Care Quality Commission

Aintree University Hospital NHS Foundation Trust

University Hospital Aintree

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
Accident and emergency	Good
Medical care	Good
Surgery	Good
Intensive/critical care	Good
End of life care	Good
Outpatients	Good

Summary of findings

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Summary of findings

Overall summary

Aintree University Hospital is a large teaching hospital in Liverpool with 706 inpatient beds, serving a population of around 330,000 in North Liverpool, South Sefton and Kirkby. The hospital provides care and treatment for people living in some of the most deprived areas in England.

The hospital provides a full range of acute services and also works with partners to provide a range of services in community settings including rheumatology, ophthalmology and alcohol services. Tertiary services provided by the trust include respiratory medicine, rheumatology, maxillofacial and liver surgery.

The hospital is one of the largest employers locally with more than 4,000 whole time equivalent staff. The trust gained foundation trust status in 2006 (one of the first hospitals in Merseyside) and has more than 13,000 public and staff foundation trust members.

The hospital is well supported by the local community and has more than 800 volunteers. The Volunteer Department provides a well-respected service with local and national recognition, particularly for its positive contribution to the patient journey and development opportunities for the local population.

All the patients we spoke with were positive about their care and treatment at the hospital. Patients felt that they were well cared for and staff treated them with dignity and respect.

There were effective systems in place to prevent patients suffering pressure ulcers, falls, blood clots and hospital acquired infections.

Staff were trained in identifying abuse and neglect and knew how to report concerns of this nature.

Operating theatre staff were undertaking the 'five steps to safer surgery' procedures, and used the World Health Organization (WHO) checklist. However, we found examples of the safer surgery checklist not being completed appropriately in all theatres and have asked the hospital to take action to correct this.

Staffing

All the wards and departments we inspected were adequately staffed. Staff had access to training and development opportunities to improve their knowledge and skills and develop professionally.

Staff were committed and enthusiastic about their work and worked hard to ensure that patients were given the best care and treatment possible. There were good examples of policy and practice being changed as a result of learning from patient experiences. Staff were well supported by their managers and felt confident in raising concerns with them.

Staff sickness rates were below the national average.

Staff were well led at both a local and trust wide level. There were a number of initiatives in place to engage staff in developing future plans for the hospital. The Chief Executive was highly visible and staff were encouraged to share their ideas and suggestions for improvement.

Cleanliness and infection control.

The hospital was clean throughout and there was good practice in the control and prevention of infection. Practice was supported by staff training and a hospital wide control of infection team.

The hospital infection rates for C.difficile and MRSA infections lie within an acceptable range for a hospital of this size

Medicines management

There were good systems in place to manage medicines and ensure that patients' medicines were provided in a timely way.

Complaints management

When we carried out this inspection we worked with colleagues from the Patients Association and looked at how complaints were managed in the trust, as we had identified concerns about complaints management in our previous inspection in September. It was evident that considerable work has been carried out to date to make improvements and that patients were now receiving

Summary of findings

timely and well considered responses to their complaints. However, this work needs to continue with pace and vigour so that the trust can be assured that complaints are managed effectively on a consistent basis.

Many patients did not know how to make a complaint and there was a lack of accessible information about making a complaint in many of the wards and departments we inspected.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Good

We found that the hospital was a safe place to receive care and treatment. There were good systems in place to prevent patients suffering harm from pressure ulcers, falls, blood clots and hospital acquired infections. Overall the trust was performing below the England average for in patient harm based on national performance indicators

The hospital was clean and well-maintained. There was a system for reporting safeguarding concerns that was supported by staff training. Staff were supported to report and learn from clinical incidents and there was evidence of learning and improvement from incidents to improve patient safety.

Are services effective?

Good

Care and treatment was delivered in accordance with national best practice guidelines and there were regular audits to monitor the quality of the services provided to patients. Where shortfalls were identified the hospital had responded positively and took action to address them. There were good examples of practice changing and improving as a result of audit findings that were making services more effective.

Multi-disciplinary teams worked collaboratively to secure effective treatment for patients in their care.

Are services caring?

Good

Patients were treated with dignity and respect and they were positive about their care and treatment. Patients told us that staff were caring, compassionate, polite and helpful.

National surveys supported this view with the exception of A&E, where patients had reported instances of poor attitudes from staff, Although patients we spoke with at the time of our inspection were pleased with the way staff had treated them in the department.

Are services responsive to people's needs?

Good

Overall, Patients' needs were met in a timely way. After targeted improvement work the hospital was meeting the national target for waiting times in A&E. Patient referral to treatment times were within acceptable limits. Similarly the number of cancelled operations and delayed discharges were within acceptable ranges for a hospital of this size. The hospital is still experiencing some difficulties in outpatients in relation to booking, cancelling and rearranging appointments and the hospital had work underway to improve this element of the outpatient's service. We found good examples of services making positive changes to meet patient's needs.

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Are services well-led?

Good

Staff at the hospital were well led and supported by their managers. The Chief Executive was highly visible and staff felt that they were listened and responded to. There were a number of initiatives in place to engage staff in developing future plans for the hospital and suggestions and ideas were encouraged by the management team. Staff were proud of the work they did and there was a sense of enthusiasm and optimism in the hospital.

Summary of findings

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

Accident and emergency

Good

The trust had worked hard to improve its performance in meeting the government's 95% target for admitting, transferring or discharging patients within four hours of their arrival in A&E. The trust was now meeting the target and seeing over 95% of patients within the four-hour timescale. Initiatives were in place to respond to patient need and to ensure patients were seen in a timely manner.

There were sufficient numbers of staff on duty to meet the needs of patients. Patients were cared for in accordance with good practice guidelines. Medical, nursing and allied health professionals worked well together as a team.

There were specialist support teams for people with mental health problems and for people who abused alcohol or drugs that meant patients were seen by appropriate professionals in a timely way.

There were processes in place to monitor the quality of the service and respond to areas highlighted as requiring improvement. Learning from incidents was shared among the staff team. Staff were supported and encouraged to attend training courses to further their skills and knowledge in order to improve the service provided to patients.

Medical care (including older people's care)

Good

Patients on medical wards received care that was safe, effective, caring, responsive and well-led. There were sufficient numbers of skilled and trained staff to meet their needs in a timely way. Infection control, pressure ulcer prevention and medicines management were well managed and monitored.

Discharge coordinators were available on the medical wards and liaised with colleagues to enable patients to be discharged home without undue delays. Patients were positive about their care and felt staff treated them with respect and maintained their privacy and dignity. However, the service needs to further develop the 'forget me not' scheme so that staff fully understand its application for the care of patients with dementia.

Surgery

Good

There were effective systems and processes in the surgical ward and theatres to provide safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care. We found one instance where controlled drugs were not appropriately stored in line with national guidance.

The surgical services followed national clinical guidelines and staff used care pathways effectively. The trust took part in national and local clinical audits. The staffing levels and skills mix was sufficient to meet patients' needs. Patients were supported with the right equipment. Patient records were

Summary of findings

completed appropriately. We found that staff had a good understating and demonstrated good compliance with the World Health Organization (WHO) theatre checklist but further improvements could be made to ensure patient safety.

Patients spoke positively about their care and treatment. There were systems in place to support vulnerable patients. There was sufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of care.

There was effective teamwork and clearly visible leadership within the critical care services. Staff were appropriately supported with training and supervision and encouraged to learn from incidents

Intensive/critical care

Good

The critical care department at the hospital was providing safe and effective care. There were sufficient numbers of competent staff in place to meet patients' needs in accordance with national guidance.

There was senior medical expertise available to patients over 24 hours, seven days a week. Multi-disciplinary team working was well established that supported optimal care for patients. Care was planned and delivered to meet individual needs.

Staff were caring and compassionate, patients and relatives spoke highly of the care they had received.

The Intensive Care Unit was the base for a medical emergency outreach team that was able to provide expert advice to help staff manage patients in all wards and departments whose conditions had deteriorated.

End of life care

Good

The hospital followed end of life care pathways that were in line with national guidelines and staff used care pathways effectively. There were enough staff with the right skills to meet patients' needs on the wards,

Care for patients at the end of life was supported by a consultant led specialist palliative care team.

Nursing and care staff were appropriately trained and supervised and they were encouraged to learn from incidents. Staff were clear about their roles and benefitted from good leadership. Care was given by supportive and compassionate staff.

Relatives of patients who received end of life care spoke positively about the care and treatment patients received and they told us patients and their relatives were treated with dignity and that their privacy was respected.

However, we found that staff in the mortuary and bereavement service felt that staff shortfalls had impacted on the quality of service they provided to grieving relatives.

Summary of findings

Outpatients

Good

Overall patients received safe and appropriate care in the department. The outpatient areas were clean and well maintained and measures were taken to control and prevent infection. The outpatient department was adequately staffed by a professional and caring staff team

Staff working in the department respected patient's privacy and treated patients with dignity and respect. Patients told us they were generally satisfied with the service they received.

However, we found that waiting times for appointments were long in some departments and there will still considerable numbers of cancelled and rearranged appointments.

The trust reported three serious incidents that occurred in the department between December 2012 and November 2013 that resulted from outpatient appointment delays. This had resulted in delayed diagnosis for three patients when treatment could have been provided at an earlier date. We saw the hospital had investigated the causes of these incidents and had introduced improvements to prevent this type of incident happening again.

Summary of findings

What people who use the hospital say

Inpatient and Accident and Emergency Friends and Family Test

The hospital was performing well above the England average for the Inpatient tests and significantly below for A&E for the period September to December 2013. The response numbers were significantly higher for the trust in the A&E data and for the inpatient test, compared with the England average for 2012/13.

Cancer Patient Experience Survey 2012/13

Out of 69 questions, the trust was in the bottom 20% nationally for 24 questions in the Cancer Patient Experience Survey. They were in the top 20% for one question and this was around "patient had confidence and trust in all doctors treating them".

National Bereavement Survey 2011

The Merseyside PCT cluster was among the top 20% of all PCT clusters nationally for six of the 26 questions in the National Bereavement Survey.

NHS Choices

Aintree University Hospital had an overall score of 3.5 stars out of 5 stars for the period January 2013 to January 2014. Negative themes from the comments included incorrect information being provided, nurse to patient ratios, A&E and unprofessional/arrogance of staff.

Patients' views during the inspection

All of the patients we spoke with during our inspection were very positive about the care and treatment they had received at the hospital. Patients felt that their needs were met by caring and compassionate staff.

Patients were very positive of the support they received from the volunteers in the hospital, who worked hard to support patients on their hospital journeys.

Listening event

We held a public listening event on 4 March 2014. Members of the local community attended the event and shared with us their care experiences. Some people raised concerns about the way the trust had responded to complaints, with particular reference to the length of time the hospital took to reply. Members of the deaf community shared with us their concerns that the hospital could do more to meet their communication needs better. Some people were still pursuing complaints about their care and treatment. Others were positive about their experience.

Areas for improvement

Action the hospital SHOULD take to improve

- Relaunch the 'forget me not' dementia care initiative in the medical wards.
- Ensure that staff are consistently completing the 'safer surgery' checklist appropriately.

Good practice

Our inspection team highlighted the following areas of good practice:

- There were good examples of innovative practice in Critical Care and in the provision of the transition service for young adults with arthritis (in partnership with Alder Hey Children's Hospital).
- There was good practice in the Surgical Assessment Unit that was improving patient outcomes and reducing mortality.
- The Volunteer project was an excellent example of including members of the local community in development opportunities.

University Hospital Aintree

Detailed Findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliffe Consultant Surgeon

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The inspection team had 30 members including medical and nursing specialists, experts by experience, lay representatives and eight CQC inspectors.

Background to University Hospital Aintree

Aintree University Hospital NHS Foundation Trust is a large teaching hospital in Liverpool with 706 inpatient beds serving a population of around 330,000 in North Liverpool, South Sefton and Kirkby. Aintree is one of the largest employers locally with more than 4,000 whole time equivalent staff. The trust gained Foundation Trust status in 2006, one of the first hospitals in Merseyside to do so and has over 13,000 public and staff members.

Currently, the trust has only one location, the Aintree University Hospital that is actively registered with the Care Quality Commission. The hospital provides 24 hour Emergency Department, Outpatients Department, a comprehensive range of elective and non-elective medical and surgical inpatients, Coronary Care Unit, Endoscopy Unit, Day Care Unit, Intensive Therapy Unit (ITU).

The trust also works with partners to provide a range of services in community settings including rheumatology, ophthalmology and alcohol services. Other tertiary services provided by the trust include respiratory medicine, rheumatology, maxillofacial and liver surgery.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme.

We chose this trust as a high risk trust as we knew that there were challenges relating to the delivery of services.

On 29 September 2013, we carried out a scheduled unannounced inspection of the trust and we found that the trust had systems and processes in place for governance and risk management. However, the implementation and quality of the systems was variable. Risk Management was a particularly poor area at all levels of the organisation, as was the timeliness to put in place risk reduction measures to prevent serious incidents reoccurring. We judged that this was a breach of Regulation 10 of the Health and Social

Detailed Findings

Care Act 2008 (Regulated Activities) Regulations 2010 and that this had a major impact on people who use the hospital. Consequently we served a notice warning the trust it must take action to secure improvement

We followed up the warning notice and the actions the trust had taken as part of this inspection.

We found that the trust had made significant progress and met the requirements of the notice at the time of our inspection. However, we will continue to monitor the trust closely to ensure that the improvements are embedded and sustained.

How we carried out this inspection

In planning for this inspection we carried out a detailed analysis of local and national data sources that was used to inform our approach and enquiries. The trust was given an opportunity to review the data and comment on its factual accuracy. Corrections were made to the data pack in light of the response.

We also sought and viewed information from national professional bodies (such as the Royal Colleges and central NHS organisations), as well as views from local stakeholders such commissioners of services and the local Healthwatch Team.

Our inspection model focuses on putting patients and those close to them at the heart of every inspection. It is of the utmost importance that the experiences of patients and families are included in our inspection of a hospital. To capture the views of patients and those close to them, we held a public listening event prior to the inspection on Tuesday 4 March. This was an opportunity for people to tell us about their individual experiences of the hospital and we used the information people shared with us to inform our inspection.

We also received information and supporting data from the trust and before and during the inspection.

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

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

The inspection team inspected the following core services as part of the inspection

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- End of life care
- Outpatients

As part of our inspection we spoke with patients in each of the service areas and actively sought their views and the views of those close to them so we could develop a rich understanding of the services provided at the hospital. We held a number of well attended staff focus groups as well as interviews with the senior management team and Board. We looked closely at staffing levels and spent time examining notes and medical records. We also checked departmental records for cleaning and maintenance checks.

We also returned to the hospital unannounced on Monday17 March 2014 and returned to theatres and the Surgical Assessment Unit (SAU)

Good

Accident and emergency

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

Information about the service

The emergency department at Aintree University Hospital consisted of two main areas, the Accident and Emergency (A&E) department and the medical admissions unit (MAU).

The A&E department provided a consultant led 24-hour service, seven days a week. It was the second biggest and second busiest in Merseyside. In the year 2011 to 2012, 85,966 patients were seen.

The A&E consisted of an initial reception and booking-in / waiting area, a triage room and five see and treat cubicles and one cubicle dedicated for children. There were three examination cubicles and a therapy department, managed by therapists, that was linked to the triage area. The major's area consisted of 10 single cubicles with trollies, of which three could be used for isolation, and five beds for ambulance drop off patients. There were six beds designated specifically for trauma patients.

Two six-bedded clinical decision units were attached to the A&E where patients awaited results and received further treatment if required.

The medical admissions unit (MAU) was split into two areas; firstly the seated area consisted of four trollies and 20 seats where patients with GP referrals or medical referred ambulatory A&E patients were seen. The MAU ward area consisted of 38 beds in total split into two medical assessment bays (MAB) consisting of 13 beds, four MAU bays consisting of 25 beds including three single rooms.

We talked to 14 patients and 5 relatives or carers and 18 staff including doctors, nurses, consultants, senior managers, therapist, support staff and ambulance staff. We observed care and treatment and looked at care records, returning to the department at a variety of times and on a number of occasions.

We reviewed comments from our listening event and from people who contacted us to tell us about their experiences. We also reviewed many items of the trust's own quality monitoring information and data.

