Liverpool University Hospitals NHS Foundation Trust

University Hospital Aintree

Inspection report

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Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at University Hospital Aintree

Inspected but not rated

Urgent and Emergency Care Services at the University Hospital Aintree are provided by Liverpool University Hospitals NHS Foundation Trust. The trust was created on 1 October 2019 following a process of acquisition, in which Aintree University Hospital NHS Foundation Trust acquired Royal Liverpool and Broadgreen Hospital NHS Trust.

In the last year, 310,869 patients have attended urgent and emergency care services at the trust. On 17 September 2023, 411 patients attended Aintree University Hospital emergency department.

The emergency department saw higher numbers of very unwell patients (requiring majors or resus care) when compared to the regional and England average. Compared to the regional average of 29.6% and England average of 30.8%, only 15.2% of patients who attended Aintree University Hospitals emergency department, required minor care or treatment

Following an inspection in June 2021, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the trust's CQC registration as we believed people were being exposed to the risk of harm within the Emergency Departments.

We carried out this unannounced focused inspection to review the safety and performance of the Emergency Departments at the Royal Liverpool Hospital and University Hospital Aintree following a comprehensive programme of improvement work which was implemented by the trust in response to the concerns that we raised.

We visited the Royal Liverpool Hospital and University Hospital Aintree on 27 September 2023. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We only inspected urgent and emergency care during this inspection. We did not rate the services at this inspection.

We considered nationally available performance data and feedback we had received from people who use services. We inspected against the safe, responsive and well led key questions.

Following this inspection, we removed the conditions that were imposed on the trusts CQC registration in June 2021.

Urgent and emergency services

Inspected but not rated

We inspected but did not rate this service. We found:

- Staff assessed risks to patients and worked together to deliver care and keep people safe.
- Staff and leaders were working together to improve access to services.
- Staff and leaders had a collaborative approach to managing risk. Robust structures were in place for the escalation of risk so that local and senior leaders had oversight.

However:

- Flow throughout the trust remained an issue and at times, this was impacting on waiting times within the Emergency Department. However, we saw that staff and leaders were working together and with system partners to improve this.
- National targets for the care of patients with confirmed or suspected sepsis were not always being met, but performance had improved, and work was still ongoing to further improve this.

Is the service safe?

Inspected but not rated

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department had an electronic patient record system which alerted staff when observations were due. At the time of our inspection, this system was working well, and patient observations were being completed on time and appropriately escalated using the National Early Warning Score (NEWS2).

Staff and leaders told us that NEWS2 compliance data was often inaccurate as there was often a delay from the observations being completed to the information being recorded on the system. Staff were not able to amend the time on the electronic patient record to accurately reflect the time. Senior nurses were completing daily audits which included a manual review of NEWS2 compliance, and these audits demonstrated the inaccuracy in data collection. Actions were being taken to improve this.

The Royal College of Emergency Medicine (RCEM) guidance on the initial assessment of emergency patients (2017) states an assessment should be carried out by a clinician within 15 minutes of arrival. At the time of our inspection, we did not see any triage delays which was an improvement from our last inspection when the average time to triage was 28 minutes. During the week commencing 18 September 2023, 82.3% of patients were seen within 15 minutes. This was an improvement from 72% during our last inspection in June 2021 but was below the trust target of 85%.

We reviewed 4 patient care records and saw that triage was completed in a timely way. We saw 1 patient who was identified as having suspected sepsis, they were triaged in a timely way and treatment was started within 20 minutes of arrival. Another patient arrived with shortness of breath and was triaged and moved to resus within 6 minutes of arrival.

Urgent and emergency services

There was a dedicated nurse who triaged all patients who were brought into the department by ambulance. We saw that patients were triaged in a timely way and moved to an appropriate area of the department dependant on their needs.

Hospital and department leaders had been working closely with the local NHS ambulance service to improve ambulance handover times and reduce the number of crews who were delayed at ED. In August 2023, 6.4% (121) ambulance handovers took over 60 minutes which was an improvement from 31.9% (492) in November 2022. In addition, the number of delayed admissions (patients held on ambulances outside of the ED) had significantly reduced since January 2023. In October 2022, the local ambulance service had reported up to 143 hours lost to delayed admissions at the University Hospital Aintree ED. In 2023, this figure had been consistently low with most weeks having no hours lost to delayed admissions.

