointment.
- Patients told us that staff were very reassuring. One patient said, “It’s been a long and emotional journey and I wouldn’t have got through it without the staff.”
- Emotional support was given to patients who had suffered a miscarriage. A room was being refurbished at the time of our inspection to make it quieter and less ‘clinical’ for counselling and emotional support. This was identified as a need after feedback from staff. Other areas of the department were being modified to facilitate this change.
- Staff said the team members were very supportive of each other if they were involved with difficult emotional situations.
- The system for informing patients that they had cancer had recently changed. Patients were previously given the news during an oncology clinic, but now they saw the same staff they had seen before. Macmillan nurses supported women when they were given difficult messages and other staff were also there to provide advice and emotional support.

Are outpatient and diagnostic imaging services responsive?

Good

The outpatient and diagnostic imaging services were responsive to patients’ needs.

Patients were positive about the range of services provided by the trust. They told us they were able to access the services easily, and that the ‘Choose and Book’ service was good.

The trust operated a number of specialised and innovative clinics that were bespoke to women’s health and cultural needs. There were effective systems to meet the needs of patients whose first language was not English.

Performance against national referral to treatment and cancer targets was very good. However, there were large numbers of patients who failed to attend for their appointments. Managers were exploring the use of telephone calls and mobile technology for follow-up appointments in an effort to engage with patients more effectively to ensure they attended their appointments.

Service planning and delivery to meet the needs of local people

- A range of specialist gynaecology and maternity clinics was provided at Liverpool Women’s Hospital in response to local need.
- The types and numbers of clinics offered in the outpatient department had increased to meet the demand in the area, and other services were being developed in response to patient feedback and consultation.
- Specialist clinics were available to meet the needs of patients who had specific conditions, such as women with a history of female genital mutilation (FGM); there was also a bariatric antenatal clinic for women who were obese, and a renal antenatal clinic for women with kidney problems or a kidney transplant.

Outpatients and diagnostic imaging

- In response to community feedback, a link clinic had been developed for women whose first language was not English, asylum seekers and refugees.

Access and flow

- Clinics and diagnostic appointments were planned and arranged to meet both the needs of patients and national referral to treatment targets.
- At the end of January 2015, 95.5% of patients had started non-admitted treatment (that is, outpatient appointments) within 18 weeks of referral; this was better than the NHS operational standard of 95%, and similar to the England average.
- In the period July 2013 to July 2014, there were no patients waiting longer than 6 weeks for diagnosis, which was significantly better than the England average.
- In 2013/14, the trust was better than the England average for the percentage of people seen by a specialist within 2 weeks of an urgent GP referral for concerns about cancer.
- The percentage of people waiting fewer than 31 days from diagnosis to first definitive treatment for cancer was better than the England average for most of 2013/14 and in the first two quarters of 2014/15.
- Patients told us they were able to access the outpatient and diagnostic service easily.
- There was a rapid access clinic for patients who had been referred by their GP for immediate assessment. Appointments were available within 2 weeks of referral.
- At the time of our inspection, 'Did not attend' (DNA) rates were worse than the England average for most of the reporting period. Senior managers were engaged in a study of DNA rates to analyse which clinics had the worst rates, and to develop a plan to improve patient attendance.
- When patients did not attend their appointments, consultants reviewed their notes in their absence and, when appropriate, rearranged the appointment. Decisions were made on an individual basis according to patients' need.
- Managers were exploring the use of telephone reminders and mobile technology for follow-up appointments. They thought these would engage patients more effectively and perhaps contribute to a reduction in the DNA rates.
- In most cases, the outpatient department was trying to move towards patients having as few appointments as possible; 'one stop' clinics and ambulatory procedures had been introduced as a result.
- Foetal monitoring unit clinics were overbooked when patients needed to be seen at short notice. However, consultants were able to see patients at weekends if there were emergencies.
- The gynaecology department had a specialist physiotherapy service. At the time of our inspection, there was a waiting time of 3 weeks to access this service. Extra resources had been allocated to address this.
- Approximately 8% of appointments were cancelled by the hospital. Some were cancelled because patients had not been booked into the appropriate clinic and alternative appointments needed to be made for them. Others were cancelled, for example, because of annual leave arrangements.
- Staff were open about patient waiting times that could be up to 2 hours. "We constantly tell our patients about waiting times. We tell everyone in the waiting area and put it on the screen. We recognise patients get anxious if they're waiting."

Meeting people's individual needs

- A link clinic was available for women whose first language was not English.
- A language line was available in the outpatient clinical rooms when interpreters were needed; they could also be booked in advance.
- Staff told us that they were able to take extra time and familiarise patients who were vulnerable or nervous in the surroundings of the hospital. We were given examples of other adjustments that had been made to meet a patient's need and ensure that they were comfortable with the care and treatment provided.
- A specialist nurse ran a support group for women experiencing bladder pain.
- Patient-led assessments of the care environment (PLACE) showed that the diagnostic imaging department scored above the national average for patient's wellbeing.
- Women attending the foetal monitoring unit were given a phone number to use if they had concerns. Staff confirmed that it was rare for the service not to be able to offer an appointment, but they would refer a patient to another centre if necessary.