Good

Accident and emergency

Summary of findings

Trusts in England are tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. The hospital was achieving the target the majority of the time, albeit for five major points between December 2012 and April 2013 where there was a sharp decline in the figures: Dec 2012 87.2%, Feb 2013 87.6% and 85.1%, Mar 2013 86.6% and Apr 2013 80.4%. After April the hospital fluctuated above and below the target. However more recently in December 2013 they performed above the target and England average at 99.7%. The hospital had worked hard to improve its performance in meeting the government's 95% target for admitting, transferring or discharging patients within four hours of their arrival in A&E.

Initiatives were in place to respond to patient need and to ensure patients were seen in a timely manner.

There were sufficient numbers of staff on duty to meet the needs of patients. Patients were cared for in accordance with good practice guidelines. Medical, nursing and allied health professionals worked well together as a team.

There were specialist support teams for people with mental health problems and for people who abused alcohol or drugs that meant patients were seen by appropriate professionals in a timely way.

There were processes in place to monitor the quality of the service and respond to areas highlighted as requiring improvement. Learning from incidents was shared among the staff team. Staff were supported and encouraged to attend training courses to further their skills and knowledge in order to improve the service provided to patients.

Are accident and emergency services safe?

Good

Safety and performance

The department was well staffed with appropriate numbers of suitably qualified staff to meet patient's needs. Nursing and medical staff worked closely as a team for the benefit patient care.

Staff were assigned to each of the patient areas within the department. The department was set out so that ambulatory patients could always be seen by staff and high risk patients were closest to the nursing station so they could intervene quickly if required.

The staffing arrangements in the MAU area were similar, each patient bay area had a nurse and healthcare assistant assigned. One four bedded bay area was set up for patients with higher care needs and was designated as a mixed sex bay area with adequate segregation to meet mixed sex accommodation requirements.

The public notice boards in each area of the department identified the staffing levels that should be assigned to the ward areas and the actual staffing levels. On the days of inspection the A&E department was short by four qualified nursing staff and the MAU was short by two. These were due to last minute sickness; however, prompt action was taken to address the shortfalls so that safe staffing levels could be maintained. The emergency department and MAU had only 2 staff vacancies that were currently being covered by bank and agency staff when required.

The department was clean, well-maintained and in a good state of repair. Staff were aware of current infection prevention and control guidelines and we observed good practices, such as:

- Hand washing facilities and alcohol hand gel available throughout the ward area
- Staff following hand hygiene and 'bare below the elbow' guidance
- Staff wearing personal protective equipment, such as gloves and aprons, while delivering care
- Suitable arrangements for the handling, storage and disposal of clinical waste, including sharps

- Cleaning schedules in place and displayed throughout the ward areas
- Clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

There were ample supplies of suitable equipment. The resuscitation room had six cubicles designated for trauma that were all well-equipped. We saw equipment in place for specific procedures that may only be carried out several times a year. All the equipment we saw was serviced and well maintained.

Staff were confident about reporting serious incidents and providing information to the ward manager (MAU) and matron if they suspected poor practice that could harm patients or staff.

Incidents of concern were reported by staff on the electronic incident reporting system. All the staff knew how to report incidents and could describe the action they would take. In addition, staff were able to describe recent incidents and clearly outline what action had been taken. Once reported, incidents were reviewed by the ward manager and the Matron for each area (A&E and MAU) before they were investigated. We saw that all members of the multidisciplinary team were involved in root cause analysis investigations and action plans had been developed and implemented to prevent reoccurrence.

The departmental risk register included risks and ratings identified for the emergency department; progress and improvements were monitored through a regular quality committee meeting and fed back at divisional, departmental and at executive level.

Serious incidents known as a "Never Events" (classified as such because they are so serious that they should never happen) and there is a requirement to report these nationally. In A&E there were no never events reported for the emergency department between December 2012 and November 2013.

Information relating to patient safety was displayed on notice boards in the areas we inspected. This provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents. The notice board reported that there had been no healthcare associated infections for Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium Difficile (C.diff) attributed to the A&E and the MAU areas since January 2013.

Information highlighted by the NHS Safety Thermometer assessment tool (used by frontline staff to measure a snapshot of these harms to patients once a month) identified there had been 5 falls in January 2014 and no pressure ulcers in the MAU since April 2013.

Staff we spoke with were aware of the safeguarding policy and knew how to escalate concerns 96% of staff had received safeguarding training.

The A&E had a Safeguarding link nurse who worked with all the specific teams to ensure patients were not at increased risk of neglect or abuse. Staff we spoke with confirmed they knew about the safeguarding lead and all the staff we spoke with were fully aware of the services that were being offered and knew who to contact when required.

Patient records were kept securely in trolleys and we were able to follow and track the patient care and treatment easily as the records we reviewed were well kept, up to date, and accurately completed. In addition staff were able to easily locate and obtain any additional notes we required when conducting our patient record review

Learning and improvement

Incidents were reported using the trust incident reporting system, trends and themes were identified by the governance lead for the division and shared with the senior team. Action resulting from complaints or serious incidents was cascaded to the department. A variety of methods were used to ensure that information had been cascaded including newsletters and briefing sessions.

Staff were able to demonstrate changes in practice as a result, for example, in the MAU area a patient who had capacity was discharged home without his family being made aware. However, on the way home the patient's mental capacity changed. As a result, a specific discharge list was implemented to ensure families or relatives were contacted before anyone was discharged from the department.

The staff we spoke with reported that they had received mandatory training in areas such as infection prevention

and control, moving and handling, and health and safety. The 2014 central log for mandatory training confirmed that nearly all staff working in the department had attended required mandatory training.

Although departmental records showed that not all staff had received appraisals, most of staff we spoke with reported they had received an appraisal within the last year. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. Information provided by the trust identified that 65% of staff had started their appraisal process. However it was noted that the trust had already begun to take action to improve its performance in this area.

Although mechanisms were in place for staff to receive clinical supervision, there were inconsistencies in practice. Some staff had not received any clinical supervision and others expressed concern in regards to the lack of structure of the supervision they had received

Systems, processes and practices

There were policies and processes in place regarding incident reporting and these were available for staff to refer to. Staff were routinely monitoring quality indicators such as falls, pressure ulcers and healthcare associated infections. There were also systems and processes in place to identify and plan for patient safety issues in advance, such as staffing shortfalls and bed capacity both within the department and throughout the hospital.

Staff were familiar with the reporting systems for incidents. Senior staff were identified as the people responsible for reporting incidents on the electronic system. However, all staff were confident in relation to the identification of 'near miss' incidents and how to report them.

A patient experience report was produced on a monthly basis for the Board and provided an overview of patient experience across all wards and departments. This report included an update on actions to date relating to issues raised from internal audits, patient surveys and complaints. The report outlined individual complaints and how they had been dealt with as well as key learnings to be shared.

Monitoring safety and responding to risk

Where staff identified potential concerns relating to patient safety, these were assessed and recorded on the directorate risk register, The directorate risk register identified concerns regarding staffing arrangements in the department and the actions that had been taken to mitigate the risks.

All patients admitted to the emergency department underwent screening for Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA). This screening was used to identify those patients who were at 'high risk' of acquiring MRSA so these risks could be minimised. Results were recorded in patient notes so other professionals, such as the patients GP, were also able to plan appropriate aftercare if required.

Staff carried out risk assessments in order to identify patients at risk of harm at the time of their admission and these included: venous thromboembolism (VTE), pressure ulcers, falls and infection control risks. Care pathways and care plans were in place for those patients identified to be at high risk, to ensure they received an appropriate level of care.

Staff we spoke with were aware of a range of risk assessments that were undertaken to ensure both patients and staff were managed in a safe environment. These included: ward environment; lone working; manual handling; Control of Substances Hazardous to Health (COSHH) and ward security.

Anticipation and planning

An Urgent Care and Trauma Centre was being built on the hospital site with an estimated completion date of 2016. The project aimed to create a Cheshire and Merseyside Major Trauma Centre Collaborative between Aintree's Emergency Department along with the Royal Liverpool Hospital and the Walton Centre. However, the future status of the trauma and stroke care was an issue strategically for staff with the emergency department. There were concerns around the sustainability of the senior staff pool as the project moved forward. One member of staff said "It feels like it's all up in the air".

Good

Accident and emergency

Are accident and emergency services effective?
(for example, treatment is effective)
Not sufficient evidence to rate

Using evidence-based guidance

Care and treatment was evidence based and followed recognisable and approved national guidance such as the National Institute for Health and Clinical Excellence (NICE) and nationally recognised assessment tools. These could be accessed via a web based electronic system. We observed patient care and then tracked the guidance for dealing with head injuries that confirmed the care of the patient followed NICE guidelines.

Policies and guidance were available to all staff electronically via the intranet and in paper format at ward level. They reflected national guidance with appropriate evidence and references. Staff we spoke with could locate policies we asked for and were aware of the content. This included the guidance for admitting and discharging patients within the emergency department.

Staff were using care pathways such as the falls pro-forma, obstetric history form and the nursing assessment documents that reflected evidence based guidance for effective risk assessment and care management. There were tools for risk assessing patient risks in terms of pressure ulcers, falls, infections and early warning tools to monitor the patient's condition so that if the patient's condition deteriorated then medical staff could be alerted quickly. These pathways were put into action as soon the patient entered the department that meant patients were seen and treated effectively by the appropriate staff and that diagnostic tests were carried out and results reviewed promptly.

We looked at care plans, clinical guidelines and observed patient care to confirm that care was planned in accordance with best practice as set down by national guidelines.

Performance, monitoring and improvement of outcomes

Performance and delivery of this service was included within the quality and safety board report for senior leaders. Performance data included outcomes of clinical audit activity. Staff we spoke with were aware of the current outcomes and this information was clearly displayed on ward notice boards.

There were clear action points in place to address actions that had been learnt from incidents and actions were assigned to specific staff members and cascaded into service areas. Learning points were also shared to all staff. An example of a positive change resulting from an audit was the pathway for patients with a fractured neck of femur was changed to include more pain relief for patients.

Clinical practice was monitored through audits such as HII and NHS Safety Thermometer Programme indicators.

Staff, equipment and facilities

Staff were positive regarding recruitment practices and told us that the induction was helpful to new starters. Staff worked in a supernumerary capacity until completion of their induction. We found that professional body registration checks took place at the time of initial recruitment and annually.

Staff from a wide range of disciplines including nursing, medical, therapy and support staff felt positive about working in the department and described access to training as good.

Staff told us there was access to mandatory training study days. They told us that the content was appropriate and included infection prevention and control, moving and handling, medicines management and health and safety. The electronic training record confirmed that most staff had completed required mandatory training

Multidisciplinary working and support

While care delivery was predominantly consultant led, we saw effective collaboration and communication among all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Daily MDT meetings, involving the nursing staff, therapists, medical staff as well as social workers and safeguarding leads, where required, ensured the patient's needs were fully explored. This included identification of the patients existing care needs, relevant social / family issues, mental capacity as well as any support needed from other providers on discharge, such as home care support or alcohol rehabilitation.

Good

Accident and emergency

We observed staff working well together, healthcare professionals valuing and respecting each other's contribution into the planning and delivery of patient care.

Communication between staff was effective, with staff handover meetings taking place during daily shift changes. We heard staff handover discussions that included information regarding risks and concerns relating to each patient of each patient. Discharge plans were also discussed as well as any issues that required follow-up. Formal hand over sheets were completed for each patient to ensure consistent information sharing took place.

Electronic patient records that detailed current care needs were available for all patients ensuring staff were fully informed of the patient's diagnosis and current physical and emotional needs

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

There was mixed feedback from patients about their experiences of the hospital. Many patients and their relatives were positive about the care and treatment they had received in the emergency department. Patients told us "The staff are fantastic and nothing is too much trouble" and "Ten out of 10 for the staff and doctors". Although there was a 100% positive patient experience in the MAU, there was some negative feedback in the A&E which included "Some of the staff have a poor attitude" and one patient, who had sat in a chair for a long period, said "I am happy with the care but not the 15 hour waiting time in the MAU". The attitudes of staff in the A&E department have been raised as a concern to us before both by patients and local focus groups.

The Friends and Family Test (asks a standard question: "How likely are you to recommend our ward to friends and family) was conducted at Aintree University Hospitals NHS Trust between August 2013 and November 2013. The results were consistently poor for the A&E meaning that patients were less inclined to recommend the department to friends and family. In the December 2013 inpatient survey, the MAU was included and was one of the five wards that people would be 'Extremely Unlikely' to recommend. Contrary to this, the majority of patients we spoke with were complimentary about the care they were receiving and the staff delivering care. On the other hand, however, the trust performed 'about the same' as other trusts for the questions in the CQC Adult Inpatient Survey that related to the Emergency Department.

We saw that staff treated patients and visitors with dignity, respect and compassion. We observed staff being conscious of maintaining patient dignity, especially when transferring people between areas. One patient said "My experience has been smashing, I can't fault the staff. Everyone's very good and caring".

We observed staff treating people with compassion and empathy. An A&E consultant told us their parent had been a patient in the emergency department and had felt the care received was very compassionate.

Compliance with same-sex accommodation guidelines was ensured in the MAU through the designation of single sex bay areas and in the A&E area whereby cubicles were all designated for single accommodation with privacy curtains. Ample provision of toilet and bathing facilities were observed in the emergency department. We observed curtains being drawn around each bed prior to the delivery of care and during private discussions with patients in regards to their care.

Involvement in care and decision making

We found that relatives and /or the patient's representatives were also consulted in discussions about the discharge planning process. In the MAU relatives were informed of potential discharge dates and patients and relatives had discussions with members of the multidisciplinary team to ensure a smooth transition home following discharge from hospital.

Staff had a good understanding of consent and were skilled in explaining to patients the benefits, side effects and complications of proposed treatments and procedures. Staff had received training about seeking consent from patients and were comfortable and competent in doing so. We observed positive interactions between staff, patients and /or their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care and treatment being delivered.

Good

Accident and emergency

Patients and their families were involved in, and were central to, decision making about their care and support.

Trust and communication

Patients individual needs were managed in a thoughtful way and staff worked hard to protect patient's privacy and dignity and secure their trust. For example, when patients had to be isolated, staff promoted the patients confidentiality and placed a sign on the door stating "Please speak to the nurse in charge before entering" rather than highlighting the patient's condition.

Staff communicated openly and honestly with patients and responded to their questions in an appropriate manner. For patients who had particular communication needs, staff would seek support so the patient could be kept informed and understand what was happening to them. Staff could access a translation service for patients if English was not their first language. Some staff within the hospital also spoke different languages and could also be called on to support patients if required. The ward manager told us there were also two staff who could communicate with deaf people using British Sign Language (BSL). However, staff on the ward were not aware of any specific support provided for this group of patients.

The mandatory training log for January 2014 noted that 96% of staff had received safeguarding & equality training. Staff applied this training when planning a patient's care, as the care planning documentation we reviewed demonstrated that staff were taking into account each person's culture, beliefs and values and delivered care accordingly.

Emotional support

Staff were clear about the importance of providing patients with emotional support We observed positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried. One patient, who had been involved in a road traffic accident, was supported to overcome their fears and anxieties about the accident and staff spoke with them in a supportive and sensitive way.

A noticeboard outlined the various multi-faith services available with timings for specific prayers and services.

Staff told us an advocacy service was available to help patients in making any crucial decisions about their future. However, we could not find any details about this service on the MAU.

Patients also had access to one to one support from the chaplaincy service if so wished.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The national Department of Health (DH) target for emergency services is to admit or discharge 95% of patients within four hours of arrival at A&E. The trust's performance in meeting this four hour target between June 2012 and December 2013 was variable However; the trust was meeting the target for the majority of this period.

In December 2012 and April 2013 there was a sharp decline in target achievement similarly in December 2012 87.2%, February 2013 87.6% & 85.1%, March 2013 86.6% and April 2013 80.4%. After April 2013 the trust fluctuated above and below the target. However more recently in December 2013 they performed above the target and England average at 99.7%.

The percentage of emergency admissions via A&E who waited between 4-12 hours from the decision to admit until being admitted was zero for the previous year. On further investigation we saw the A&E were able to use 12 short stay beds on the Clinical Decision Unit (CDU) should a patient require further monitoring and medical admissions were admitted to the MAU.

Ambulance turnaround times were well managed with almost 80 percent of turnaround within 15 minutes. The A&E noticeboard had a "virtual fine" system whereby they placed a 'virtual 'cost of £200 per handover that lasted more than 15 minutes. The fines for the two weeks preceding our visit were £2400 and £8000 that showed staff a potential loss. The clinical lead for the emergency department told us any ambulance waits over 60 minutes were automatically raised as an incident and a root cause

analysis investigation was undertaken. There had been a recent wait that had lasted over 90 minutes due to very complex issues with a patient. Ambulance staff we spoke to was complimentary of the commitment shown by staff at all levels to accept patients swiftly into the department.

The department is tending towards worse than expected for the percentage of patients who leave A&E without being seen.

Information obtained by staff and patients we spoke with confirmed that staff were meeting the needs of patients admitted to the emergency department and the MAU. Staff were knowledgeable regarding the community they provided services for and knew how to obtain additional support when required.

During our inspection the department had sufficient capacity to manage patient flow in a safe and way. Systems and processes to identify and plan any for potential staffing and bed capacity issues were applied so that patients received care and treatment without undue delays.

At times, the availability of beds on the wards could cause a backlog of patients in A&E that could potentially breach national performance targets and prolong patients waiting times. To minimize this risk, 3 bed management meetings were held daily. Information from these meetings was shared across the trust so staff knew how many inpatient beds were available in each specialty. The electronic patient administration system used in A&E and MAU enabled the flow to be managed responsibly so patients could be moved to the appropriate ward setting as quickly as possible.

As well as medical and surgical emergencies, the department also dealt with patients who experienced problems with alcohol, drugs and social issues as well as patients who may present with mental health problems. The hospital had responded to these needs and commissioned specific teams to support these patients.

A hospital alcohol specialist team consisted of nurses and consultants who reviewed patients who were admitted under the influence of alcohol. The team advised the A&E staff on any treatment that may be required as well as facilitating early discharge for medically fit patients who could be seen at home or from an outreach team.

The department had a team in place to treat patients with mental health issues. There was a dedicated team who were part of the Mersey Care NHS Trust. There were a number of support staff as well as a mental health nurse specialist on site who assessed any patients attending the department who were mentally ill.

Staff who we spoke with told us there were nurses who were specially trained in dealing with patients with learning difficulties. The nursing staff told us they would ask for a “Passport to health”, a document that captures the patients care needs, and if one wasn’t available, they would complete one. There were signs and posters in the department to encourage staff to adhere to this system.

Although the emergency department didn’t provide a service for children as there was a specialist children’s hospital not too far away, staff told us they could respond to the needs of children if required. There were children’s trained nurses as well as specialist resuscitation equipment for children. There was also a specific children’s card / pathway that included details for ailments such as dog bites and suicide attempts. Referral details for social services were also included.

The Medical Admissions Unit (MAU) had an “extended hour’s service” from pharmacy including evenings and weekends that ensured patients medicines were provided in a timely way. This service was not extended to the SAU.

Vulnerable patients and capacity

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). In addition to the mandatory training, staff had received training for caring for patients with dementia and those who displayed challenging behaviour. Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as the safeguarding lead.

When a patient lacked capacity staff sought the support of appropriate professionals so that decisions could be

made in the best interests of the patient. We reviewed the records for three patients and saw mental capacity act assessments had been carried out with clearly documented decisions.

A "Forget-me-not" scheme for patients with dementia was in place in the MAU. We saw the Forget-me-knot card on patient tables and bedside lockers. A phlebotomist, who was the lead for the scheme, told us the scheme gave staff information about the patient's likes, dislikes and choices and helped staff manage the care of patients with dementia in a sensitive and person centred way.

Access to services

The department offered a wide range of services to the local population and access to the A&E, MAU. Services were provided on the first floor level with specific access for patients arriving by ambulance and those who came by foot. In the previous three months to our inspection, between December 2013 and February 2014 the A&E received 2706, 2866 and 2645 patients per month.

Leaving hospital

The discharge and transfer of patients was well managed within the emergency department. Patients from the A&E were either discharged straight home if they were medically fit, to the CDU or the MAU if they required additional investigation, observation or care. Patients leaving A&E and awaiting transport home were also placed in CDU under the care of the A&E team.

Effective systems were in place to ensure that discharge arrangements met the needs of patients. For example, a specific patient discharge list, which included details such as a drugs chart, mental capacity assessment and infections data was appended to the final page of the nursing assessment document in A&E. These details were completed and copies sent with the patient on discharge along with an Advice after discharge (After emergency medical admission) leaflet.

Due to the nature of the A&E, all patients were assigned a four hour discharge slot which commenced at the point of admission for all patients. Although this timescale was set by government targets, staff did increase this time for patients with severe trauma or any patients who needed further tests. Generally the doctors we spoke with in MAU made an effort to state an estimated date of discharge. However, this was not a consistent approach and wasn't the main focus in the fast paced MAU environment.

Multidisciplinary team meetings (MDT) were held and patient discharges were discussed at the MDT and all the staff worked towards the provisional agreed discharge date. Staff told us that there was no pressure to discharge patients earlier, nor were discharges delayed as a result of awaiting decisions about funding. Patients could be fast tracked without the full MDT panel if they were deemed to be medically fit.

In terms of the percentage of unplanned re-admittance within 7 days of a previous attendance at A&E was close to or slightly above the England average for Sep 12 to Aug 13 this level of performance indicates that discharge from A&E is well managed.

Learning from experiences, concerns and complaints

Staff told us that the trust was open and transparent about complaints and concerns and as such they were encouraged to improve or develop services where issues had been raised by patients and their families. The hospital's Board meetings included a patient experience report which looked at trends in complaints, compliments and other patient feedback such as the friends and family tests (FFT). The July 2013 to September 2013 report identified that the most frequently occurring negative themes from FFT comments were the waiting times and the environment in the emergency departments.

Staff were knowledgeable in regards to the processes available to advise patients and relatives about how to make a complaint and aware that a log of all complaints was held on a centralised system.

Staff told us that local resolution of complaints was preferred and staff were involved in the investigations. In cases where the complaint was escalated, an independent investigator from outside the specialty was appointed. Then a formal process, monitored by the customer service team, was followed. A process, including defined timescales for investigation and draft response and development of action plans addressing areas of concern, was identified within the complaint.

Complaints were reported monthly and we were told that the matron cascaded this information to staff. Staff told us that discussions were held with staff involved in the complainant's care and that any issues raised by patients outside of the complaints process would be addressed

immediately. The trust also collected feedback from people who used the service and acted on the results. We tracked three ongoing complaints in the MAU via the online recording system and found they were following the correct process and timescales. For example, one complaint was about a doctor who had been rude to a patient; the actions required had been assigned and information and learning had been shared with staff.

We saw "A commitment to learn" poster on the corridor outside the MAU directed at staff to be "open and honest" and to report all incidents and near misses. However, we were unable to find any literature or signage in relation to raising any complaints within the A&E and MAU patient areas. The only apparent routes to raise a complaint were to ask a staff member or to ask at the reception desk in the booking in area for a procedure document which was cumbersome and difficult to understand, especially for patients who may require different formats.

Are accident and emergency services well-led?

Good

Vision, strategy and risks

Staff were clear about the organisation's vision and underwent a corporate induction that included the trust's core values and objectives for the organisation. Information relating to core objectives and performance targets were visibly displayed in the ward areas within the emergency department.

The trust's priorities, as outlined in the Developing the Quality Strategy document was presented to the board in December 2013 and focused on patient safety. The strategic objectives, that were applicable to the emergency department, were to deliver high quality safe patient care, to develop effective external partnerships, to deliver the service commitments and to develop staff potential.

We looked at performance and quality data at ward level. This showed that information relating to patient safety and risks and concerns was accurately documented, reviewed and updated at least monthly.

Senior staff we spoke to were aware of the risk register, performance activity, recent serious incidents and other quality indicators such as the nursing key performance indicators.

Governance arrangements

The emergency department was part of the acute medicine clinical business unit (CBU). Each CBU had a clinical head of division, divisional chief operating officer, a clinical head of business unit, a clinical business manager and a clinical lead who was responsible for the day to day management of the department. Two leads were in place, one for the A&E areas and one for the MAU. The department has access to and support from clinical governance (quality and safety standards), patient experience and human resource (personnel) support.

Acute care CBU team meetings were held monthly and discussed issues such as staffing, training and feedback from patients. These issues were fed up to the Board who received monthly and quarterly reports that included information such as staffing vacancies, numbers of falls and pressure ulcers, medications incidents, serious incidents and indicators in relation to healthcare associated infections by service level.

Leadership and culture

The ethos in the emergency department was that patient safety was paramount and any breaches of the target that resulted in a target breach were a secondary issue. Staff told us the recently employed medical director had improved relationships with consultants and was in regular communication with the department.

Staff spoke highly of the chief executive and told us she was very visible. Staff told that as a result of their concerns the CEO had moved a patient from an inappropriate area in the MAU and reassigned the room for another purpose. One staff member said "The CEO will visit the department when things go good as well as bad and we feel that she cares".

The emergency department was well-led locally by the matrons and senior staff. The team were motivated and worked well together with good communication between all grades of staff. Staff we spoke with felt free to challenge any staff members who were seen to be unsupportive or inappropriate in supporting the effective running of the service.

Staff said they felt supported by their colleagues, senior medical and nursing staff and managers and felt able to share ideas and practice.

Patient experiences, staff involvement and engagement

Staff received communications in a variety of ways, for example newsletters, emails and briefing documents. We saw evidence of this. Staff told us they were made aware when new policies were issued and that they felt included in the organisation's vision.

Learning, improvement, innovation and sustainability

Staff new to the trust received both a corporate and local induction. Nursing staff had the opportunity to join a preceptorship scheme while junior medical staff were assigned a consultant mentor within the emergency department. Newly qualified staff also received a three day induction. Staff were supernumerary to the identified staffing requirements until they had received the required mandatory training.

An online training matrix listed the courses that staff had completed and outlined the core modules required for each staff member grade and position. Mandatory training modules included infection prevention and control and safeguarding adults and children. Staff in the emergency department had received additional in-house training in areas such as introduction to trauma management, CBRN (Chemical Biological Radiological and Nuclear) Decontamination systems and triage management. This training meant staff in the emergency department were able to deal with the patients that presented. We noted that the majority of the training was done through e-learning; this is a computer generated way of learning. Other training such as management of trauma patients was classroom based as staff needed to carry out practical tests to confirm competence.

There was no specific in- house emergency department programme for consultants. However, consultants from the emergency department participated in the generic trust teaching programme. The radiologists provided a training revision session twice monthly to teach the consultants about fracture management.

Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. The mandatory modules were attached as a competency in the online training matrix so compliance could be monitored.

We found a number of initiatives in place, for example, emergency nurse practitioners (ENP) had been trained to see and treat patients in the minor's areas and secondly a fast track medical referral access from A&E to the GP was in place to manage patient's admission and discharge from the emergency department. Another initiative in place was that a frailty unit had opened in the Trust to provide multidisciplinary care. It is managed by the Department of Medicine for the Elderly and allows for rapid assessment of older patients to support timely care and treatment.

Good

Medical care (including older people's care)

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

Information about the service

The acute medical care services provided care and treatment for a wide range of medical conditions We visited wards 8, 20,21,22,23,30,31,32 and 33 (the stroke unit) over the course of a two days. We observed care, looked at records for 11 people and spoke with 22 patients, six relatives and 27 staff across all disciplines.

We also visited the coronary care unit, observed care and treatment and reviewed a sample of care records. During our visit we talked with two patients and three members of the nursing and clinical staff.

The coronary care unit provides eight beds for patients with coronary heart and associated disease and is managed under the department of medicine. Patents requiring acute or prolonged intensive cardiac treatment are sent for admission to the Liverpool Heart and Chest Hospital

The unit at this hospital provides intermediate cardiac care.

Summary of findings

Patients on medical wards received care that was safe, effective, caring, responsive and well-led. There were sufficient numbers of skilled and trained staff to meet their needs in a timely way. Infection control, pressure ulcer prevention and medicines management were well managed and monitored.

Discharge co-ordinators were available on the medical wards and liaised with colleagues to enable patients to be discharged home without undue delays. Patients were positive about their care and felt staff treated them with respect and maintained their privacy and dignity. However, the service needs to further develop the 'forget me not' initiative so that staff fully understand is application for the care of patients with dementia. We also found that the service could improve communication with patients who are deaf.

Good

Medical care (including older people's care)

Are medical care services safe?

Good

Safety and performance

Staff recognised the importance of safe staffing and the impact it had on providing care. An audit of the dependency levels of patients had recently been undertaken in order to establish whether staffing levels were sufficient and the mix of skills and experience appropriate, as a result the ward manager role had been re-designated as supernumerary, enabling ward managers to act in a supervisory capacity on a full time basis. This allowed ward managers to supervise care delivery, develop the ward team and manage the ward effectively. We reviewed duty rotas and found that there were sufficient numbers of skilled staff to meet the needs of patients.

The wards and coronary care unit were visibly clean and well maintained.

There was an ample supply of hand washing facilities and liquid soap and hand towel dispensers were adequately stocked. Alcohol hand gel was available in the ward and at the bottom of each bed.

Staff observed bare below the elbow guidance and wore personal protective equipment, such as gloves and aprons while delivering care.

Equipment was clean well maintained and safely stored. Emergency equipment such as the defibrillator was checked daily and was charged and ready for use if required.

During our inspection we reviewed 11 sets of patient records on six wards. In all the records we looked at 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 such as the waterlow score (a tool for assessing patients at risk of pressure ulcers) and falls risk assessments were well documented and regularly reviewed. Care plans contained clear accounts of actions in place to reduce and manage risks to patient safety.

We discussed actions the staff had taken in order to reduce the number of falls with harm and found examples of good practice throughout the medical wards. These included caring for patients with a diagnosis of dementia, who were at a high risk of falls, on a one to one basis, that considerably reduced their risk of falls and the use of illuminated signs on toilets, that enabled patients to find their way more easily during the night reducing the risk them becoming disorientated and falling.

In terms of pressure prevention staff were appropriately using pressure relieving mattresses and safe moving and handling techniques to prevent pressure ulcers.

Information from the NHS safety thermometers (a tool designed for frontline healthcare professionals to measure a patient harms such as falls, pressure ulcers, bloods clots, catheter and urinary infections) indicates that the proportion of patients suffering new pressure ulcers grades 3, including in patients over 70, being cared for by the trust was consistently below the England average from November 2012 to November 2013, (with the exception of patients over 70 in November 2013). The data also indicated that the number of patient falls that resulted in patient harm was consistently below the national average at this hospital. With the exception of October 13 for all falls with harm. In addition The proportion of patients suffering from new urinary infections is consistently below the England average reaching 0% in April, May and November 2013.

The trust has an effective medicines incident reporting structure in place. A multidisciplinary Medicines Safety team met on a monthly basis and once a month the weekly harm meetings included a discussion about medication errors. A quarterly report is produced to review and summarise medication errors (including near misses). The error reports show a decreasing number of errors over the last three quarters in 2013 compared to the same quarters the previous year. There was one declared serious incident involving medicines in the final quarter of 2013 that was under investigation.

There were systems to ensure that patients with swallowing problems are prescribed appropriate formulations of their medicines. A system to identify which medicines may increase the risk of falls has also been implemented.

Good

Medical care (including older people's care)

There was a system for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training the majority of staff on the medical wards had undertaken safeguarding training.

Learning and improvement

There were robust systems for reporting incidents and' near misses across the whole directorate. Staff were confident in reporting incidents and near misses and were supported by managers to do so. Feedback was given and there were examples of learning from incidents being applied and evaluated. As an example of learning from incidents we found that practice had been revised in relation to falls and medicines management.

In response to the findings of the quarterly reports to improve medicines' safety. A new checklist had been implemented for patients who were discharged to ensure that their medicines were removed from the medication lockers before the next patient occupied the bed in order to avoid medicines being given to the wrong patient. Ward managers received a daily "missed dose report" so that the reasons for patients not getting the prescribed doses of their medicines can be investigated and the frequency of missed doses reduced. Staff acted on the information in the emails and showed a decrease in doses missed for avoidable reasons.

Wards throughout the medical directorate had a patient safety officer in place who coordinated safety information, incident feedback and shared learning from other wards and departments. We also saw examples of patient safety newsletters that were used on some wards as a way of sharing patient safety information to staff.

Systems, processes and practices

Ward staff used the Modified Early Warning Score (MEWS) tool which was designed to identify patients whose condition was deteriorating. We found that this tool was in use throughout the medical directorate and staff understood how to use it. When a patient's condition began to deteriorate there was a clear escalation policy that ensured timely intervention by appropriately trained personnel. Junior medical staff were complimentary about the prompt response provided by the medical emergency team and the night nurse clinician service for patients whose condition was deteriorating.

We also reviewed the risk assessments and care pathways for a sample of patients on coronary care. We found that the modified early warning system (MEWS) was used to alert staff regarding changes in a patient's medical condition. The criteria was clearly written and instructed staff to call The Emergency Medical Team if patients scored highly on the MEWS track and trigger observation tool unless a consultant or registrar had revised these instructions and updated the patient's plan of care. We found that staff on the coronary care unit understood the criteria for calling the Medical Emergency Team.

Records indicated that between April 2013 and February 2014 the MET had been called to the coronary care unit on 10 occasions

Monitoring safety and responding to risk

'Safety huddles' took place on wards throughout the hospital at least once daily and there were systems in place to identify patients who were at risk of falls or pressure ulcers. Risks were recorded and care planning amended to include this new information.

Anticipation and planning

Overall, the hospitals bed occupancy averages have been consistently higher than England averages for the entire period between April 2011 and September 2013.

The directorate was an active participant in the capacity and bed management meetings that were held 3 times daily. Staff worked hard to manage patient flow and timely discharge so the service was able to manage unplanned admissions and avoid patients 'outlying' in other specialties.

Patients who were outlying on other wards were well managed and were seen regularly by medical staff. Transfers across the wards were managed sensitively and without undue delay.

Good

Medical care (including older people's care)

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

Good

Using evidence-based guidance

Care and treatment was delivered in line with current legislation, national standards and evidence-based practice. The medical directorate had clinical pathways for care in place for a range of medical conditions including stroke care.

An analysis of the most recent data submitted by the trust in January 2013 as part of the Sentinel Stroke National Audit Programme (SSNAP) (was a Programme of work that aimed to improve the quality of stroke care by auditing stroke services against evidence-based standards placed the hospital in the top 25% of trusts nationally for the effective management of stroke patients. We discussed the audit with the ward manager and found that some further improvements had been made. The improved data for January 2014 had been submitted to SSNAP but the analysis was not available at the time of our inspection.

Two additional indicators for SSNAP, the number of patients scanned within 1 hour of arrival at hospital, and the number of potentially eligible patient's thrombolysed, indicated that there was no evidence of risk for both indicators for the period October to December 2012.

In relation to The Myocardial Ischaemia National Audit Project 2012/13 (MINAP The hospital was performing tending 'better than expected' in relation to the proportion of patients with a discharge diagnosis of nSTEMI who were referred for or had angiography during 2013/13. The hospital was performing within expectations for the proportion of eligible patients with a discharge diagnosis of nSTEMI (non-ST segment elevation myocardial infarction) who were seen by a cardiologist or member of their team and for the proportion of eligible patients with a discharge diagnosis of nSTEMI who were admitted to a cardiac unit or ward.

An analysis of the National Diabetes Inpatient Audit 2013 showed that the hospital was performing well against most of the indicators analysed. However, the hospital was not performing well in relation to diabetic foot risk assessment; we discussed the audit with a senior clinician. They were able to describe several initiatives, based on current research and best practice guidelines that had been put in place to improve the outcomes for patients who already had active foot disease. This included the use of pressure prophylactic relieving equipment on the unaffected foot for patients who had foot problems related to their diabetes (this was because it has been shown that if one foot is affected then it is possible that the other one will become affected if care is not taken to prevent ulceration). There was a consultant led multidisciplinary review of every patient in the hospital who had a foot problem related to their diabetes.

There were plans to start an initiative whereby the foot pulses and sensation will be checked for every diabetes patient admitted to identify those patients more likely to run into problems related to poor circulation or neuropathy at an early stage, so that action could be taken before the foot deteriorated.

NICE (national institute for Health and Clinical excellence) recommends that pharmacists are involved in medicines reconciliation as soon as possible after admission. We saw that pharmacy staff offered this service on the all wards we visited.

Performance, monitoring and improvement of outcomes

Regular audits took place to promote patient safety and improve practice. These included a weekly hand hygiene audit, monthly mattress audit and an infection control audit that focused on different aspects of infection control, such as catheters and intra-venous access sites. Matrons within the medical directorate regularly audited a random selection of patients' care records and individual ward managers audited other aspects of patient safety that included wrist band (patient identification) audits and the cleanliness of the ward environment. If any issues were highlighted as a result of the audits, we saw recorded evidence that prompt and appropriate action had been taken to address the issue

Performance boards, known as 'How we're doing' boards were visible at the entrance to each ward and were updated monthly. Staff were informed of the performance of their ward against key indicators, such as the number of falls and pressure ulcers and were encouraged to make suggestions about ways in which performance and the patient experience could be improved.

Good

Medical care (including older people's care)

There were processes for performance and professional management of staff. Mandatory training for all clinical staff included safeguarding vulnerable adults, infection control, pressure ulcer prevention and manual handling. Medical supervision of trainees was good within the directorate. Most staff of all disciplines told us that they felt managers encouraged them to take up training opportunities.

Multidisciplinary working and support

Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team. We saw that teams met at various times throughout the day, both formally and informally, to review patient care and plan for discharge. MDT decisions were recorded and care and treatment plans amended to include changes.

A Clinical Liaison Forum met regularly to discuss ways in which the hospital, local GPs and the Clinical Commissioning Groups could work together and representatives from General Practice formed part of the Avoidable Mortality Reduction Group.

Are medical care services caring?

Good

Compassion, dignity and empathy

We found that medical services were delivered by a hardworking, caring and compassionate staff. We observed that all staff treated patients with dignity and respect. All the people we spoke with were positive about their care and treatment

One visitor requested to speak to us regarding the care they had observed of a patient with a diagnosis of dementia. They commented, "I have watched the staff day in and day out and they have never lost their patience. It is lovely to see someone with dementia being treated with respect."

We spoke with 17 patients and seven relatives and everyone spoke very positively about the care that they, or their family member, had received. Some comments made were, "Everyone is brilliant", "I can't fault them" and "The care I have received here has been excellent."

We also saw examples of ways in which people were encouraged to share their impression of the hospital and ways in which improvements could be made.

Nursing staff carried out regular 'comfort' rounds to ensure that patient's needs were met. Staff ensured that patients had drinks, were comfortable and had easy access to call bells.

Involvement in care and decision making

Staff planned and delivered care in a way that took into account the wishes of the patient. We saw staff obtaining verbal consent when helping patients with personal care. Patients we spoke with told us they felt involved in their care and treatment consent was sought appropriately and staff explained benefits and risks to patients about care and treatment. Patients also told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.

Trust and communication

Staff worked hard to develop positive relationships with patients and those close to them. Staff were open and honest with patients and encouraged questions about care and treatment. One patient told us, "They look after me like I'm one of the family."

Patients told us they understood what medicines they were taking. This was because staff explained about any new medicines they were prescribed or why doses were changed. They said that the nurses told them all about the medicines they would be taking home with them when they were discharged.

Emotional support

Patients and their relatives and carers were supported to cope emotionally with the treatment and care provided during their stay in hospital. During our review of patient records we saw examples of multi-disciplinary team meetings taking place and the patients and their families were included. Patients we spoke with confirmed this and told us they found the meetings informative and useful. There were a variety of support groups for various medical conditions that were supported by the trust and patients were encouraged and supported to access them.

Are medical care services responsive to people's needs?

Good

Medical care (including older people's care)

(for example, to feedback?)

Good

Meeting people's needs

The acute frailty ward had been completely redesigned and refurbished in order to be more suitable for frail elderly patients. Staff from the ward had visited another hospital in order to gain ideas about best practice and as a result had designed an outside garden/courtyard section in order to provide horticultural therapy for patients.

Comprehensive information folders were available on each ward we visited giving valuable information regarding access to services for people who had disabilities, including patients who were deaf and patients with a learning disability.

The 'Forget me not' scheme had been introduced throughout the medical directorate for people with a diagnosis of dementia. The scheme involved a forget me not symbol behind the patient's bed and on their wrist band to denote their dementia and a folder containing personal information about themselves, compiled on admission with the help of those close to them. There was also information on a stand up card on their lockers to remind staff of their immediate needs. A care plan for dementia had also been introduced. However, staff informed us that the scheme had not been piloted or introduced with clear instructions and some staff had reservations about its usefulness. There was very little information in the folders we reviewed and staff were unclear about where the folders should be kept, what should be included in them and at what level of dementia the folders should be used. On each ward we visited staff were using them in different ways. The care plans were being used as an initial 'checklist' but there was little of any longer term value contained within the care plans with regard to the care and welfare of patients with dementia.

All of the patients we spoke with were complimentary about the meals served at the trust. People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day. Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food. We spoke with three patients who required a special diet who confirmed that they had received suitable meals during their hospital stay. We saw that, where possible, there was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assistance was given to those patients who needed help. We also saw that a red tray system was in place to highlight which patients needed assistance with eating and drinking. A 'finger food' menu had been introduced, predominantly for patients with a diagnosis of dementia. Staff told us this menu was popular and useful in meeting the dietary needs of these patients. During our inspection we observed staff assisting people who required help with meals sensitively and patiently.

However, there were occasions when the evening meal was delivered late on the medical wards. This left less than 30 minutes for staff to serve the meals, assist patients to eat and prepare them for visiting time. This meant that staff were rushing to serve the meal and clear away the trays and some patients told us they left the meal partially eaten so that their visitors would not be left waiting outside the ward. On these wards the visitors were sometimes left waiting for up to 15 minutes while the patients finished their meals.

Many of the televisions that were situated over patients' beds were not working, had no sound, or could only access very limited channels. None of them could use subtitles. This meant that staff were moving beds in order to enable patients to access a working television or that patients were unable to watch television when confined to bed.

Vulnerable patients and capacity

Staff demonstrated a good knowledge of the Mental Capacity Act 2005 and the implications of this in order to protect patient's rights. Through a review of patient records, we saw that staff had assessed patients' mental capacity for making decisions and when patients lacked capacity staff sought advice from appropriate professionals so a decision could be made in the patient's best interest.

Access to services

At the time of our inspection most patients were in wards that were appropriate for their medical condition. However there were times due to pressures on medical beds as a result of emergency admissions when patients were placed in wards outside the medical specialty. If patients were being cared for within another specialty there were

arrangements in place for patients to be treated and reviewed by appropriate medical staff. Patients were moved in to the correct specialty as soon as beds were available.

Leaving hospital

The Service had discharge coordinators in place to facilitate the efficient and timely discharge of patients. The coordinator liaised with patients, social services, families and hospital departments to ensure that patients could be discharged safely with appropriate support in place. An expected date of discharge had been discussed with most of the patients we spoke with and arrangements were already underway. The number of delayed discharges from hospital were within the range expected for a hospital of this size.

Learning from experiences, concerns and complaints

Information on how to make a complaint was not freely available throughout the medical division. We looked at a patient information board and three patient information leaflets and found no information regarding complaints; however one ward we visited had included this information in their patient information folders. Patients and relatives we spoke with knew how to complain in person to the individual ward managers but did not know how to complain directly to the trust. The trust did not overtly offer people the opportunity to make a formal complaint verbally. The trust did not overtly offer people the opportunity to make a formal complaint verbally or in British Sign Language. This means that people with poor levels of literacy and some deaf people could be excluded from formally complaining unless they were directed to appropriate support.

Are medical care services well-led?

Good

Vision, strategy and risks

Staff we spoke with from all disciplines and at all levels within the directorate could tell us about the trust's vision and values. They described an increasing sense of pride to be working within the hospital and were knowledgeable and engaged in the plans to develop the hospital site.

Governance arrangements

The division was part of a Clinical Business Unit (CBU). Each unit had a Clinical Head of Business Unit, a Clinical Business Manager and a Matron who was responsible for the day to day management of the service. The division had access to and support from clinical governance (quality and safety standards), patient experience and human resource (personnel) support.

The Division had monthly governance / assurance meetings as did the CBU's and discussed issues such as staffing, training and feedback from patients. These issues were reported to the Board who received monthly and quarterly reports that included performance information such as staffing vacancies, numbers of falls and pressure ulcers, medications incidents, serious incidents and indicators in relation to healthcare associated infections by service level.

Leadership and culture

The culture within the division was positive and promoted the delivery of high quality care for patients. Staff spoke highly of the leadership in the hospital, particularly the chief executive and the ward matrons. Nursing staff told us their matrons were highly visible and very approachable and that the chief executive was "very supportive" and always prepared to listen. However staff were not as familiar with other members of the executive team.

The new Medical Director was having a positive impact on engaging clinicians within the division who were positive about the new leadership. We also saw several examples of good leadership by individual managers at ward level throughout the division who were positive role models for staff.

Patient experiences, staff involvement and engagement

Staff in the division had been involved in the 'Big Conversation' that was a trust wide initiative designed to inform the executive team of staff views regarding proposed developments. Listening events had also been undertaken at ward level, with a focus on initiatives that could be taken locally. Staff could describe changes that had occurred as a result of the listening events.

Learning, improvement, innovation and sustainability

There was a recognition and reward scheme in place within the trust. The medical division, in response to staff

feedback, had set up a recognition scheme to include the most improved ward, in addition to the trust wide recognition of the best performing ward. This scheme had encouraged wards to develop new ways of working that enhanced patient care and the ward environment.

Good

Surgery

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

Information about the service

The hospital provided a range of surgical services, including General Surgery, Urology, Colorectal, Gastroenterology, Liver, Trauma and Orthopaedics, ear, nose and throat (ENT), Head and Neck, Ophthalmology, Oral and Maxillofacial, Cardiothoracic and breast surgery. There were 19 theatres, including four day surgery (elective) theatres and three emergency surgery theatres.

As part of the inspection, we inspected the surgical assessment unit (SAU), emergency general surgery ward (Ward 1), urology ward (Ward 2), upper gastrointestinal, liver and colorectal surgery wards (Wards 3 and 4), head and neck ward (Ward 28) and the head and neck, breast and ophthalmic surgery ward (Ward 29). We also inspected the pre-operative assessment unit, day surgery theatres and general theatres

We spoke with 22 patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, matrons and members of the senior management team. 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.

Summary of findings

There were effective systems and processes in the surgical ward and theatres to provide safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care.

The surgical services followed national clinical guidelines and staff used care pathways effectively. The trust took part in national and local clinical audits. The staffing levels and skills mix was sufficient to meet patients' needs. Patients were supported with the right equipment. Patient records were completed appropriately. We found that staff had a good understating of the World Health Organization (WHO) theatre checklist. However, the checklist was not always completed properly and practice in this area required improvement.

In the Surgical Assessment Unit (SAU) there was a consultant led teaching and a multi-professional approach for emergency surgery. A team of consultants were available to support middle grade and junior doctors and specialty-specific training was provided to clinical staff within the team. This approach had led to a reduction in overall mortality for patients needing emergency general surgery between 2006 and 2012 and a reduction in the mortality rates for patients needing emergency laparotomy procedures. The average length of patients in the unit had been also been reduced.

Patients spoke positively about their care and treatment. There were systems in place to support vulnerable patients. The end of life care services engaged with other care providers and professionals to

Good

Surgery

make sure that coordinated care took place. There was sufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of care.

There was effective teamwork and clearly visible leadership within the critical care services. Staff were appropriately supported with training and supervision and encouraged to learn from incidents

Are surgery services safe?

Requires improvement

Safety and performance

The surgical wards and theatres at Aintree University Hospital had measures in place to monitor patient safety and reduce the risk of harm to patients.

The wards and theatres we inspected were clean well organised and well maintained. Staff were aware of current infection prevention and control guidelines. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice and '**bare below the elbow'** guidance.

Staff wore personal protective equipment, such as gloves and aprons, while delivering care

Gowning procedures were adhered to in the theatre areas.

Medicines, including controlled drugs, were safely and securely stored.

Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Equipment was well maintained, clean and safely stored in both theatres and in the ward areas. Emergency equipment such as the defibrillator was regularly checked and charged and was ready for use if required.

We observed three theatre teams undertaking the 'five steps to safer surgery' procedures, and used the World Health Organization (WHO) checklist.

The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures. We identified that a theatre team in main A theatres verbally confirmed patient identification but did not confirm patient identification by checking the patient wristband during the "time out phase" during one of our observations. Within the main B theatres, we also observed that a surgeon and operating department practitioner (ODP) did not confirm the patient identification by checking the patient wristband during the "sign in phase".

Good

Surgery

The trust had carried out an audit to monitor adherence to the existing WHO checklist policy during January 2014 and this had highlighted areas of non-compliance. As a result there was an action plan in place that included specific actions relating to updating processes and procedures and providing additional training for staff through a DVD and briefing sessions. Some actions were ongoing and the updated process was due for implementation in April 2014.

There had been two never events (events that are so serious they should never happen) reported by the trust between December 2012 and November 2013. One related to a swab that was retained inside a patient following a surgical procedure. The other incident related to a patient that underwent surgery on the wrong finger. There was a clear process for investigating never events and patient safety incidents, including serious incidents requiring investigations We saw that root cause analysis (RCA) investigations were carried out following any serious incidents. We looked at four RCA reports for serious untoward incidents (including the two never events) and saw these involved appropriately trained nursing and clinical staff in the investigation process. However, the action plans from both never events made reference to the WHO safer surgery checklist not being completed appropriately. This was still found to be the case when our inspection team visited theatres as part of our inspection.

There were no plans to audit compliance with the checklist again until May 2014. The SUI progress report dated February 2014 stated that some 28 actions were overdue (outside of timescale for completion).

The trust has revised its incident, complaint and claim investigation procedures and held a launch event for these in February 2014. It is envisaged these changes promote SMART action plans to improve learning from incidents, complaints and claims. The investigations we looked at use recognised RCA tools and identified areas for improvement to minimise reoccurrence.

Staff in the wards and theatres were familiar with the electronic incident reporting system to record incidents and near misses. We looked at the system and found that incidents were investigated and remedial actions were put into place to minimise reoccurrence. The staff we spoke with told us they received feedback to aid future learning however the feedback was variable and this is an area that the trust acknowledges needs to improve.

Staff told us incidents and complaints were discussed during routine staff meetings so shared learning could take place. Records of meetings confirmed this.

In the ward areas there were sufficient numbers of trained clinical, nursing and support staff with appropriate skills to deliver care and treatment to patients. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis. Staffing rotas confirmed staff numbers and skill mix were appropriate to meet the needs of patients.

The trust had identified the levels of qualified nursing staff in the theatres as a concern and this was logged on the divisional and trust-wide risk registers.

We spoke with the matrons responsible for main A theatres and the elective (day surgery) theatres. They informed us that the trust had recently recruited approximately 13 nurses and the majority of nursing vacancies within theatres had either been filled or were in the process of being filled.

Staffing rotas confirmed that staffing levels in theatres were maintained in accordance with national guidance.

The Hospital had also identified that out of hours junior medical cover on ward 28 (head and neck surgical ward) was not provided by an ear, nose and throat (ENT) specialist but currently by doctors working in orthopaedics. Staff could contact an ENT registrar by phone if needed. This was logged as a risk on the local and trust-wide risk registers. The trust had recently appointed two ENT specialist doctors that were starting employment in late March 2014 to address this shortfall.

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The tool measures people who fall, develop pressure sores, **venous thromboembolism (VTE)** (blood clot in the veins), or a catheter urinary tract infection (UTI). We looked at performance data between November 2012 and November 2013. The hospital performed better than the national average for the number of patients with falls with harm and catheter or urinary tract infection (UTI). The number of patients with new pressure ulcers and **venous thromboembolism (VTE)** (blood clot in the veins) fluctuated above and below the national average.

We looked at the records for two patients that had been assessed with a pressure sore grade 2 to 3 in ward 1

(surgical assessment unit and general surgical ward) and ward 3 (emergency surgical, gastroenterology and colorectal surgery ward). The patient in ward 1 had been assessed on 28 February 2014 with a pressure sore grade 2 to 3. The patient had an overlay pressure relieving mattress but the records showed that the patient had not been referred to the tissue viability nurse for specialist advice and support.

The patient in ward 3 was assessed with a pressure sore grade 2 to 3. The patient records stated that a risk assessment (Waterlow) score of 17 required a pressure cushion or foam mattress to be used but this had not been done. The ward staff were able to explain the reasons why pressure relieving equipment had not been used for this patient but had not clearly documented this in the patient records. We discussed this with the ward manager, who acknowledged that further staff training and support may be needed for staff in relation to grading pressure ulcers properly to ensure patients received the right level of care.

Staff received mandatory training in pressure ulcer prevention and we saw that a staff nurse had a pocket guide for pressure ulcer care. There was a hospital wide pressure ulcer prevention group in place that oversaw pressure ulcer care processes.

Information relating to patient safety was displayed on notice boards in all of the areas we inspected. This provided up-to-date information on performance in areas such as infection control data, falls and pressure ulcers. The information showed performance over the past 12 months and was updated monthly by the ward managers in each area. Staff carried out routine scheduled audits for key processes such as infection control; medication and NHS Safety Thermometer audits and any issues identified were subject to local remedial action and shared learning.

There was an effective system in place for monitoring patients within the surgical areas and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns relating to patient care and treatment.

Staff received mandatory training in consent and safeguarding vulnerable adults that included aspects of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). Staff understood the legal requirements of the Mental Capacity Act 2005.

Learning and improvement

In the Surgical Assessment Unit (SAU) there was a consultant led teaching and a multi-professional approach for emergency surgery. A team of consultants were available to support middle grade and junior doctors and specialty-specific training was provided to clinical staff within the team. The consultant provided us with information that showed that this approach had been effective and had led to 40% reduction in overall mortality for patients needing emergency general surgery between 2006 and 2012. The data also showed there had been 50% reduction in the mortality rates for patients needing emergency laparotomy procedures and the average length of stay of patients in the unit had been reduced by 20% to 3.3 days.

Data submitted by the trust showed that mandatory training competency compliance up to February 2014 in the surgical division was 71.92%. The data also showed that 51.48% of staff within the surgical division had completed the electronic (Compass) appraisal process. The trust highlighted that problems with the electronic appraisal system (that was under review) and staff on maternity or long term sick leave accounted for some of those who had yet to start their appraisal. The hospital had recognised that its performance in both these areas were low and had developed an action plan to achieve 80% compliance with staff appraisal and 90% mandatory training over the coming months.

Systems, processes and practices

Clinical pathways were in place in the surgical directorate. (A care pathway is anticipated care for a particular condition placed in an appropriate time frame, written and agreed by a multidisciplinary team. It has locally agreed standards based on evidence to help a patient with a specific condition or diagnosis move positively through their hospital experience).

Patients care and treatment was assessed and planned using evidence based guidance and risk assessment tools.

Patient records showed that the risk of patients developing blood clots (VTE), pressure sores, catheter and urinary tract infections were, in the main, well documented and supported by appropriate care and regular monitoring.

Patient safety issues were routinely discussed and recorded through multi-disciplinary staff meetings and actions were taken as a result of issues identified.

Good

Surgery

Monitoring safety and responding to risk

Staff used an Early Warning System to alert them to changes in them to changes in a patient's condition. If a patient's condition began to deteriorate medical staff were alerted quickly and they attended the patient promptly. There was a Medical Emergency Team outreach team (linked to the critical care team) that was able to provide expert advice and guidance to support ward the effective care management of patients whose conditions had deteriorated. Staff valued the support provided by the Medical Emergency Team and were complimentary about this service.

Are surgery services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

The service was using national and best practice guidelines to care for and treat patients.

Clinical audits included monitoring of National Institute for Health and Clinical Excellence (NICE) and other relevant professional guidelines. The Hospital was eligible to participate in 35 national audits; the trust did not participate in 8 of them.

There was participation in national audits such as the National Bowel Cancer Audit, hip surgery audit and performance and action plans were reviewed at monthly divisional clinical governance meetings.

National Bowel Cancer Audit 2013 showed that the trust was performing better than the national average for case ascertainment (97% compared with national average of 95%), for the number of patients that had a computerised tomography (CT) scan (93.2% compared with national average of 87%) and 99.5% of cases reported to the audit were discussed at multidisciplinary team (MDT) meetings. The national level was 98%.

The National Bowel Cancer Audit 2013 highlighted that trust performance was performing better than the national average for the level of data completeness. There were 114 cases having major surgery. For these cases, the level of data completeness for patients undergoing major surgery was 87% compared to national average of 71%). The audit also highlighted that only 69.1% of patients were seen by a clinical nurse specialist compared to the national rate of 87%.

The National Hip Fracture database report 2013 showed that hospital performance was comparable with the England average for all the data sets.

Information on patient-reported outcome measures (PROMs) was gathered from patients who had had groin hernia surgery, vascular vein surgery, or a hip or knee replacement. No risks were identified in relation to outcomes for these groups.

Performance, monitoring and improvement of outcomes

An analysis of the Summary Hospital-level Mortality Indicator (SHMI) data submitted by the trust showed that trust mortality was above the expected target at 115.97. The Hospital Standardised Mortality Ratio (HSMR) data submitted by the trust showed the overall mortality rate was better than expected at 94.4.

The trust is aware of the discrepancy between the SMHI and The HMSR data but was unable to clearly describe a process by which this issue could be resolved expeditiously. Although the trust had formed a group to look at this, we noted that there were some decisions from the group meeting that had not been actioned and we considered that this must take priority.

Mortality reviews were carried out by specialty and each incident was reviewed and investigated. The trust had an avoidable mortality reduction action plan in place and was working towards reducing mortality rates. Patient mortality and progress against action plans were reviewed on a monthly basis by a trust-wide mortality reduction action group that was led by the Medical Director.

The trust has a higher than expected rate of readmission following an elective (planned) admission.

We spoke with a consultant in the SAU, who had carried out a study of all patients readmitted to the emergency general surgery unit between March 2012 and March 2013. The study showed that 493 of the total 7,400 patients were readmissions (6.7%). 254 of the 493 readmitted patients were general surgery patients and 40% of these patients were readmitted due to pain and 46% for post-operative complications, such as wound complications,

haemorrhage or infections. The study highlighted a number of recommendations including additional advice for patients and prescribing guidelines for clinical staff involved in the discharge of patients on appropriate pain relief. These recommendations were being implemented by the hospital staff team and the reduction in readmission rates were being monitored.

There was an audit programme in place that included clinical audit, nursing care indicators, infection control and health and safety processes. The audits took place on a routine and scheduled basis. Audit records indicated that patient safety performance data across the surgical department was collated into a trust-wide "ward-to-board" dashboard and this highlighted where performance levels fell below acceptable levels. Compliance levels were monitored and reviewed on a monthly basis within the surgical division and information was cascaded to staff across the departments to aid improvement.

Staff, equipment and facilities

The clinical head of business unit (CHBU) for theatres confirmed that the trust planned to recruit three additional anaesthetic consultants including a consultant with day surgery expertise to improve the services provided and manage patient demand.

Staff received mandatory training in dementia awareness as well as mandatory training relating to the care and treatment of surgical patients.

Multidisciplinary working and support

We saw that multi-disciplinary staff worked well in the majority of areas we inspected. There was effective communication between the teams within the surgical specialties. Trainee doctors and nurses we spoke with told us they were supported well.

Allied Health Professionals worked well with ward based staff to support patient's recovery and timely, safe discharge following surgery. Multi-disciplinary team meetings were well established to support patient safety, good recovery and timely discharge home.

Are surgery services caring?

Good

Compassion, dignity and empathy

Patients were treated with dignity, compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. The majority of patients we spoke with were complimentary about staff attitude and engagement. The comments received included "all the staff are caring and attentive" and "staff are friendly, helpful and compassionate". The comments received from patients demonstrated that staff cared about meeting patients' individual needs.

The areas we visited complied with same-sex accommodation guidelines. Where this was not possible, patients were cared for in side rooms. We saw that patients' bed curtains were drawn and staff spoke with patients in private. The majority of patients we spoke with told us the staff respected their privacy and dignity. One patient commented that the doctors consulted with her in a side room to ensure privacy. However, two patients we spoke with in the surgical assessment unit (SAU) told us they were concerned that their discussions with staff could be heard by other patients in the bay areas.

We saw that staff respected patient dignity while transferring patients between the wards and operating theatres. Within the SAU, we saw a member of staff assisting a blind elderly patient to the bathroom. The patient was not hurried while walking and the member of staff regularly checked to see if they needed assistance. One patient told us they requested intimate nursing care from a female nurse, who refused and told the patient that a male nurse had been assigned to support them. The patient told us the issue was resolved immediately after they had spoken with the ward manager.

Involvement in care and decision making

Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff had received mandatory training in consent. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or

treatment. We looked at records which showed that both verbal and written consent had been obtained from patients and that planned care was delivered with their agreement.

Staff respected patients' right to make choices about their care. The patients we spoke with told us they were kept informed about their treatment. They told us the clinical staff fully explained the treatment options to them and allowed them to make an informed decision. We observed staff speaking with patients clearly in a way they could understand.

Trust and communication

Patient records we looked at included person-centred treatment plans specific to their needs. The patients we spoke with were complimentary towards the staff and told us they had full trust in the staff. The patients we spoke with were able to describe their treatment plans and discharge arrangements that demonstrated that staff had explained their care and treatment to them.

The majority of patients we spoke with told us they would recommend the hospital to others. One patient on Ward 3 told us the ward manager was very supportive and had arranged short home visits for the patient when they were admitted to the hospital for an extended period of time.

We spoke with a patient and their relative who had been admitted to Intensive care as part of their post-operative care. They felt that they had all the information they needed prior to the operation including a DVD that explained what was likely to happen to them. They found the DVD was very informative and helped allay their anxieties about their operation. They also said that everything on the DVD was available in paper format as well so that they had been able to read through all the information in their own time.

Emotional support

We observed staff providing reassurance and comfort to patients. The patients we spoke with told us they were supported with their emotional needs. One patient commented that a member of staff held their hand while they were being transferred to the operating theatre and this helped to calm their nerves.

One negative comment we received was that a patient told us they had not been able to wait with their family prior to surgery. The patient had found this upsetting as they was going for major surgery and would have preferred to have the support of their family. Staff in the main A theatres told us they restricted family members in the pre-operative waiting areas due to space constrictions.

Patients could access the multi-faith chaplaincy services for support. Information on how to access chaplaincy services was displayed on notice boards in the majority of areas we inspected. Staff told us they regularly interacted with the trust's palliative (end of life care) team who provided support and advice during bereavement. Relatives of patients could also access bereavement booklets that provided additional information. Patients could be transferred to side rooms to provide privacy and to respect their dignity.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The Department of Health data showed national targets for 18 week Referral to Treatment (RTT) standards for admitted and non-admitted patients at the end of December 2013 were being met for most specialties. The data showed that the trust was just below the waiting time target of 90% for oral surgery (89.6%).

The Department of Health data showed that the trust performed better than expected for the proportion of patients whose operation was cancelled. 75 patients had an operation cancelled versus the England average of 86 between July and September 2013. 86 patients had an operation cancelled versus the England average of 92 between October and December 2013.

The trust had implemented the "Forget Me Not" dementia guidelines for patients with dementia. We saw that two patients with dementia in the surgical wards had additional records that included their life history and preferences. Staff on the surgical wards spoke positively about the "Forget Me Not" process and told us they found this useful in meeting the needs of patients with dementia.

For patients whose first language was not English, staff could access a language interpreter if needed. Staff told us

they would liaise with social services when dealing with homeless and vulnerable patients (such as refugees or asylum seekers). There was a policy in place which provided staff with guidance on how to provide care for patients with learning disabilities. We spoke with the carer and a relative of a patient with a learning disability in the SAU. They told us the staff were supportive and good at explaining the care. They also told us the staff aware of the patient's vulnerability and had dealt with them in a professional manner.

Vulnerable patients and capacity

Where patients lacked the capacity to make their own decisions staff sought appropriate professional help and consulted with patients families so a decision about care and treatment could be made in the best interests of the patient.

Access to services

Patients could be admitted for surgical treatments through accident and emergency, general practitioner (GP's) referral or transfer from other hospitals.

The Hospital had developed a unit within the SAU specifically for the assessment of GP referrals, discharged patients or emergency readmissions, so that patients could be seen promptly by a consultant. The unit had a waiting room with capacity for up to eight patients and there was a separate consultation room for examining patients. The service had allocated a consultant each day to hold a clinic after the morning ward round to see and manage such patients.

Leaving hospital

The systems in place for the discharge of patient's were securing timely and supported discharge from hospital. Patients were informed when they were likely to be discharged or transferred to other wards. The patients we spoke with told us the staff had given them clear information relating to their likely discharge date and confirmed this once it was clear that the patient was medically fit. One patient commented that "the discharge procedure was good and staff had given him a number they could ring if there were problems after discharge".

Data from the CQC adult inpatient survey 2012 showed the trust was rated as 'similar to expected' to other trusts for both questions relating to process of discharge.

Staff were supported by a discharge team for support relating to patient discharge. Patients were discharged from a dedicated discharge lounge that was staffed so patients could be monitored during their wait. There was a discharge form in the patient records that included a checklist to ensure patients were discharged in a planned and organised manner. There was an escalation process in place for staff to escalate to the matron if a patient's discharge was likely to be delayed.

Learning from experiences, concerns and complaints

When a patient raised a complaint, the centralised complaints team contacted the ward managers and theatre leads to investigate formal complaints relating to their specific areas. The ward managers we spoke with told us they aimed to respond to requests from the complaints team within a week. We looked at the records for five complaints in the areas we inspected and saw that the ward managers had responded to the complaints team in a prompt manner.

We did not see any patient information relating to complaints readily available or displayed in the areas we inspected. The patients we spoke to were not fully aware of how to make formal complaints. They told us they would speak with the ward or theatre staff if they had any concerns.

The areas we inspected had notice boards that included information such as the number of complaints received as well as results from the Friends and Family Test or patient experience questionnaires. Between September 2013 and October 2013, the trust had performed better than the national average for the Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment. This was reflected in the Friends and Family Test information we looked at within the surgical wards we inspected.

The trust had a process for seeking feedback from patients through patient experience questionnaires. However, this process was not fully implemented in the areas we inspected. The notice boards in the ward areas indicated low numbers of questionnaires had been completed over the past year. Staff told us they also sought informal feedback from individual patients during their stay. Staff told us that information about complaints was discussed during routine team meetings to aid learning. This was confirmed in the meeting notes.

Good

Surgery

Are surgery services well-led?

Good

Vision, strategy and risks

The trust had a clear vision and strategy with clear aims and objectives. The trust vision, values and objectives had been cascaded across the surgical departments and staff had a clear understanding of what these involved. Information relating to core objectives and performance targets were visibly displayed in the majority of areas we visited.

The trust had developed a draft quality strategy for 2014 – 2017. The trust's core objectives were focused on patient safety, clinical effectiveness and patient centred care. We saw that routine audit and monitoring of key processes took place within the areas we inspected to monitor performance against objectives.

Governance arrangements

There was an effective clinical governance system in place that allowed risks to be escalated to divisional and trust board level through a range of committees and steering groups. Performance was monitored from 'board to ward' and risks were managed. There were routine staff meetings to discuss local performance risks and staff issues. Staff had confidence in their managers to escalate and manage issues of concern.

Leadership and culture

There were clearly defined and visible leadership roles within the surgical division. The division of surgery and anaesthesia was divided into four clinical business units based on specific surgical specialties. Each unit was led by a clinical head of business unit (CHBU) and supported by a clinical business manager, clinical matrons and clinical consultant leads.

All leaders were visible within the department and staff felt well supported by managers. Staff reported an open culture and felt managers listened to them. Staff were very positive and proud of the work they did and felt their efforts were acknowledged by managers.

Patient experiences, staff involvement and engagement

The Chief Executive was highly prominent and engaged well with staff at all levels. The trust had developed a 'Proud of Aintree' branding to support its vision of 'Getting it right, for every patient, every time.' All staff we spoke with were enthusiastic, committed and motivated. They were also very positive about the new initiatives and were complimentary about the visibility of the Chief Executive. Staff were engaged in the change and planning agenda for the hospital through a range of staff engagement and focus groups. Team successes were celebrated and published through newsletters and in public areas around the hospital site. There was a sense of positivism and optimism throughout the directorate.

Learning, improvement, innovation and sustainability

There was a recognition and reward scheme in place within the hospital that encouraged and supported staff to suggest and implement ideas to improve the service. If the suggestions were implemented staff were acknowledged and the ideas shared.

Good

Intensive/critical care

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

Information about the service

The critical care unit is managed under the division of surgery and anaesthesia services. The unit at Aintree Hospital provides 23 medical and surgical high dependency beds. Six of these are allocated for elective or planned post-operative surgical recovery patients.

There are approximately 100 patients treated on the unit each month.

We visited the unit and observed care and treatment and we reviewed a sample of care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. During our visit we talked with five patients or their relatives and 14 members of the nursing and clinical staff. We looked at policies and procedures and reviewed the trust's performance data.

We also looked at the coronary care unit in relation to the service they received from the Medical Emergency Team who are closely linked with the critical care unit.

Summary of findings

The critical care department at the hospital was providing safe and effective care. There were sufficient numbers of competent staff in place to meet patients' needs in accordance with national guidance.

There was senior medical expertise available to patients over 24 hours, seven days a week.

Multi-disciplinary team working was well established that supported optimal care for patients.

Care was planned and delivered to meet individual needs.

Staff were caring and compassionate, patients and relatives spoke highly of the care they had received.

The Intensive Care Unit was the base for a medical emergency outreach team that was able to provide expert advice to help ward staff manage patients whose conditions had deteriorated in both the medical and surgical ward areas.

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Safety and performance

Care was provided in a clean , well-organised and well maintained environment

A consultant-led multi-disciplinary ward round was completed twice each day. This meant that patient benefitted from their clinical needs being frequently reviewed by an experienced and expert clinician supported by nursing staff and Allied Health Professionals such as physiotherapists and pharmacists.

A consultant critical care doctor remained on the hospital premises 24 hours each day.

The nursing establishment was based on a recognised staffing assessment tool and met the Royal College of Nursing recommendation of one nurse to each patient assessed at level three dependency and one nurse between two patients assessed at level two dependency.

There was a (nurse) shift coordinator supervising the unit throughout the day and night. This nurse was not allocated patients. One of the functions of the coordinator was to monitor the clinical status of each patient twice a day to confirm that the appropriate care was being safely provided.

Staff were aware of current infection prevention and control guidelines. There was a sufficient number of hand washing facilities and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice and 'bare below the elbow' guidance.

Staff wore personal protective equipment, such as gloves and aprons, while delivering care

Medicines, including controlled drugs, were safely and securely stored.

Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Equipment was well maintained, clean and safely stored. Emergency equipment was regularly checked and was ready for use if required. The hospital employed a specially trained technician who was responsible for the maintenance and supply of equipment on the unit. We found that they were enthusiastic about their role and described how equipment was decontaminated and the processes for replacing equipment. It was confirmed that because of the nature of the unit priority was given to replacing any equipment required.

We discussed infection control with the matron and a ward sister and they described the robust audit processes used to reduce the risk of harm from cross infection or poor hygiene. From our review of the audit report, we found that remedial action was taken in response to adverse findings. For example following a microbiological audit a policy of checking and deep cleaning all mattresses weekly was introduced. This was regardless of whether the patient was leaving the unit. This procedure was closely monitored and the outcomes recorded. We found that with the exception of when patients were not well enough to be moved, every mattress was inspected and either cleaned or replaced each week. The outcome was positive and the adverse microbiology result had not been repeated.

As a safety precaution and in keeping with infection control good practice all patients admitted to the hospital were screened for the Methicillin-resistant Staphylococcus aureus (MRSA) and treatment provided if required. The unit had three side rooms available so that patients with infections or at risk of infection could be isolated while receiving critical care.

We also reviewed a sample of the repositioning and pressure care audits. We saw clear guidance and information about the intervals for repositioning patients to prevent the development of pressure ulcers. The intervals were determined by a specialist pressure area risk assessment called a Waterlow risk assessment. The policy was that all patients must have a pressure ulcer risk assessment and care plan completed as a part of the initial admission process to the unit. The pressure care audit took place monthly. We found that the audit dated 06 August 2013 showed that assessments had been completed for six out of thirteen patients and the result dated 27 February 2014 showed that eleven out of twelve patients had been risk assessed and the correct intervention and pressure

area care provided. The audits confirmed that the trust had taken effective steps to improve performance and ensure that staff promoted safety with respect to pressure care. We found improvements in all the audits we reviewed.

Patients had well organised individual care files in and we reviewed reports, risk assessments, care plans, and other records and found them to be fully completed with appropriate risk assessments in place and clear treatment plans that were regularly reviewed.

Records reviewed confirmed that there was robust risk management for the prevention of patient harms such as blood clots and infections. There were specific care plans for caring for patients who were unconscious including mouth care and safe moving and handling. Report entries confirmed that care plans had been followed and the risk reassessed daily

There were comprehensive shift handovers that were used to share information about patient's condition and care and treatment requirements. The team also shared safety information through holding a 'safety huddle' meeting three times each day. The safety issues considered during the huddle included staffing, patient discharges, planned admissions and any other specific concerns. In addition there was also a patient whiteboard that provided key information for staff at a glance.

Steps were taken to protect patients from intruders as a result of the of the following security measures:-visitors had to ring to enter the unit and the door had to be opened by staff. We noted that staff were diligent about checking the identity of visitors. The matron told us that regular visitors were issued with a ward pass. It had been rationalised that ward security was not compromised and relatives who had to visit regularly would benefit because they were not put under the additional stress of having to repeatedly confirm their identity.

Learning and improvement

The senior managers told us that staff had access to a comprehensive training programme that included advanced life support, moving and handling, dementia awareness and medication management. The training matrix (record) confirmed that 78% of staff were up to date with this training. The practice (training) co-ordinator felt that the matrix was inaccurate and required updating because her personal records indicated that actual figure for mandatory training completed was between 85 and 90%.

In terms of providing a specialist critical care service we found nurses had completed a significant number of specialist courses and academic qualifications including: advanced practice in critical care, assessment of the critically ill patient, management in ITU and BSc specialist critical care practice.

Staff told us that training opportunities were provided: "Training is good –I'm up to date with mandatory training, fire, infection control etc. We have a training tracker."

The critical care lead consultant and the matron gave many examples of improvements made in response to the experience of patients and the findings of best practice guidance. One of the most successful was the introduction of the wound assessment chart. This incorporated body diagrams and tables. The chart was used to record and detail all of the invasive monitoring lines, cannulae, catheters, drains, surgical wounds and non-surgical wounds. The tool was intended to support effective wound management, prevent infections and ensure wounds and insertions were not overlooked. The wound assessment chart was initiated and piloted by the Aintree Critical Care Department and is currently being integrated as a trust wide tool.

The trust held a specific critical nurse education delivery group. The notes from the meeting in February 2014 showed that educational needs and priorities were identified and planned for. The meeting identified clear goals in relation to ensuring nurses continued to gain skills through the continual professional development process, and also providing support to new critical care nurses. We noted that the trust was looking at different methods for delivering training and supporting development including study days, away days and e-learning.

Systems, processes and practices

Clinical pathways were in place in the unit. Patients nursing care and treatment was assessed and planned using evidence based guidance and risk assessment tools.

Patient records showed that the risk of patients developing blood clots (VTE), pressure sores, catheter and urinary tract infections were, in the main, well documented and supported by appropriate care and regular monitoring.

Good

Intensive/critical care

Patient safety issues were routinely discussed and recorded through multi-disciplinary staff meetings and actions were taken as a result of issues identified.

Monitoring safety and responding to risk

Referrals to the critical care unit were made from the accident and emergency department and all other areas of the hospital. This was achieved through contacting the medical emergency team (MET).

The MET team provided an outreach service to support the care and treatment of patients whose condition was deteriorating or who had been admitted as an emergency with critical care needs. The MET service was available 24 hours a day and was highly valued within the hospital.

We reviewed the guidelines for calling the MET. We noted that the criteria were detailed and precise in relation to monitoring, measuring and interpretation of the patient's vital signs. This was so that a prompt response was made to provide the appropriate level of care. The criteria was clearly written and instructed staff call this service if patients scored four or above on the track and trigger observation tool used at the hospital. The system used was the Modified Early Warning System (MEWS).Staff were instructed that the MET had to be informed of a score of 4 or more unless a consultant or registrar had revised these instructions and updated the patient's plan of care.

The MET team aimed to receive urgent referrals in to the unit within 15 minutes of agreeing that this level of support was needed.

Anticipation and planning

The matron and the critical care lead clinician described the contingency plan in place to divert patients to an alternative critical care unit when required. There was a straightforward process was in place that allowed the bed manager to identify hospitals where vacant critical care beds were available. Therefore the North West Ambulance service was informed before patients were transported to the hospital. This meant that systems were in place to ensure that patients were protected from a delay in treatment because they would be sent to a hospital that could meet their needs.

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

Good

Using evidence-based guidance

Care and treatment was planned and delivered in accordance with evidence based guidance and national standards. The trust contributed data to the Intensive Care National Audit and Research Centre (ICNARC). The centre aims to improve critical care across the UK. It is good practice for intensive and critical care units to provide ICNARC with data. ICNARC then analyses the data and produces a report.

The results are compared with the national average and the other intensive and critical care contributors.

The ICNARC report for 2012-2013 had identified that the service was underperforming as the results indicated that more patients died on the unit than would be expected.

The hospital responded and investigated this finding. The senior management team consulted with a professional critical care consultation body; the trust's divisional management team; the trust's medical director and ICNARC to review the results further.

The trust's investigation identified that the ICNARC score had been based on incomplete data and so remedial action included allocating dedicated staff to input the data within the required timescales. There had been an improvement in the most recent score (December 2013) however the data continued to show that the ICNARC mortality remained higher than would be expected (although there were fluctuations).

The unit also completed another intensive care unit 'patient scoring' protocol called the Acute Physiology and Chronic Health Evaluation II (APACHE). This scored each patient on admission to the unit and the outcome classified the severity of the patient's illness. This score was also used to assess the mortality rate on the unit. The most recent APACHE II result placed the unit's mortality rate within acceptable parameters. The mortality rates in the APACHE II data showed a downward trend.

The disparity between the two mortality indicators was the subject of ongoing investigation and action. Targets for improvement of quality and clinical outcomes including a reduction in the mortality rate identified through ICNARC were in place.

Good

Intensive/critical care

The December 2013 ICNARC report also indicated that the unit performed well in relation to keeping patients safe from the risk of infection. The results showed that the number of patients who acquired infections on the unit was either below or equal to the national average for the period evaluated in the report.

The critical care unit also provided aftercare and outpatient appointments. This was in keeping with National Institute for Health and Clinical Excellence (NICE) guidelines about continued support for patients who have suffered a severe trauma or illness that required intensive treatment or life support.

Performance, monitoring and improvement of outcomes

The Critical Care Team was part of the Cheshire and Mersey Critical Care Network (CMCC). The overall aim of the network is to improve the patients experience and outcomes, improve access to critical care services and ensure critical care units practice high quality, individualised care.

Critical care units within the network undergo an annual service specification assessment. We reviewed the 2012 and 2013 reports for the CCU. We found that the unit compared extremely well with other critical care units in the network. The report showed that team were achieving high scores in the majority of the areas reviewed. We saw that in 2012 only four recommendations were made out of the 53 areas reviewed, and two of these four concerned the physical environment.

The 2013 CMCC review confirmed that continual improvements were being made on the unit. We also found that the unit had already completed a number of the recommendations made during that review. These included the introduction of patient diaries for those who had been kept in an induced coma and also a process for a formal handover protocol between critical care and the receiving ward staff when transferring a patient from the unit.

Staff, equipment and facilities

There were plans in place to relocate the CCU as part of the development of the new Urgent Care and Trauma Centre was being built on the hospital site with an estimated completion date of 2016.

The service would be placed in a new purpose built facility within the new centre

Multidisciplinary working and support

Staff worked closely with allied health professionals such as dieticians, occupational therapist and physiotherapist. AHP's were well informed about patients on the unit and completed their assessment within hours of a patient being admitted. This resulted in the prompt commencement of specialist regimes such as rehydration or nutrition, passive movement or other therapy that would promote a good recovery for patients.

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

We talked with five patients or their relatives on the unit and they felt that the nursing and medical staff were caring. One patient told us care was "Excellent, every nurse has been brilliant; they have a 'tender loving care' attitude." Another patient said: "I've been very happy…everyone is very attentive."

Comments from relatives and friends included: "The nurses are great." and, "Apart from parking, visiting is absolutely wonderful."

We saw that medical and nursing staff treated patients with respect and dignity. We saw that time was taken to listen to and speak with patients and their relatives. Patient's anxieties were allayed and staff worked hard to establish a rapport with patients and those close to them.

Staff were considerate and respectful and took into account that unconscious patients may hear potentially distressing conversations so they ensured that discussions about some aspects of care and future plans occurred away from the patient's bedside

Involvement in care and decision making

We talked with patients and relatives on the unit and they felt they had been involved in planning care and making decisions as appropriate. One patient told us they were given "clear information" and described the preoperative information provided in relation to been admitted to the unit after their operation. A relative told us: "They explain anything we ask. They don't mind us staying here because they know that …responds better when we're here."

Good

Intensive/critical care

We reviewed the records for three patients. We saw that in these cases doctors had made the decision to provide emergency care and treatment in the person's best interest. The rational for the admission was clearly documented and the signature of the doctors recorded.

Trust and communication

There was a pre-admission procedure for planned surgical patients. This included a visit to the post-operative critical care section of the unit. This gave people the chance to speak with staff and receive reassurance and information about any area of concern such as pain control, intubation and other related topics.

The trust has also commissioned a short introductory film about the unit that is still at the developmental stage. It is planned that people who do not visit the unit can download the film to view in their own time so they can understand and prepare for their admission to the unit.

There were processes in place to promote good communication and trust between patients those close to them and staff. One such process was the provision of a dedicated phone number for relatives to use when making enquiries. The nurses give the ward clerk a written update about each patient that could be read out to relatives. This meant that the phone was answered quickly and reduced the frustration for the person enquiring and nurses were not taken away from patient care unless necessary.

Emotional support

Emotional support was given to patients and those close to them. Time was taken to explain to patients what was happening to them and why. We saw that there were protocols in place for giving difficult messages and discussing continued active treatment with the family of patients when the clinical team felt this to be appropriate. We noted that the senior nursing staff and consultants were particularly aware of the importance of recording conversations and being open and transparent about end of life care.

Staff on the unit had completed a 'safety culture' survey and this had highlighted that many staff felt that more support was required to help them manage the stresses associated with working on the unit. We found that the matron was aware of this finding and more formalised and frequent staff supervision was being considered. We discussed this issue with nurses on the wards who agreed that some events were particularly harrowing and stressful; however, staff we talked with stated that in practice they received the level of support and debriefing they required.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The unit was well set out with sufficient space between beds for nurses and doctors to provide appropriate support including emergency intervention when required. The bed areas were clean and comfortable. Bathing facilities included a shower room.

There was a visitor's lounge and a kitchen for making drinks and light refreshments. This promoted the comfort of patient's visitors and allowed them to stay close to the patient while they were critically ill.

Staff were committed to improving patient experiences and had introduced the use of IPads to improve communication and provide diversional and recreational opportunities for patients.

We talked with the nurse who first recognised the potential of using the IPad as a means of communication. The nurse confirmed that they were encouraged to investigate the practical and financial implications of using IPads on the unit by managers and to research the communication applications that could be best adapted to meet the needs of the patient. The initiative had proven successful and IPads were used to communicate with people who were intubated. Since this initial idea the use of the IPad had expanded and they were used to provide entertainment for patients. Patients could access films, music and social networks. Social relationships were also promoted (in the context of security and privacy guidance); patients were also able to have 'video calls' with friends and family.

The IPad could also be adapted for patients who had a learning disability as easy read versions of books and information could be down loaded. There were also applications for patients whose first language was not English.

Patients and those close to them were very positive about the scheme.

We discussed the use of interpreters in relation to patients whose first language was not English. This was so plans and procedures could be explained in the patient's first language as this helped them to make an informed decision about their care and treatment. We were informed that an interpreter service was available. Staff were clear that family members could not to act as interpreters for patients. Staff were aware that the service included British sign language interpreters for patients who were deaf.

Vulnerable patients and capacity

Consultants and nurses understood the care of the unconscious patient and worked on the principle of acting in the persons 'best interest'.

We saw that the rights of the patient were promoted and discussed. We observed that a multidisciplinary discussion with appropriate personnel took place before doctors agreed to write a prescription for 'mitts'. Mitts are equipment used in order to prevent a patient pulling out intubation tubes or intravenous lines while unconscious. This meant that patients would not be restrained unnecessarily.

When conscious patients lacked capacity, staff adopted the same best interest principles and sought advice and support from appropriate professionals to support decisions in the best interest of the patient

Access to services

The ICNARC data indicated that at times planned surgery was cancelled and yet the overall occupancy rate for the unit was 82%. We discussed this with the matron and the critical care lead consultant. Both were aware of the findings and their analysis showed that the surgical cancellations were due to emergency admissions of critically ill patients who required a nurse staff ratio of one to one. This meant that the unit was no longer sufficiently staffed to accept post-operative patients as staffing levels would have become unsafe. In response to this a business case had been presented to the board for additional nursing staff and the staffing establishment had been increased. The effect of this increase on the cancellation of operations was being monitored.

Admission and discharge from critical care was carried out in accordance with agreed policies and protocols that were clearly understood by medical staff. When the service had reached capacity, there was a divert plan in place to support patients receiving timely care in another hospital.

Leaving hospital

Patients who were discharged from the critical care unit were generally discharged on to a medical or surgical ward within the hospital. We saw that transfers were well organised and conducted through completing the critical care discharge pack which included a completed set of observations, completed risk assessments and a comprehensive description of the patients treatment while on the unit.

Staff negotiated the time of transfer with the receiving ward and escorted the patient. The critical care nurse then handed over directly to a nurse on the receiving ward. This promoted a 'seamless' transfer and so protected the patient from the risk of information being over looked and ensured that the receiving ward were fully aware of the patient's needs. We noted that the transfer process was in keeping with National Institute for Health and Clinical Excellence (NICE) guidelines about transferring patients from critical care units.

We found that there was close collaborative working between the critical care unit and other departments in the hospital

Learning from experiences, concerns and complaints

Copies of the trust's complaints procedure were readily available at the entrance to the unit. We discussed complaints with the nursing staff. No written complaints had been received. Staff told us that patients and relatives did give verbal feedback and any concerns were generally dealt with immediately.

We reviewed the findings in the patient satisfaction survey February 2014 results. We saw that the unit scored 100% satisfaction in three areas out of five. The area of complaint that patients frequently highlighted was the quality of sleep on the unit. The results had improved over time because of the action taken but further steps were still required to improve in this area. Initiatives already in place included steps to reduce the noise level such as using paper towels instead of the blow-drier, signs reminding staff and visitors

to consider the amount of noise they make and diming the lights at night to remind people that it was night-time. However, all the written comments were positive and complimentary about the care and treatment.

We reviewed the 'Staff assurance check' report for February 2014. This was a unit based report which provided the results of unit's audits. The report included the actions needed to improve patient care and an update of the initiatives already in place.

The service improvement lead also provided an update newsletter informing staff about events, projects and other developments taking place or planned for the unit. The report also updates staff about patients who have accessed the clinic and rehabilitation services and gives staff an insight into the residual effects that some people had after being treated on the critical care unit.

We found that the unit capitalised on every opportunity to encourage staff to follow guidelines, be aware of risks and incidents on the unit and think innovatively about improving patient care. The nursing and medical team were dynamic and eager to learn from the information provided by patients and stakeholders.

Are intensive/critical services well-led?

Good

Vision, strategy and risks

Part of the trust's strategy for the future included the provision of an Urgent Care and Trauma Centre built on the hospital site with an estimated completion date of 2016. The project aimed to create a Cheshire and Merseyside Major Trauma Centre in collaboration with the hospital's emergency department the Royal Liverpool Hospital and the Walton Centre (a specialist trust nearby that provided neurological services). The provision of critical care services were central to this strategy and staff were enthusiastic about its development

Managers told us that the trust board provided strong support for the development and improvement of these specialist care services.

Governance arrangements

Robust, comprehensive and well embedded governance arrangements were in place and the effectiveness and quality of the service was continually under review. The management team was adept at measuring performance and quality and ensured information flowed from' board to ward' unimpeded so that patients benefited quickly from agreed improvements and developments.

Leadership and culture

The service was well managed and well led. Medical, nursing and allied health professionals worked well together to continuously improve the service. Staff were passionate about their roles and proud of the work they did. There was a strong message in relation to achieving an excellent standard of patient care in the management team and this was reflected in the way the unit was run and the way patients were treated.

There was a very positive 'can do' culture in the unit. An example of this was the fund raising activity staff participated in to provide the first IPads that patients used on a regular basis.

There were some excellent role models in all disciplines that inspired and supported junior staff.

Patient experiences, staff involvement and engagement

The trust ensured that patients were able to make their views known. However more care is required in documenting and monitoring verbal concerns and complaints that could provide additional opportunities for learning and development. Although it was acknowledged that most concerns raised by patients and those close to them were dealt with immediately.

There was a strong emphasis on staff development and staff were continually encouraged to become involved in the development of the service through monitoring activity and outcomes, taking on responsibilities for projects or joining groups concerned with promoting improvement in care and treatment.

With regards to engagement initiatives we found that there is a trust wide patient safety programme been implemented. All staff were invited to make suggestions about the top three risk areas in their department and make suggestions to reduce them.

Learning, improvement, innovation and sustainability

We found that the trust responded well to performance and quality data and worked hard to understand and

address identified shortfalls. Staff were well supported to expand and consolidate their knowledge and skills and were given opportunities to be innovative. The IPad scheme was a good example of this.

Good

End of life care

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

Information about the service

Care for patients at the end of life was provided on the medical wards in the hospital. We visited five wards where end of life care was being provided. We also visited the hospital mortuary, chapel of rest, bereavement services and the chaplain service.

We spoke with the relatives of two patients who were receiving end of life care and with staff on each of the wards we visited. We also spoke with members of the hospital specialist palliative care team (HSPCT) including the clinical lead for palliative care, the clinical nurse line manager and nurses from the HSPCT. We met with Macmillan nurses who operate a support service at the hospital and a member of the volunteer championship service who support end of life patients and their families.

We reviewed care records and policies and procedures as part of our inspection of this service.

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 service

Summary of findings

The hospital followed end of life care pathways that were in line with national guidelines and staff used care pathways effectively. There were enough staff with the right skills to meet patients' needs on the wards,

Care for patients at the end of life was supported by a consultant led specialist palliative care team.

Nursing and care staff were appropriately trained and supervised and they were encouraged to learn from incidents. Staff were clear about their roles and benefitted from good leadership. Care was given by supportive and compassionate staff.

Relatives of patients who received end of life care spoke positively about the care and treatment patients received and they told us patients and their relatives were treated with dignity and that their privacy was respected.

However, we found that staff in the mortuary and bereavement service felt that staff shortfalls had impacted on the quality of service they provided to grieving relatives.

Good

End of life care

Are end of life care services safe?

Good

Safety and performance

The hospital consultant led specialist palliative care team (HSPCT) coordinated and planned care for patients at end of life on the wards. The HSPCT provided support for patients across the hospital 24 hours a day. Patients who required end of life care were looked after on the medical wards in the hospital.

Ward staff had contact details for the HSPCT and confirmed that the team had always responded promptly when needed.

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 safe and well cared for in all he wards we visited.

We looked at Do Not Attempt Cardio-pulmonary Resuscitation (DNACPRs) orders on all of the wards we inspected. In all cases, staff had completed these in line with guidance published by the General Medical Council (GMC). The trust had systems in place to audit all DNACPR forms. Relatives of end of life patients told us that DNACPR orders had been fully explained to them prior to completion.

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 and abuse.

The end of life care teams monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to patients, staff or visitors. All incidents, accidents, near misses, never events, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system. Staff had access to the electronic system and confirmed that reporting of incidents was encouraged by managers.

Learning and improvement

In response to the national independent review of the Liverpool Care Pathway (LCP) published in July 2013, the Department of Health asked all acute trusts to undertake an immediate clinical review of everybody who was on the LCP. Following on from this the trust made a decision to phase out the LCP and they launched the End of Life Communication Record in November 2013. This was the first step in the process of phasing out the LCP. The new End of Life Communication Record was developed by a working group within the trust to address some of the main issues highlighted within the review. We viewed copies of the new communication records that were in place for end of life patients who were on the wards at the time of our inspection. These showed that clear decisions had been discussed and agreed with the patient and their families and they included clear notes for staff to refer to so that a consistent message was communicated to patients and their families. We saw that the principles of the LCP were still being following by staff on the wards for end of life patients and that they were part of the patients ongoing care records. The new communication record provided a detailed account if the initial decision making process and the reason for the agreed care pathway however it did not provide any details of the patient assessment or ongoing care. The trust reported was in the process of developing a replacement nursing care record for the last days of life that will be implemented on the wards from April 2014.

The trust policy for end of life care specifically stated that any if a patient or their family do not wish to use the LCP a discussion with them should take place to explore their concerns and a full explanation of the LCP should be given and following that if they still have concerns then their decision not to use the LCP must be respected. In this instance the new end of life communication record would still be used and placed on the patient's case notes.

Systems, processes and practices

The hospital palliative care team held a weekly clinical meeting to provide clinical supervision and peer support for the hospital team. Members of the HSPCT reported that relationships between the team and ward staff were exceptionally good and helped to ensure effective care and treatment for patients

The HSPCT also provided a resource to ward staff regarding the use of specific drug treatments for end of life care. This included the information on syringe driver prescription and drug infusions to manage patient's symptoms and keep them comfortable and pain free.

Good

End of life care

Monitoring safety and responding to risk

There were systems in place for checks to be carried out in relation to the use of syringe drivers. These included the checking the needle site, battery and volume of infusion remaining in the syringe.

Early warning systems were in place that alerted medical and nursing staff in changes in the patient's health so appropriate and timely action could be taken.

Anticipation and planning

The members of the specialist palliative care team told had agreed plans to pilot an alternative communication record the AMBER Care Bundle.

It was envisaged that by having conversations with patients and recording their preferences and wishes, and ensuring that everyone involved is aware of care plans, people are more likely to have their needs met

Are end of life care services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

The HSPCT provided a resource pack to ward staff in relation to end of life care. The resource pack included national guidance, including guidance provided by the National Institute for Health and Care Excellence (NICE) and recognised tools for the management of end of life care. For example we saw information on advanced care planning from the NHS National End of life Care Programme and the Supportive and Palliative Care Indicators Tool (SPICT) that provided a guide to identifying people at risk of deteriorating and dying.

Staff, equipment and facilities

The trust operated a volunteer companionship service. Volunteers from the service provided support to end of life patients and those close to them. We met with an end of life companion who confirmed that they had received specific training in palliative and end of life care that enabled them to carry out their role. We saw good examples of a volunteer providing support to a relative. The patient's relative made positive comments about the support they had received from the service and described it as "excellent". Another patient's relative told us that an end of life companion had been comforting by listening at a time of distress.

The hospital had a Christian chaplaincy service that provides spiritual support to patients and those close to them. Staff were also able to obtain the services of ministers from other faith groups if patients wished to see them.

We visited the hospital chapel that was close to the wards. The chapel was multi faith and provided a place for prayer and reflection that was suitable for different faith groups.

Multidisciplinary working and support

The Multi-disciplinary team worked well together to coordinate and plan the care for patients at the end of life. There was a daily MDT meeting on all the medical wards to discuss and manage patient risks and concerns. Patients at the end of life were included in this discussion so all disciplines could contribute to effective and consistent care for patients at the end of life.

Are end of life care services caring?

Good

Compassion, dignity and empathy

Patients and their families were treated with respect and dignity. Staff showed compassion while providing care and treatment to patients receiving end of life care and when they were supporting those close to them. Staff talked to people in private and were observed speaking with patients and relatives politely and sensitively.

Relatives of patients receiving end of life care commented positively about the way they and their relative had been treated. A relative of one patient receiving end of life care told us the care had been 'second to none' and another relative told us all the staff had been 'superb'.

Family members told us they had been fully informed on a regular basis about their relative's condition and that they had been consulted regarding decisions made about their relatives care and treatment. The relative of one patient told us that staff had been good at communicating with them and that they had answered all their questions in relation to the care and treatment of their relative.

Good

End of life care

Involvement in care and decision making

Patient records we looked at included person-centred care plans. This meant that staff were able to deliver care in accordance with patient's individual preferences and wishes.

Staff had been given training regarding seeking patients consent and were skilled in explaining the benefits and risks to patients so they could make an informed choice about their care and treatment. Records we viewed for patients who were receiving end of life care included signed consent forms and agreements for all aspects of their care and treatment including the use of equipment, medication and Do Not Attempt Cardio-pulmonary Resuscitation (DNACPRs) orders.

Trust and communication

Staff worked hard to establish a good rapport with patients and those close to them. Staff encouraged patients to ask questions about their care and responded honestly and openly.

The patients we spoke with were complimentary about and the manner in which they communicated with them and those close to them.

Emotional support

Staff were very supportive to both patients and those close to them and offered emotional support to provide comfort and reassurance. Staff also referred patients to other support services such as the chaplaincy and bereavement counselling services where appropriate.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patient care was planned and delivered in a highly personalised way. Patient records we looked at included care plans specific to a patient's individual needs and preferences. Care plans took account of patient's spiritual and cultural needs and appropriate support was provided. Staff respected people's confidentiality and sought permission where personal information needed to be shared with other professionals involved in their care. Patients and those close to them were very complimentary about the care that was given.

Patients and those close to them told us staff ensured that prescribed medication was given in a timely way to avoid distress and discomfort and equipment that could aid comfort was readily available.

We saw a range of leaflets and booklets on display around the hospital including on the wards we visited. They provided patients and their families with information relevant to patient care and treatment. Information about support services relevant to end of life care was also available, including McMillian and bereavement support services within the hospital.

The hospital provided a bereavement service. Staff in this service provided bereaved relatives with emotional and practical support after a patient's death. Staff dealt with grieving relatives sensitively and supportively. There was information available for bereaved families and friends to take away with them.

Staff felt that shortfalls in staffing levels meant that they could not spend as much time with grieving families as they would wish.

The mortuary had an appropriate viewing room that was sensitively decorated

Vulnerable patients and capacity

Staff received mandatory training in safeguarding vulnerable adults that included relevant aspects of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). Staff demonstrated a good understanding of the legal requirements of the Mental Capacity Act 2005.

Mental capacity assessments were carried out to identify patients that could not make decisions for themselves. We saw evidence in patient records that capacity assessments had been carried out. Where patients lacked the capacity to make their own decisions, staff consulted with other professionals so that a decision could be made in the patients' best interest.

Good

End of life care

Access to services
Nursing staff and medical staff were aware of the process for referring patients to the palliative care team. The team responded quickly to referrals seeing patients within 24 hours but very often the same day. Patient records confirmed the prompt response to referrals.

Leaving hospital
There was a rapid discharge checklist in place. The aim of the rapid discharge checklist was to facilitate a safe, smooth and seamless transition of care from hospital to the community for patients with a terminal illness who wish to be cared for in their own home or a hospice. The lead consultant for the HSPCT reported to us that four out of five patients each month had been supported to return home on rapid discharge. They said the team "would pull out all stops to enable a patient to go home if that is their wish".

A nurse gave an example of how staff recently supported the rapid discharge of dying patient using the rapid discharge checklist. The nurse also provided an example of when it was decided that it was unsafe for a dying patient to return home. The nurse explained that a risk assessment had been carried out and the result was that it was unsafe for the patient to be transported home due to a rapid deterioration in the patient's condition. We spoke with the patient's relative who told us that the decision for their relative to remain in hospital was fully explained to them and they said they had understood the reasons for the decision.

Learning from experiences, concerns and complaints
Complaints about the service were recorded centrally. The team did not receive a large number of complaints however; staff demonstrated a good understanding about responding to complaints and often resolved them locally. Learning from complaints was shared and staff amended practice accordingly.

Are end of life care services well-led?

Good

Vision, strategy and risks
The team worked hard and were committed to ensuring that all dying patients in the hospital received a high standard of palliative and end of life care. The team worked within national guidelines for best practice however meeting patient's individual needs was central to their work.

Governance arrangements
There was a palliative care and end of life governance group that met regularly. The group monitored progress on plans and performance and included items such as; incidents, review of end of life planning, training and the implementation of new initiatives. The governance group fed into the trust wide governance system and performance and proposals were reported at board level.

Leadership and culture
Leadership in this service level was good. There was a shared commitment within the palliative care and ward teams to provide the best for patients. There was a culture of collaboration and improvement. Staff were keen to continuously develop the service so that patients received the best care possible. Staff were positive about their colleagues and managers. Staff supported each other .well and knowledge and skills were generously shared for the benefit of patients and those close to them.

Patient experiences, staff involvement and engagement
The National Bereavement Survey, 2011, asked bereaved people about the quality of care provided for relative in the last 3 months of life. The Merseyside PCT cluster that includes this hospital was performing in the top 20% of all PCT clusters nationally for six of the 26 indicators, with three of the indicators appearing within 'Respect and Dignity Shown Always'

Patient experiences were also monitored through complaints. There were very few complaints about this service with many relatives thanking staff for their care and support during a very difficult time.

Learning, improvement, innovation and sustainability
The volunteer `end of life' companionship service, introduced in May 2012, is now operating on thirteen wards and has already had a significant impact on the quality of end of life care delivered within the trust. During the last 12 months, the End of Life Volunteer Companions have received three awards in recognition of this work: Aintree

Good

End of life care

Hospital University Excellence Award for Partnership Work, Runner up for Liverpool PCT Quality Award for Patient Choice and the Volunteer Department Team of the Year Award.

Good

Outpatients

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

Information about the service

The hospital has a large outpatients department that provided outpatient services across the whole range of medical and surgical services. There also specialist outpatient clinics for people with long term conditions and a separate out patient's location for breast care. There were 444,226 patients who used the outpatients departments across the trust in 2012/ 2013.

Summary of findings

Overall patients received safe and appropriate care in the department. The outpatient areas were clean and well maintained and measures were taken to control and prevent infection. The outpatient department was adequately staffed by a professional and caring staff team

Staff working in the department respected patient's privacy and treated patients with dignity and respect. Patients told us they were generally satisfied with the service they received.

However, we found that waiting times for appointments were long in some departments and there will still considerable numbers of cancelled and rearranged appointments.

The trust reported three serious incidents that occurred in the department between December 2012 and November 2013 that resulted from outpatient appointment delays. This had resulted in delayed diagnosis for three patients when treatment could have been provided at an earlier date. We saw the hospital had investigated the causes of these incidents and had introduced improvements to prevent this type of incident happening again.

Good

Outpatients

Are outpatients services safe?

Good

Safety and performance

The department was clean and well maintained. There was an ample supply of hand washing facilities and alcohol hand gel. Soap and hand towel dispensers were adequately stocked. Staff observed 'bare below the elbow guidance' and were observed to be adhering to the hospitals control and prevention of infection guidance.

Equipment was clean, well maintained and safely stored.

We checked the resuscitation equipment in all of the outpatients areas visited; all had been checked regularly by a designated nurse. The equipment was in working order and ready for use if required.

The department was well staffed and the Sister in Charge and band 7 nurses were supernumerary within the department and were available to provide supervision, guidance and cover for staff in the department. No agency or bank staff were used; staff covered the clinics between themselves. Seven health new care assistants had recently been recruited for the department.

Staff had access to the emergency medical team. The team was called if the medical condition of a patient attending the department deteriorated.

Staff were aware of the incident reporting system and could tell us about the range and nature of incidents that should be escalated.

The trust reported three serious incidents that occurred in the trust between December 2012 and November 2013 as a result of outpatient appointment delays. This had resulted in delayed diagnosis for three patients when treatment could have been provided at an earlier date. Delays in diagnosis were attributed to a number of circumstances. For example, an incorrect clinic letter stating the wrong information about a follow up appointment and the subsequent processing of the patient's invitation letter delayed this further. Another patient was not followed up for a diagnostic scan after six months and was seen after two years. This delay may have had an effect on the outcome for the patient's diagnosis and treatment. The incidents were declared as serious incidents and investigated. Actions arising as a result of the investigations were to monitor the use of the patient follow up appointment policy, to review and re launch patient leaflets within all outpatient settings so that patients received a copy directly from the area they were attending. For patients requiring follow up diagnostic procedures within 12 weeks were to be given an appointment prior to leaving the department and an alert system had been applied to the electronic waiting list to identify patients requiring urgent, routine and planned follow up. Systems had been agreed to ensure that all patients that cannot be given a follow up appointment within the requested timescale received a medical review of their follow up arrangements. This was to be introduced in April 2014 and as a result we were unable to assess the impact of this work at the time of our inspection.

The training records confirmed that staff in the department had received mandatory safeguarding training. When we spoke with staff it was clear that they were aware of how to raise and escalate concerns in relation to adult neglect or abuse.

Learning and improvement

There was a monthly meeting called the 'grand round'. The meeting included consultants and senior managers to discuss clinical outcomes and outpatient performance. Senior staff were encouraged to attend and then cascade the learning and performance information to staff to support improvement.

Systems, processes and practices

There were good systems in place for managing patient's records and ensuring that medical staff had timely access to patient information and test results.

We looked at ten patient records. It was easy to find the documentation relevant to the patient's appointment including investigations and results. A clinic outcome form had been introduced that enabled staff to record relevant information on a single form that was then transferred to the electronic records system. The electronic system could be accessed from the consulting room so clinicians had all the relevant information to hand.

Anticipation and planning

Improving the outpatient's service is part of the hospitals transformation agenda and the transition to 7 day working. Project plans have been developed and are monitored monthly at board level.

Good

Outpatients

Reducing the numbers patients who do not attend for their appointment has been identified as a key project for delivery in 2013/14. This included improvements to the appointment booking system, confirmation of appointments by letter followed up by a phone call or text message to remind patients of their appointments and encourage the patient's intention to attend.

Staff were aware of the clinical implications of patients failing to attend and were keen to seek robust solutions to ensure clinic appointments and consultations were not missed.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Care and treatment in the department was provided in accordance with National Guidelines for a range of long term conditions including COPD (Chronic Obstructive Pulmonary Disease) Diabetes and Arthritis.

For patients who required planned admission to hospital care was managed in accordance with evidence based care pathways.

Departmental performance was monitored monthly and there had been targeted work regarding the number of cancelled appointments. The cancellation rate for period December 2012 -2013 was 7.9% and the hospital had plans in place for reducing the number of cancelled appointments further.

Multidisciplinary working and support

There was evidence of good multidisciplinary working in outpatients. Doctors, Nurses and Allied Health Professionals such as physiotherapists and occupational therapist worked well together in the rehabilitation of patients following surgery, a stroke, admission to critical care as well as for patients with long term conditions such as arthritis.

Are outpatients services caring?

Good

Compassion, dignity and empathy

Patients were all very positive about the care provided by staff they told us "Staff here are always caring, I visit regularly and always find them caring. Staff spoke with patients respectfully and were open and friendly in their approach. Vulnerable patients were managed sensitively and attended to as quickly as possible. Staff listened to patients and responded positively to questions and requests for information.

Patients spoken with in the audiology, gastroenterology and ophthalmology clinics were very positive about the staff support they had received saying "Excellent staff, always friendly" and "This is my fourth appointment and staff are always the same friendly ones".

Involvement in care and decision making

We spoke to fourteen patients regarding the information they received in relation to their care and treatment. Patients were aware of why they were seeing a consultant or nurse specialist. Staff explained care and treatment to patients in a language they understood. Requests for consent to treatment included an explanation of benefits and risks so that patients could make an informed choice about their treatment options.

One patient told us, "Mr… said the surgery might not take and there was a chance of rejection. The tissue was rejected and he did the operation again. I have just seen him, he said it's been successful and I feel like my life has been saved, I'm ever so grateful to this hospital".

Trust and communication

Staff worked hard to establish a rapport with patients from their first appointment. In the diagnostic departments staff allayed patients fears about procedures, scans and tests. Patients were positive about staff attitudes and had confidence in the staff's ability to look after them well during a procedure.

Emotional support

Difficult messages were given to patients and those close to them sensitively and privately. Patients were given time to understand the messages and ask questions. Staff stayed with the patient until they left the department

Good

Outpatients

(unless the patient requested otherwise) and gave them contact numbers should they require further support or information when they returned home. Cancer patients were allocated a liaison nurse who gave the patient individualised support following their diagnosis.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Outpatient's clinics were, in the main, comfortable and patient friendly. There were ample seating areas and facilities for patients to purchase drinks and refreshments nearby. Clinics were well sign posted and members of the trust's volunteer group were available to support and guide patients around the departments and diagnostic areas escorting patients to their destinations in a helpful and supportive way.

The rheumatology department provided a nurse led treatment service for people living with inflammatory diseases or conditions. Part of the service included educating patients about their condition and lifestyle changes that could benefit them. There was also an outpatient treatment programme where patients could receive their medication by injection. This service also supported and taught patients to administer their own injections if they wished to do so. This meant that patients did not have to visit the hospital and encouraged patients to take more control of their condition.

The audiology service provided a service where patients could be sent replacement hearing aid batteries, tubes and cords directly to their home address to save them attending the hospital. The audiology clinic had produced a wide range of patient information about common ear conditions to support self-management. There was also information about clinical trials and opportunities for patients to contribute if they wished. The audiology department also hosted support groups for people with hearing related conditions such as tinnitus or Meniere's disease.

Transport

The department offered a transport service to bring people to and from their appointments. Staff in the department booked transport for patients and gave the relevant pick up and drop off times. Transport staff escorted patients into the department and reported their arrival to reception staff. Patients we spoke with were satisfied with the arrangements. However, patients who drove themselves to their appointment found car parking difficult as the demand for spaces was high, particularly if their appointment was scheduled at hospital visiting times.

Vulnerable patients and capacity

The outpatient department had access to chaperones, and other health and social care professionals trained in working with vulnerable patients. This meant that particular needs of vulnerable patients could be managed sensitively and supportively within the department

Where patients were identified as lacking capacity, staff sought advice from appropriate professionals so a decision could be mace in the patient's best interest. Those close to the patient were also consulted as part of this process.

Access to services

Referral to treatment times were closely monitored and patients were given appointments in accordance with the urgent referral pathways and routine referral pathways. There were no risks identified in relation to referral to treatment times in the hospital. However there were concerns regarding the cancellation and rearranging of appointments. In response to these concerns, the 'Meridian' report was commissioned by the trust in 2013 to look at increasing capacity in the surgical directorate and out patients. The report was presented to the executive board in the autumn of 2013 and made recommendations for improving capacity in outpatient clinics. The recommendations included the monitoring of the personal performance of consultants against planned work streams as well as peer pressure so that staff could challenge the reasons why clinics were staring and finishing late or over capacity. There were plans to implement the recommendations in April 2014; consequently we were unable to assess the impact of the improvement plans at the time of our inspection.

However, There were a number of actions already in place to address waiting times and appointment cancellations, including the implementation of a process for booking appointments six weeks in advance to facilitate improved

planning. There were also processes for reducing the numbers of patients who did not attend clinic appointments and preoperative assessment appointments including reminder phone calls and text messages.

Learning from experiences, concerns and complaints

Most of the complaints received about outpatients related to waiting times in the department and patients often raised this directly with staff as clinics started to overrun and waiting times increased.

This issue had been acknowledged by the hospital and staff told us following the 'Meridian Report' (referred to earlier) they have been told to log the reason for delays and overruns on an incident form so they can be considered and addressed in the transformation project work streams. We saw from the incident records that this process had begun and staff were recording reasons for delays on the system.

Are outpatients services well-led?

Good

Vision, strategy and risks

Plans for the service included addressing identified risks in relation to capacity planning, clinic over runs, missed and cancelled appointments, as well as anticipated demand for surgical services from the local population. The Meridian report (referred to earlier) made a number of recommendations that would improve the service, increase capacity and promote responsive and effective treatment for patients. The recommendations were due for implementation in April 2014, although staff had already started to collate and record information through incident reporting to inform this work.

Governance arrangements

Senior managers held regular departmental meetings to discuss and monitor departmental performance. Performance was reported monthly and was considered by the trust board. Improvement plans were in place. There was 'board to ward' ownership of the plans and a commitment at all levels to secure the required improvements.

Leadership and culture

There was good local leadership and a positive culture within the service. Staff worked well as a team and supported each other. Staff had confidence in their managers and all disciplines worked together for the benefit of patients.

Staff were aware of the challenges within the service and demonstrated a commitment to address them.

Patient experiences, staff involvement and engagement

Staff were very positive about the Chief Executive and the visibility of senior staff, one of the managers told us "The CEO (Chief Executive officer) has been here for two years. I find she has focused on staff engagement, because the board recognised this needed to improve. We are improving as the focus is on quality and not the budget. I am expected to keep within my budget, but there is more flexibility on how it is spent".

Patients are satisfied with the care given. In the last published out patients survey in 2011 patients overall satisfaction rates were in the expected range for a hospital of this size.

Learning, improvement, innovation and sustainability

A clinical nurse specialist in the rheumatology clinic provided us with evidence of developments within the clinic that had led to the clinic receiving a national award. The consultant and the nurse specialist had set up a transition service between the trust and Alder Hey Children's hospital for young adults transferring to adult rheumatology services. We saw the clinic had been awarded the British Rheumatology Society Best Practice Award 2013 for the early arthritis clinic.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	**Reg 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to- (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.' The provider has established a quality assurance system but this is not sufficiently embedded yet to be assured that all risks are identified, assessed and managed to protect people using the service