At a previous inspection we said the service should ensure clear interpretation of the RCEM guidance around consultant response times. In September 2023, 42.1% of patients received a clinical review within 60 minutes compared to 23.7% regionally and 31.3% nationally. This was an improvement from 26% from January to September 2022. Of the 4 patient care records that we reviewed, all of the 4 patients received a clinical review within 60 minutes. However, on the day of our inspection, the longest wait for a clinical review was 7 hours and 49 minutes.

The National Institute for Health and Care Excellence (NICE) recommends that patients with suspected sepsis should receive antibiotics within 1 hour. The most recent data available at the time of the inspection was from June 2023 when 61.9% of patients received antibiotics within 1 hour which was better than the regional average and was an improvement from 26.7% in July 2022.

Staff and leaders acknowledged that sepsis performance needed improvement. The trust had implemented a dedicated sepsis improvement programme overseen by the Chief Medical Officer and several changes had already been implemented which had resulted in the improvement in compliance.

The electronic patient record system automatically initiated the sepsis pathway if a patient had a high NEWS2. Staff could also manually initiate the pathway if required. Clinicians in the department were able to see an overview on the system of all patients on the sepsis pathway.

A sepsis nurse was present in the department from Monday to Friday, 9am to 5pm. They supported staff to deliver safe and timely care to patients with suspected sepsis and delivered tailored training to staff in the department.

Staff used a patient safety checklist to ensure the fundamentals of care were monitored for patients in the department. The checklist was developed to provide assurance that risk assessments were completed in a timely way and to monitor compliance with intentional rounding. As part of the trust improvement plan, a fundamentals of care collaborative was being led by the trust Chief Nurse. All staff we spoke with were aware of this programme of work and spoke passionately about some of the quality improvement work that was ongoing in the department.

We reviewed 4 patient care records and found that risk assessments were completed in a timely manner for all 4 patients. However, data showed that across the trust completion rates for falls risk assessments and pressure areas assessment had improved but was still below target. In July 2023, 72% of patients admitted to the trust had a pressure ulcer risk assessment completed within 6 hours of admission. This had improved from 65% in September 2022 but was below the trust target of 90%. In July 2023, 77% of patients had a falls risk assessment completed within 6 hours of admission. This was an improvement from 66% in September 2022 but was below the trust target of 90%.

Urgent and emergency services

Is the service responsive?

Inspected but not rated

Access and flow

Effective processes in relation to access and flow were in place and staff and leaders worked well together to deliver safe care in a timely way. However, wider system issues were impacting on the trust's ability to discharge patients from the hospital which meant that there were often significant delays admitting patients onto wards. Waiting times had improved but were not always in line with national standards.

During our inspection, we saw staff streaming patients to GP services, the medical and surgical assessment units and other appropriate services. Of the 255 patients who attended the department on the day of our inspection, 105 were admitted to hospital. All other patients were seen by alternative services or treated and discharged from the emergency department.

There were multiple pathways available for patients to be seen and there was a clear focus on admission avoidance. When we spoke with divisional leaders they told us about the plans they had for the future to further develop services and pathways to ensure patients received the right care in the right place.

Expected waiting times were displayed in the department and regularly updated by reception staff**.**

During our inspection, clinical staff demonstrated that they had good oversight of all patients in the department, including those in the waiting room. We observed those staff prioritising patients with the most urgent care needs.

The clinical leads in the department utilised the electronic patient system which allowed them to see the status of each patient. All patients were discussed at 2 hourly board rounds which were attended by the lead clinicians in the department. The nurse in charge of the department had an emergency department co-ordinator communication booklet which they used to record the board rounds and any actions they had taken to manage the safety of the department.

By March 2024, NHS England expects providers to achieve 76% of all patients spending less than 4 hours in ED. On 17 September 2023, 66.5% of patients spent less than 4 hours in the ED at the University Hospital Aintree, compared to a regional average of 68.6% and an England average of 68.8%. However, performance had been variable, and improvement was needed to achieve and maintain the 76% target.

In July 2023, the number of patients spending more than 12 hours from a decision to admit to admission at the trust was 10.9% which was worse than the trust target of no more than 2%. On the day of our inspection, the department was very busy and there were 19 patients being cared for on the corridor. One patient had waited over 45 hours for a bed at another healthcare facility. Leaders had initiated the trust full capacity protocol and actions had been taken in accordance with the protocol to maintain the safety of the department. Despite, the lack of capacity in the department and the pressure the staff were under, we were able to see that staff and leaders had good oversight of all patients in the department, including those in the waiting room and we did not identify any safety concerns. We observed staff prioritising patients with the most urgent care needs. All patients who had waited a long time in the department were discussed by the multi-disciplinary team at 2 hourly board rounds and bed management meetings to maintain safety.