Outpatients and diagnostic imaging

- After treatment, leaflets and contact details were given to patients to allay fears and anxieties and support their understanding.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Initial complaints were dealt with by the outpatient manager, who resolved them locally whenever possible. When a complaint was not resolved, the patient was directed to the Patient Advice and Liaison Service (PALS). If they then still had concerns, they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department.
- There were few complaints about the service. However, staff described how they responded positively when patients did raise matters of concern, and then used the complaints to make improvements in the department.
- The diagnostic imaging department had a complaint, compliment and suggestion box clearly visible and easily accessible on the desk at reception. However, staff said they had not received any feedback about complaints, so there was no chance to learn from them.
- One outpatient told us, "I feel like the department responds to issues raised by patients" and gave us an example of this.
- Most patients said they had nothing to complain about. One commented, "I would feel confident it would be handled properly if I did complain."

Are outpatient and diagnostic imaging services well-led?

Good

Outpatient and diagnostic imaging was led by the outpatient and deputy outpatient managers who reported directly to the executive team.

Staff felt supported by their local managers and were positive about seeing the chief executive regularly; however, they said they rarely saw other managers. They said they would like to see senior nurse leaders more visible within the service. 'Walkabout Wednesdays' were being introduced as a result of staff feedback in this regard.

Staff were proud of the work they did; they worked well together and supported each other when the service was under pressure from increased demand.

Managers had a good knowledge of performance in their areas of responsibility, and they understood the risks and challenges to the service.

Staff in the outpatient and diagnostic imaging departments were proud of their innovative work in setting up a specialist endometriosis clinic and trialling a new drug for endometriosis.

Vision and strategy for this service

- All staff were given an induction that covered the trust's vision and values. However, when asked, some new staff did not know what the vision was.
- Managers were aware of the hospital's vision and values.
- Staff said, "We see the drive for better patient care from our manager and other staff."

Governance, risk management and quality measurement

- Since our last inspection, the trust had undertaken a great deal of work to address their risk management processes. Divisional and monthly meetings were held to discuss risks to the outpatient and diagnostics service.
- Complaints, incidents, audits and quality improvement projects were discussed at monthly departmental meetings.

Leadership of service

- Clinic managers had a strong focus on the needs of patients and the roles staff needed to play in delivering a good service. They were visible and respected by their colleagues.
- Line managers encouraged staff to achieve performance development objectives and this was having a positive impact on overall performance.
- Staff told us they did not see senior managers as much as they would like. In response, 'Walkabout Wednesdays' were being introduced when senior managers would visit staff in the department. This was expected to be implemented in the next couple of months.
- Staff told us that executive staff currently visited clinics about every 2 months.

Culture within the service

- There was a positive culture in the department; staff were committed and proud of their work.

Outpatients and diagnostic imaging

- Staff supported each other and there was good team working within the department. Staff said, “We have good team working” and “It’s a great place to work”.
- Staff told us, “The team is very strong on issues of confidentiality. For example, we will not discuss diagnosis or treatment options in public areas.”

Public and staff engagement

- Staff were keen to engage their patients and the public to improve the patient experience. They considered “How can we improve the service?” as part of their performance development review.
- Reviews of care and treatment included patient experience surveys. Staff were given feedback from the NHS Friends and Family Test during weekly staff meetings, and the information was displayed on the noticeboard.
- Patients’ views were taken into consideration. Men were asked to sit in the waiting area, rather than the urodynamics areas to protect the patients’ dignity.
- Patients had nominated a urology nurse for a ‘Focus on Excellence’ award that had been introduced across the trust.

Innovation, improvement and sustainability

- The antenatal clinics set up specialist clinics that contributed to the implementation of national guidance. Examples of these were clinics for patients with diabetes, multiple pregnancies and teenage pregnancies in the 1990s.
- To be able to provide the care and treatment necessary in as few appointments as possible, ‘one stop’ clinics and ambulatory clinics had been introduced.
- Liverpool Women’s Hospital had just been accredited for its dedicated endometriosis clinic. This had been achieved in a short time frame and involved multi-agency working with specialists from other services.
- The diagnostic and imaging department was working with Liverpool University to trial a new drug for the treatment of endometriosis.

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital MUST take to improve

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

Action the hospital SHOULD take to improve

- Review the number of hours of consultant cover in maternity, which were lower than the recommended minimum from the Royal College of Obstetrics and Gynaecology for a unit this size.
- Ensure that issues identified during audits are addressed.
- Review the numbers of incidents reported in all services.
- Ensure that domestic violence referrals from the police are reviewed within agreed timescales.
- Review practice with regard to the artificial rupture of membranes during induction of labour.
- Improve the response rates for the NHS Friends and Family Test.
- Consider including emergency appointments in the induction suite diary.
- Ensure that there is an effective system in place for testing portable electrical appliances.
- Allocate a non-executive director with responsibility for termination of pregnancy services.
- Review the timing of resuscitation decisions so that discussions are initiated with patients at a time when they are well enough to fully consider their wishes.
- Initiate work on advanced care planning with patients at a time when they are well enough to fully consider their wishes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The provider has not protected the service user against the risks associated with the unsafe use and management of medicines with regards to the safe storage of medicines. Regulation 13.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The provider has not protected the service user against the risks of unsafe

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Requirement notices

Treatment of disease, disorder or injury	or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record of the care and treatment provided. Regulation 20 (1)(a).