Urgent and emergency services

Patients who were deemed medically fit but were waiting for a bed in a mental health facility were often kept in the department for long periods rather than being admitted to a ward. Staff and leaders told us that if patients were admitted to a ward, the delays for a bed in a mental health facility were often longer as they were considered to be in a place of safety. Staff and leaders acknowledged that this was not the best environment for patients with mental health conditions to be cared for, but they felt it was safer than the acute ward environment and mitigations were in place to ensure that patients were safe and cared for during the delays. We saw staff delivering safe care and treatment to mental health patients in the department during our inspection. Department and hospital leaders were working with system partners to improve pathways for patients with mental health problems.

At the time of our inspection, the trust had a high number of admitted patients with no criteria to reside due to issues with capacity in adult social care and community services. This inability to discharge people from the hospitals meant that flow throughout the trust was an issue. Hospital and trust leaders were working collaboratively with system partners to improve this. Each hospital site had a flow improvement plan which was overseen by trust leaders as part of the trust improvement plan.

The University Hospital Aintree flow improvement plan had 4 workstreams which focused on areas for improvement. Each workstream had a nominated senior responsible owner. Relevant system partners were involved in the workstreams, actions were identified, and progress was being measured. Risks related to the flow improvement plan were clearly identified and actions were in place to mitigate the risk.

On the day of our inspection 255 patients attended the emergency department. Of these, 25 patients left the department without being seen. There was a trust policy in place for absconding patients dated February 2023. The policy included a flow chart for staff to follow in the emergency department which included a clinical risk assessment taking place to determine what action was needed. We saw posters on display in the department asking patients to notify staff if they intended to leave before being discharged.

Is the service well-led?

Inspected but not rated

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Risks were captured on a divisional risk register and were rated in terms of likelihood and consequence. The trust had risk management processes which meant that risks were escalated appropriately from the department up to board level when required.

The trust had recently commissioned an independent review of leadership and governance at the trust including risk management. The report identified that the trust has adopted a sophisticated approach to using risk management tools and a strong risk management structure.

Risk management was included in the trust improvement plan to ensure that clear processes were in place so that ‘risks and issues could be transparently escalated and managed from ward to board’.

Urgent and emergency services

Staff and leaders at all levels demonstrated a good understanding of the risks within the department and the action being taken to mitigate or remove risks. We discussed the top risks for the service with the leadership team. During our inspection, we were able to see the associated mitigations and actions in action and found them to be effective.

We saw that there was a strong focus on risk management within the department. Risks were discussed at safety huddles, board rounds and bed management meetings and staff and leaders were proactively managing and escalating any concerns.

Department, division and hospital leaders had access to live data which meant they could be proactive in managing performance in real time. In addition, a programme of audits was in place to support this. We saw staff and leaders utilising systems to support them to keep patients safe and they worked collaboratively with teams in other divisions to balance risk across the hospital and trust rather than working in silo.

Staff and leaders were realistic about the performance and were open about the challenges they faced and how they planned to continue to make improvements to safety and quality. All staff and leaders we spoke with demonstrated a passion for improving patient safety and experience.

Areas for improvement

MUSTS

Urgent and Emergency Care

- The trust must ensure that work continues to improve patient access and flow through the hospitals. This includes but is not limited to ensuring patients can access the service when they need it and patients do not stay longer than they need to. Regulation 12(1)
- The trust must ensure that improvement work continues to deliver safe care and treatment to patients with suspected or confirmed sepsis. Regulation 12(1)
- The trust must ensure that work continues to improve performance against national urgent and emergency care standards; including time to triage, time to clinical review, and time in the department. Regulation 17(2)(a)

SHOULDS

Urgent and Emergency Care

- The trust should ensure that work continues to improve compliance with, and the timely recording of patient observations (NEWS2). Regulation 17(2)(a)
- The trust should consider working with system partners to improve care pathways for patients who attend the emergency department with a mental health condition who need to be transferred to another place of care.

Our inspection team

The inspection team was made up of 1 Operations Manager and 1 Inspector. As part of this inspection, we observed care and treatment of patients in waiting, triage and treatment areas including patients being cared for on the corridor. We looked at 4 care records. We spoke with 6 staff members across the department, observed board rounds and interviewed the divisional leadership team. We also observed a bed management meeting. You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance