Liverpool University Hospitals NHS Foundation Trust

Inspection report

Royal Liverpool University Hospital
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Liverpool University Hospitals NHS Foundation Trust was formerly called Aintree University Hospital NHS Foundation Trust. It changed its name on 1 October 2019 when it acquired Royal Liverpool and Broadgreen Hospitals NHS Trust.

The trust has four hospitals – University Hospital Aintree, Royal Liverpool University Hospital, Liverpool University Dental Hospital and Broadgreen Hospital – which provide a full range of acute services, including acute medicine, urgent and emergency care, acute frailty units, rehabilitation services, dental services and surgical services, to a population of approximately 630,000 people.

When a trust acquires another trust in order to improve the quality and safety of care we do not aggregate ratings from the previously separate trust at trust level for up to two years.

The ratings for the trust in this report are therefore based only on the ratings for University Hospital Aintree and our rating of leadership at the trust level.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic.

At Royal Liverpool University Hospital we inspected only those services where we were aware of current risks. We did not rate the hospital overall.

In our ratings tables starting on page 30 we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect this time.

We carried out an unannounced inspection of Urgent and Emergency Services, Surgery, and Medical care at University Hospital Aintree and Royal Liverpool University Hospital because of continuing concerns about the quality and safety of some services.

Our findings

We also inspected the well-led key question for the trust overall.

Overall, we rated the trust as requires improvement.

Following this inspection, due to the concerns we had identified in Urgent and Emergency Services at University Hospital Aintree and Royal Liverpool University Hospital, and Medical Care at University Hospital Aintree, we wrote to the trust under Section 31 of the Health and Social Care Act 2008, in a Letter of Intent to take urgent action. Following this we received limited assurance and therefore issued urgent conditions requiring the trust to take urgent action.

Safe

- Mandatory training compliance was low for medical staff in urgent and emergency services
- Patients in emergency departments did not always receive appropriate care and treatment in a timely way, exposing them to the risk of harm.
- There were not always sufficient medical and nursing staff with the right qualifications, skills, training and experience to keep patients safe in emergency departments and medical wards.
- Staff did not always have the correct level of training on how to recognise and report abuse and not all staff at the trust had completed safeguarding children level three training.
- Staff did not always adhere to trust and national infection prevention and control guidance in urgent and emergency and medical care services at Royal Liverpool University Hospital.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines in line with requirements.
- Staff did not always recognise and report incidents and near misses in the emergency department at Royal Liverpool University Hospital, and medical care and surgery at University Hospital Aintree. Services did not always manage patient safety incidents well and did not always share lessons learned with the whole team.

However:

- In surgery there was enough staff to care for patients and keep them safe. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- The emergency department at Royal Liverpool University Hospital was well designed in the major's area with individual rooms with glass sliding doors.

Effective

- Staff did not always provide care and treatment based on national guidance and evidence-based practice and in urgent and emergency departments and medical care fluid documentation was not always accurate and complete.
- Staff did not always assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way.
- Services did not always make sure staff were competent for their roles.
- Key services in medical care were not available seven days a week.

However:

Our findings

- Staff provided good care and treatment, gave patients enough to eat and drink. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

Caring

- The trust did not always maintain patients' privacy and dignity, specifically when needing to be cared for in a corridor in the urgent and emergency department.

However:

- Staff treated patients with compassion and kindness and took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.

Responsive

- The trust did not always manage the access and flow of patients, in the urgent and emergency care department and in medical care services; with patients spending long periods waiting for an in-patient bed.
- Surgery services performed worse than the national average for the percentage of cancer patients treated within 62 days. The average length of patient stay was worse than the national average.
- Provision for patients who had a diagnosis of dementia was not well developed and there was variation in appropriate care to meet individual needs for these patients.

However:

- The trust planned care to meet the needs of local people and made it easy for people to give feedback.

Well-led

- Although the trust had an overall vision and strategies, the trust strategy was due to launch and was not yet embedded. Not all services had their own vision and strategy.
- Staff were supported by local leadership, but some did not always feel respected, supported and valued. Senior managers were not always visible in services.
- Trust governance processes were not robust or always effective. Risks were not always identified correctly with appropriate mitigations put in place.
- However:
- Staff were focused on the needs of patients receiving care. Most staff were clear about their roles and accountabilities. The trust engaged with patients and the community to plan and manage services and all staff were committed to improving services continually.
- The trust had been a lead participant in several COVID-19 research programmes.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Our findings

Outstanding practice

We found the following outstanding practice:

Royal Liverpool University Hospital Medical Care

The joint respiratory clinics held with the speech and language therapy teams and respiratory consultants meant better care for respiratory patients with the aim of providing better outcome for patients.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to Accident and Emergency, Medical and Surgical services.

Trust wide

The trust must ensure that care and treatment of service users is appropriate for, meets the needs of, and is reflective of their preferences, for service users who have a diagnosis of dementia. Regulation 9 (1)(a)(b)(c)

The trust must ensure that it takes action to ensure that persons providing care or treatment service users have the qualifications, competence, skills and experience to do so safely (Regulation 12(1)(2)(c)

The trust must ensure that incidents are identified, acted upon and investigated in a timely way. Regulation 12 (2)(b)

The trust must review the effectiveness of the complaints process and improve on the timeliness of responses to complaints. Regulation 16 (2)

The trust must ensure that there are robust and effective governance processes. Regulation 17 (1)(2)(a)

The trust must ensure that risks in the organisation are correctly identified and timely and appropriate action is taken to mitigate these. Regulation 17 (2)(b)

The trust must ensure that staff receive appropriate support, training, professional development, supervision and appraisals, this should include but not be limited to training in life support training, recognising the unwell child training and safeguarding training, as is necessary to enable them to carry out the duties they are employed to perform (Regulation 18).

Royal Liverpool University Hospital Urgent and Emergency Care

Our findings

The trust must ensure that staff receive appropriate support, training, professional development, supervision and appraisals, this should include but not be limited to training in life support training, recognising the unwell child training and safeguarding training, as is necessary to enable them to carry out the duties they are employed to perform (Regulation 18).

The trust must ensure that effective and timely care is provided; including at triage, assessment and for decisions to admit, to improve patient access and flow through the emergency departments to safe discharge or transfer to inpatient services. (Regulation 12).

The trust must ensure the health and safety risk assessments are reviewed and up to date for patients and mitigate risks to patient safety. This includes ensuring tools to identify patients at risk of deterioration are used in an accurate and timely manner by staff. Regulation 12 (1)(2)(a)

The trust must ensure that staff are assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. Regulation 12 (1)(2)(h)

The trust must ensure the proper and safe management of medicines in line with the requirements of (Regulation 12(1)(2)(g).

The trust must ensure that they are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided by the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (1)(2)(c)

The trust must ensure it operates effective governance processes to enable managers to assess, monitor and improve the quality and safety of services. It must ensure leaders have oversight of key performance and safety indicators (Regulation 17).

The trust must develop and embed governance structures across the division (Regulation 17).

The service must operate effective systems and processes to assess, monitor and improve the quality of services provided and mitigate any associated risks. This includes but is not limited to ensuring patients can access the service when they need it, patients do not stay longer than they need to, and patient moves for non-clinical reasons are minimised. Regulation 17 (1)(2)(a)(b)

University Hospital Aintree Urgent and Emergency Care

The service must ensure that staff receive appropriate support, training, professional development, supervision and appraisals, this should include but not be limited to training in life support training, recognising the unwell child training and safeguarding training, as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1)(2)(a)

The trust must ensure that effective and timely care is provided; including at triage, assessment and for decisions to admit, to improve patient access and flow through the emergency departments to safe discharge or transfer to inpatient services. (Regulation 12).

Our findings

The service must ensure the health and safety risk assessments are reviewed and up to date for patients and mitigate risks to patient safety. This includes ensuring tools to identify patients at risk of deterioration are used in an accurate and timely manner by staff. Regulation 12 (1)(2)(a)

The service must ensure that equipment is maintained and serviced in accordance with trust policy. Regulation 15 (1)(e)

The service must ensure that they are maintaining securely an accurate, complete and contemporaneous records in respect of each patient, including a record of the care and treatment provided by the patient and of decisions taken in relation to the care and treatment provided. (Regulation 17)

The trust must ensure the proper and safe management of medicines in line with the requirements of Regulation 12 (1)(2)(g).

The service must ensure it operates effective governance processes to enable managers to assess, monitor and improve the quality and safety of services. It must ensure leaders have oversight of key performance and safety indicators. Regulation 17 (1)(2)(d)

The service must develop and embed governance structures across the division. (Regulation 17)

The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17)

The service must operate effective systems and processes to assess, monitor and improve the quality of services provided and mitigate any associated risks. This includes but is not limited to ensuring patients can access the service when they need it, patients do not stay longer than they need to, and patient moves for non-clinical reasons are minimised. Regulation 17 (1)(2)(a)(b)

Royal Liverpool University Hospital Medical Care

The trust must ensure that staff receive the appropriate training relevant to their roles to enable them to carry out their duties and maintain the necessary skills to keep patients safe. Regulation 18 (1)(2)(a)

The trust must ensure that there are sufficient numbers of nursing staff that can meet peoples care and treatment needs and keep them safe from avoidable harm. Regulation 18 (1)

The service must ensure that care and treatment is provided in a safe way and that they do all that is reasonably practical to mitigate any such risks and staff follow policies and procedures about managing medicines. Regulation 12 (1)(2)(b)(g)

The trust must ensure that the premises are suitable for the purpose they are being used for, meet the needs of patients and are clean and well maintained. Regulation 15 (1)(a)(c)(e)

The service must operate effective systems and processes to assess, monitor and improve the quality of services provided and mitigate any associated risks. This includes but is not limited to ensuring patients can access the service when they need it, patients do not stay longer than they need to, and patient moves for non-clinical reasons are minimised. Regulation 17 (1)(2)(a)(b)

Our findings

University Hospital Aintree Medical care (including older people's care)

The trust must ensure that they deploy sufficient numbers of competent and skilled nursing and medical staff. Regulation 18 (1)(2)

The trust must ensure they assess and mitigate the risks to the health and safety of patients, specifically ensuring appropriate risk assessments are completed for patients, including accurate completion of fluid balance charts. Regulation 12 (1)(2)(a)(b)

The trust must ensure the proper and safe management of medicines, particularly in relation to timely administration of antibiotics and safe storage of emergency medicines and controlled drugs. Regulation 12 (1)(2)(g)

The trust must ensure it operates effective systems and processes to assess, monitor and improve the quality and safety of services. This includes but is not limited to ensuring patients can access the service when they need it, patients do not stay longer than they need to, and patient moves for non-clinical reason, particularly at night, are minimised. Regulation 17 (1)(2)(a)(b)

The trust must ensure complaints and feedback are acted upon and all patient records are kept up to date. Regulation 17 (1)(2)(c)(e)

The trust must ensure that all equipment is checked in accordance with manufacturers' and local policy and that premises are suitable for the purpose for which they are being used, including adjustments for patients with additional needs such as patients living with mental health problems or dementia. Regulation 15 (1)(c)(e)

Royal Liverpool University Hospital Surgery

The trust must take actions to embed an effective patient safety culture within theatres. Regulation 12 (1)

The trust must continue to take actions to improve average length of patient stay and referral to treatment waiting time performance in line with national standards. Regulation 12 (1)

The trust must take actions to improve the timeliness of patient complaint responses to within the timescales specified in the trust complaints policy. Regulation 16 (2)

The trust must take action to ensure there are effective processes for identifying, reporting and shared learning and improvement from incidents, including never events. Regulation 17 (1)

The trust must ensure there are suitable systems in place to assess, monitor and improve quality and performance of key processes effectively. Regulation 17 (2) (a)

University Hospital Aintree Surgery

The trust must take actions to embed an effective patient safety culture within theatres. Regulation 12 (1)

The trust must take action to ensure there are effective processes for identifying, reporting and shared learning and improvement from incidents, including never events. Regulation 17 (1)

Our findings

The trust must take actions to improve average length of patient stay and referral to treatment waiting time performance in line with national standards. Regulation 12 (1)

The trust must ensure that the Deprivation of liberty and safeguards are managed appropriately and consistent practises around the division of surgery. Regulation 13 (5)

Action the trust SHOULD take to improve:

We told the trust that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Trust wide

The trust should ensure that it continue to make improvements in culture across the organisation.

The trust should ensure that it continues to develop engagement processes with service users, staff and the public to identify improvements in services.

The trust should consider:

Royal Liverpool University Hospital Urgent and Emergency Care

The service should ensure clear corridors and access to cubicles.

The service should ensure patients paper records are maintained securely.

The service should ensure that emergency medications are stored in tamper evident containers.

The service should ensure that they are monitoring patient outcomes and learning from the results in a timely manner.

The service should ensure they develop a process to prioritise patients with chest pain.

The service should increase the visibility to waiting rooms with a clear process to assure safety of patients.

The service should consider developing a clear vision and strategy that is aligned across both sites.

The service should consider developing an effective system to monitor compliance with mandatory training.

University Hospital Aintree Urgent and Emergency Care

The service should ensure, that during periods of high demand, people using the service are supported to appropriately socially distance themselves from others.

The service should consider developing a clear vision and strategy that is aligned across both sites.

Royal Liverpool University Hospital Medical Care (including older people's care)

Our findings

The trust should consider a review of services provided over seven days so that patients receive a consistent safe effective service each day of the week.

The service should consider a review of safety information displayed in ward areas so that staff and patients are informed of safety performance and ensure that it is used to drive improvements.

The service should ensure that all patients needs and preferences about their care are considered and that appropriate reasonable adjustments are made to meet their needs.

University Hospital Aintree Medical care (including older people's care)

The trust should ensure that all staff receive training specific for their role on how to recognise and report abuse.

The trust should ensure that there is access to enough lockable storage for all patients who were being taught to make up drinks with thickeners and that they carry out a risk assessment for this.

The trust should ensure that all safety huddles are multidisciplinary.

The trust should ensure that all meetings, such as weekly governance meetings, are minuted.

The trust should ensure that all ward rounds are consultant led to assure effective and timely review of patients.

The service should ensure all patients needs and preferences about their care are considered and appropriate adjustments made to meet their needs, particularly for patients with dementia.

The service should consider amending the discharge checklist to include space to document actions for patients at risk of a fall.

Royal Liverpool University Hospital Surgery

The trust should take appropriate actions to improve staff mandatory training, including safeguarding training and life support training, in line with trust compliance targets.

The trust should take actions to maintain safe nurse staffing levels across the surgical wards.

The trust should continue to monitor and take appropriate actions to improve readmission rates across the surgical services.

The trust should take actions to improve clinical audit outcomes.

The trust should take actions to implement a more dementia-friendly environment across the surgical wards and theatre areas.

University Hospital Aintree Surgery

Our findings

The trust should take appropriate action to improve staff mandatory training, including safeguarding training and life support training, in line with trust compliance targets.

The trust should take actions to improve the timeliness of patient complaint responses to within the timescales specified in the trust complaints policy.

Is this organisation well-led?

We rated it as inadequate because:

Not all senior leaders demonstrated the necessary experience, knowledge, and capacity to lead effectively. They did not always identify and manage priorities in an effective and timely way. They had limited insight for the scale of the challenges of integrating services in order to become one overall provider organisation. Although there was some recognition of individual strengths in different leaders, there were significant concerns about leadership capacity and capability at board level, and the ability of the board to respond at pace to key areas of risk. Staff we spoke with told us senior leaders were not always visible and approachable in the organisation.

Whilst the trust had recently identified a strategy and a vision for what it wanted to achieve, this was due to be launched following our inspection and plans for sustaining future delivery of the strategy were unclear. The trust had not identified a strategy for meeting the needs of patients with dementia or delirium.

In core services we found the culture was mixed and not all staff felt supported, respected or valued. There was a lack of cultural integration between the two hospital sites we inspected. Although we saw examples of collaborative teamworking, there was variation in positive culture and staff experience at all levels of the organisation.

The arrangements for governance were not clear and did not always operate effectively. Not all staff were clear about their roles and accountabilities. Processes were not always effective and completed in a timely manner.

Risks, issues and poor performance were not always managed and acted upon by leaders in an effective or timely manner. Following the inspection, we formally wrote to the trust requesting evidence that key patient safety risks identified by CQC, specifically in relation to the care of patients in the trust's accident and emergency departments, were being effectively managed and mitigated.

The trust did not always collect reliable data, analyse and use it to make improvements. Systems to manage performance were not always used efficiently. Staff accessed data on multiple electronic and paper platforms and for some services, information was difficult to access promptly.

Leaders and staff engaged with patients, staff, equality groups, and the public. However, in our core service inspection we frequently heard from staff that leaders were not visible.

Whilst the trust had systems in place to identify learning from incidents, deaths and complaints; these were not always effective or delivered in a timely way, which delayed any required improvements to patient care.

However:

Our findings

Leaders expressed pride and recognised trust staff, who were described as 'resilient and caring and absolutely fantastic' during this pandemic. During our inspection we observed in different ways how staff continued to work with a caring approach, often under demanding and challenging circumstances.

Staff were committed to continually learning and improving services. They used quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We found that the Fit and Proper Person Procedure was fit for purpose and the files were predominantly in line with the requirements of the regulation.

Leadership

Not all senior leaders demonstrated the necessary experience, knowledge and capacity to lead effectively. Leaders did not always understand and manage priorities effectively or in a timely way to ensure high quality, sustainable care. They had limited insight into the scale of the challenges they faced to enable the effective integration of the previous two organisations to become one organisation. Senior leaders were not always visible and approachable in the organisation.

The leadership of the trust had a challenging agenda to deliver. In addition to the national Covid-19 pandemic the trust had recently gone through a major acquisition and was still in the process of integrating services and staff across multiple sites. There was also the management of significant multiple service reviews linked to the relocation of the existing Royal Liverpool University Hospital to a new build over the coming 12 months.

There had been little change to the senior leadership at trust board level since the acquisition of Royal Liverpool and Broadgreen Hospitals NHS Trust by Aintree University Hospital NHS Foundation Trust in October 2019, with five of six executive directors having been in their roles since then. The chief executive (CEO) had previously been the CEO of Aintree; the Executive Chief Nurse, Chief Operating Officer and the Medical Director had also previously held executive director roles in the same organisation, with the Chief People Officer having previously been Executive Director of Workforce at Royal Liverpool and Broadgreen Hospitals NHS Trust. The Finance director had been appointed externally, joining the trust in April 2020. They were supported by two deputies, each of whom held the director of finance role at the two predecessor Trusts; between them they had the history of the organisations and the apparent drive to do things differently.

Since the last inspection, the trust had appointed a director of Strategy, director of communications and a new director of quality improvement to support development and delivery of the trust's new strategy.

There was a lack of a cohesive view of the strengths and development needs of the executive team. Some senior leaders recognised there were gaps in skills and areas for development, in terms of experience and knowledge, to enable them to lead effectively at executive level. Leaders reflected that one of the central challenges for directors was the ability to 'step into a wider organisation' since the trust acquisition in October 2019. The acquisition had significantly increased the breadth, size and complexity of the trust. Another senior leader observed there was a 'key lack of overarching strategic responsibility across the executive leadership'. We also heard differing views about the board's capabilities; one director stated the board's strengths were seen as having a range of skills and experience at board level, with 'a balance of people with organisational knowledge of both sites'. However, others commented on the immaturity of the executive team together with a lack of curiosity and cohesion.

Our findings

Not all of the senior leaders' portfolios and reporting lines were clear, especially between the medical director and the executive chief nurse; this had been highlighted in a recent external governance review and was starting to be addressed by the trust. We also heard concerns that although a new leadership structure had been identified since the 2020 inspection, this was complex, described as 'too distant', with no clear accountability. There had been a divisional restructure, with the appointment of two new site-based directors of nursing for University Hospital Aintree and Royal Liverpool University Hospital. The aim was to provide nursing leadership at site level and enhance the voice of nursing within the division. However, there were unclear systems for these roles to be able to function with full effect, with an apparent disconnect to key forums and central communication processes. Although both site-based directors of nursing had regular meetings and reported to the Executive chief nurse, we heard there were gaps in communication from a divisional level, with important information often coming to light retrospectively. This included information relating to significant decisions, such as initiating the trust's full capacity protocol at times of surge and peak demand. It was unclear how these two new posts sat within the reporting and governance structures.

The trust senior leadership was also in receipt of a significant element of external leadership support to address the substantial challenges it faced. There was a "support triumvirate" which had been in place for approximately six months, prior to the Well led inspection, with part of its role being to enable the development of a quality improvement strategy.

The trust chair had been in post since October 2019 and had previous experience of chairing an NHS board. There was a varied mix of skills and experience across the non-executive directors (NEDs). We were told that the existing skill set was reviewed to determine any specific requirements when new NEDs were recruited. There was a process for induction of NEDs which was tailored to their individual background and needs. There had been some recent new NED appointments. The newer NEDs had limited time onsite and face-to-face to date, due to the need to work virtually because of COVID-19. It was felt that this had hindered gaining a full understanding of the organisational context in some areas. Which had in turn, in some instances, impacted on effective engagement in key discussions. The NEDs acknowledged their role felt more reactive than proactive at times and that they had identified and raised concerns recently about the lack of grip over key operational concerns.

During the well led inspection, it was apparent that trust executives frequently worked in a silo approach and that they did not act effectively as a unitary board. There was a lack of evidence of collective leadership to address the challenges the trust faced and there was a lack of recognition of some of the key concerns identified on inspection. We heard comments from individual leaders to reflect this, including 'we are not where we would like to be overall' and 'there is more work to do to build the focus on quality.' There was also concerns from the NEDs about a lack of traction and pace by the executives, particularly in relation to the speed of responding to external reports, including the last CQC inspection report, and other reports which identified trust-wide patient care issues.

At this inspection, and previous inspections undertaken during 2020, we were told by staff that not all senior leaders were visible. From our core service inspections, we often heard that staff felt well supported by local and service leadership, however, they did not perceive there was the same support from more senior levels of the organisation. Staff told us they felt the board did not respond to the concerns and risks they raised or considered staffs' views and ideas. Senior leaders were seen as out of touch with what was happening on the front line; being unable to understand the risks or issues described by staff. For example, we were told the chief executive had visited the accident and emergency department following the introduction of a new electronic records system. The executive view was this had been a successful implementation. However, the staff experience had been entirely the opposite experience; significant issues had been found with the new system, which had severely impacted on service delivery and continuity in the emergency department.

Our findings

Although the board engaged in discussions about the challenges that the trust faced and where improvements needed to be made, they were not always able to respond with clear actions to address these. There was a lack of constructive challenge to ensure there was effective and timely holding to account for the actions required to improve and deliver sustainable services for patients. One of the trust's leaders felt there had been improving challenge at board over the last few months, with the trust board starting to set strategic direction, and identify a balance of finance, safety and quality. However, it was evident that the leadership team faced several considerable challenges to deliver the required improvements and was not always sighted on the immediate priorities for these. A key area of concern we raised with the trust on the first day of our core service inspection was regarding patient safety in both accident and emergency departments, where we saw long waiting times for patients, delays in patients having medical reviews, and significant concerns regarding access and flow. Ineffective processes in relation to access and flow of patients into and through the emergency department were creating and contributing to significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. In other areas, where we did see that improvements were planned, many were still in progress and were not yet embedded. Overall, there was limited assurance as to the impact of the planned changes on improving outcomes and service quality.

The trust had a council of governors, with regular governor meetings which were attended by varying NEDs, some executive officers and some members of corporate governance team. There was a mix of longer serving and newer governors on the Council. The collective view from council members we spoke with was that the trust was heading in the right direction. Although engagement with governors had been more limited than they would have liked in development of the trust's strategy, the governors told us the content of the strategy was felt to be generally positive. The lead governor received reports and met monthly with the trust chair and company secretary. The governors told us that sometimes there could be issues in receiving timely communications, including delay and late arrival of board agendas and papers. There were other issues in communication: it had taken nearly 18 months to establish email addresses for the governors.

It was acknowledged that talent management for leadership progression was still being established; this had been delayed due to COVID-19. An executive team development programme had initially been identified. However, again following delays due to COVID-19, this was in early stages of progress. There had been some board development days since January 2021. We were told that the executive director team was working with an organisational psychologist and each executive director had access to a mentor and a coach as part of this approach.

The finance team had a comprehensive staff development strategy and had recently appointed a lead for staff development. The team had an aspiration to be best in class, with the objective of gaining level 1 accreditation in Financial Skills Development this year.

Operationally the trust was run through five divisions; Acute and Emergency Medicine; Specialist Medicine; Surgery; Anaesthetics, Critical Care, Head and Neck, Theatres. Each division was led by a team made up of a divisional medical director (DMD), a divisional director of nursing (DDN), and a divisional director of operations (DDO). At the time of the inspection, the DDNs were line managed by the DDOs. It had been highlighted by an external report that it was unclear why the DDNs were not on an even leadership footing with the rest of the triumvirate in terms of the management and reporting structure. This was a concern as it potentially affects the profile and voice of nursing/AHPs in the organisation, and the overall message it could give around prioritisation of operational performance. We were told that from the 1 September 2021 the divisions would be chaired by the DMD with the DDN and DDO accountable to the DMD. In addition, the DDNs would be clinically and professionally accountable to the deputy chief nurse. Supporting the divisional leadership structures were clinical directors and care group leads within specialist clinical services.

Our findings

The pharmacy staff team had continued to integrate as one team across all locations and was working as a whole trust team rather than individual hospitals. A new full time Medicines Safety Officer (MSO) had been appointed to work across the Trust and several other posts had been appointed. Ten pre-registration pharmacists were joining the team, with seven working jointly within the hospital and in the local Primary Care Network (PCN).

We found that the Fit and Proper Person Requirements (FPPR) procedure was fit for purpose and the files were predominantly in line with the requirements of the regulation. There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. The company secretary had been in post for four months and was responsible for oversight and compliance with the FPPR procedure, working closely together with the trust chair to oversee application of FPPR. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the FPPR (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed a random sample of six executive and non-executive director files in total, including six monthly self-declarations checks for directors. We observed the trust had effective systems, including automated DBS checks, for compliance with FPPR.

The chief executive had responsibilities working in partnership with key stakeholders in the integrated care system (ICS) regionally. The director of finance was a proactive leader in the wider system and chaired the provider directors of finance group for the Cheshire and Merseyside ICS

Vision and Strategy

The trust had a vision for what it wanted to achieve and had recently identified a strategy to turn it into action, which had been developed with relevant stakeholders. The vision and strategy were aligned to local plans within the wider health economy for Liverpool and the surrounding areas. The trust strategy had not yet been implemented; it was due to be launched following the inspection. Action plans to support delivery of the strategy were not robust. The trust did not have a strategy for caring for people with dementia or delirium and there was limited senior leadership to ensure the trust met the needs of patients who had dementia.

Following our September 2020 inspection, we told the trust that they must develop a clear vision and strategy and ensure that it was aligned across all divisions. At this inspection the trust had a vision and strategy, however, it was yet to be launched and aligned across all divisions. Although the strategy had been identified, plans for supporting the future delivery of the strategy were not robust for the strategy outcomes to be achieved.

The trust's vision was: "Healthier, happier, fairer lives". The vision of the trust focused on providing high standards of compassionate care and listening to patients, staff and partners.

The trust had developed a three-year corporate strategy, initiated from a 'Big Conversation' listening exercise conducted in early 2020. The strategy had been approved by the board in May 2021 with a planned launch date of 31 July 2021. Liverpool University Hospitals NHS Foundation Trust strategy 'Our future together' 2021-2024 outlined a central principle of working together: as a trust, with partners and with the communities served by the trust. Strategy plans were based on four strategic priorities: great care, great people, great research and innovation, and great ambition. The vision and strategy supported the 'One Liverpool' plan which set out how system partners would come together to deliver improved health in the city of Liverpool. The One Liverpool vision aimed 'to work together to tackle health inequalities and respond to what matters most to people: supporting better health and wellbeing across all stages of life'. The strategy's key goals included:

Our findings

- working together to improve our services and to deliver planned merger benefits for our staff, patients and communities
- collaborating with patients and partners to expand participation in clinical research and innovation opportunities
- maximising our social and economic impact as an anchor institution
- providing a rewarding, supportive working environment
- working with partners to lead improvements in healthcare outcomes and reduce inequalities in the populations we serve.

The trust had also identified a number of related enabling strategies; these included the People Strategy; Digital strategy; Research and Innovation strategy; Sustainability strategy, which had been approved since October 2020. Further strategies were in development and scheduled for approval in 2021, including the Quality & Safety strategy (July 2021); Clinical Service strategy (Oct 2021); and Estates strategy (Nov 2021). Given the financial challenges facing the organisation there was no explicit supporting financial strategy which together with other strategies would communicate to a wider audience the approach to integrating services and efficiency priorities.

During the core service inspection, we found staff at all levels had varying awareness of the trust strategy, and senior leaders in several core services we inspected had not yet identified a strategy which reflected the organisational visions and values. Service leaders could not always clearly articulate their service plans in relation to the trust strategy, beyond an acknowledgement of the trust's shared vision and values. This may have been because the strategy had not been formally launched; although we were told many staff had been involved in its development.

Originally the organisational focus for 2020/21 was to implement the post-acquisition plan for integrating services across the two predecessor Trusts, as well as improving access and quality of care, this was intended to generate c£30m of efficiencies. This has been impacted by the Covid pandemic and other than some work in trauma and orthopaedics little progress has been made with this agenda apart from ENT (ear, nose and throat) services. The integration of services was being led by an Innovation team with a phased programme of work and was expanded to include the delivery of the move to the new hospital which was planned for 2022. There were 16 specialities as part of the integration programme; seven of which will require public consultation which has yet to commence.

The trust had not identified a strategy for meeting the needs of patients with a dementia diagnosis and there was no board representation or senior leadership for oversight for dementia. Whilst there was a very dedicated and proactive small clinical team for the care of people with dementia and delirium across the trust, this service had not been prioritised strategically. There was limited evidence of ensuring the provision of dementia friendly environments and responding with individualised support for patients who had dementia. At the time of the inspection, the team were about to launch the Butterfly scheme, a nationally recognised approach to support people with dementia. The focus for the clinical team was to 'establish the basics', including staff training, and develop a dementia policy and strategy. They observed that this was a 'huge task' and a resource issue to effectively deliver this across the trust's sites. Although initial progress had been made in different dementia initiatives, such as the start of a carers' café and development of dementia champions, this had stopped due to COVID-19, and was about to restart at the time of inspection. During the pandemic there had been some opportunity for progress in updating clinical guidelines related to dementia and delirium, as well as implementation of a pilot audit tool with positive results.

Culture

Our findings

Most but not all staff felt supported, respected and valued by their local leaders. All staff we met were focused on the needs of patients receiving high quality and compassionate care. There was a lack of cultural integration between the two hospital sites we inspected. The trust was working towards an open culture where patients, their families and staff could raise concerns without fear. However, not all staff felt secure to raise concerns.

We found there was a mixed culture at the trust which predominantly reflected differences between the two main hospital sites we inspected. This was noticeable from the executives we spoke with; those who had been in post at Aintree prior to October 2019, voiced a greater focus and positive bias towards the University Hospital Aintree site, with less supportive language used when talking about the Royal Liverpool University Hospital site.

All the executive leaders we spoke with acknowledged a cultural difference between sites, which had continued since the new trust organisation was established in October 2019. Leaders reflected this had also been a factor in limiting ongoing progress, particularly with service integration programmes and work to embed consistent approaches trust-wide. Progress in cultural work was described as still in early days; this was following delays in the launch of the trust strategy and interruptions due to the COVID-19 pandemic.

During inspection we heard some concerns from senior leaders about different behaviours at executive level, referencing 'an element of defensiveness and blame due to COVID-19' and lack of maturity as an executive team. We also received some comments questioning the executive team's ability to be open and transparent in their communications.

The majority of staff we spoke with during inspection were proud to work for the trust, with a shared loyalty to the communities the trust served, and a commitment to providing good care and positive experiences for patients. During our inspection we observed in different ways how staff continued to work with a caring approach, often under demanding and challenging circumstances.

Leaders described a culture of openness and felt that staff were not afraid to raise concerns without the fear of retribution. However, during the core service inspection we heard mixed views from staff about their confidence to raise concerns. Staff side organisations told us there could be tensions between staff side and the executive team, with a perceived lack of productive engagement to build progress, referencing the clash of cultures between the trust's two main hospital sites as 'being enormous'. Communications were frequently challenging, and any concerns raised by staff side appeared as not being acknowledged. One area of particular concern had been identified regarding an award-winning trust service 'Aintree at home'. This service provided rehabilitation and support for patients being discharged from hospital, with the aim of limiting rates of patient readmissions. The service had been decommissioned during the last six months, with concerns from staff about lack of engagement in this process, and a resulting sense of low morale when the service was closed. Staff side representatives said that in general, themes from concerns raised by trust staff were focused on maintenance of staffing levels and risks to patient safety, including those arising from staff shortages. Specific concerns had also been raised regarding lack of role clarity, with the example of inconsistencies for band 2 and band 3 staff.

The trust results for the 2020 NHS Staff Survey was the first year of survey data provided for the new trust. The trust was rated worse than comparators for the questions around Immediate managers and a Safe environment from violence. It was rated better than comparators for questions around Safe environment from bullying and harassment. The trust was in line with average for the benchmark group for all other themes in the survey. As this was a new trust there were no significant comparisons from the 2019 report.

Three themes where the Trust deviated (negatively) from the average were: Immediate Managers; Morale and Safety Culture.

Our findings

Key issues relating to Immediate Managers show that staff want the following to improve:

- Managers to provide regular feedback to staff on their work
- Managers to seek feedback from staff before taking decisions that affect staff members' work
- Managers to find out from the staff how they want their work to be valued and recognised

Key issues relating to Morale show that staff want the following to improve:

- Regularly encourage staff in a way that they find motivating – need to ask them what this looks like for them at local and individual level where possible
- Wherever possible, allow staff the freedom to choose how they do their work – set clear outcomes or objectives but allow the staff to decide how those objectives are achieve
- Involve staff in decision making – use suggestion boards, survey tools, feedback posters, team meetings and staff survey data to inform decisions

Key issues relating to Safety Culture show that staff want the following to improve:

- Review processes relating to the reporting of incidents to ascertain how they are applied and where any unfairness may occur and embed framework of values and behaviours into processes, hold focus groups with staff involved in recent incidents to explore their experience and identify possible improvements
- Ensure that feedback is given to staff who have reported incidents – review all tools used for incident reporting to identify how process is working and where feedback can be improved – important to note that feedback must be understood not just provided
- Review patient and service user processes to ensure that this is acted upon and equally importantly that this is fed back to staff

A trust-wide action plan had been formulated to address key themes at organisational level, with a template for local action plans to be formulated, based on local issues.

The trust's Freedom to Speak Up Guardian (FTSU) informed us there had been general development of the FTSU role and network since the last inspection, with ten champions now available to support staff who wished to raise concerns. The majority of FTSU champions were based at University Hospital Aintree, with fewer champions at the trust's other hospital sites; champions were accessible by phone, email and via the trust's website. Contacts were allocated between FTSU champions for response, and systems were in place for working across the trust's locations. Identified themes from FTSU contacts during the past year were across two main areas, firstly related to concerns about patient safety, with the remainder relating to staff behaviour and communication issues. The FTSU guardian had noted that between April and June 2021 there had been an increase in staff groups coming forward to raise a shared concern; this made for added complication in reporting the trust's data to the National Guardian's office. There had also been a slight increase in the numbers of nursing staff who had raised concerns. The FTSU Guardian had commented there had been a swift response from a leader to one recent concern, observing that when issues were raised at the appropriate level, these could be managed more effectively. The FTSU Guardian now had regular and routine engagement meetings, particularly with the trust's governance teams for monitoring, as well as presenting quarterly reports to the trust board, and six-monthly reports to the Workforce Education committee.

The trust also had in place a Guardian of safe working hours who routinely reported to the board on a quarterly basis. The figures from the February 2021 board report demonstrated an increase in exception reporting from the previous

quarters on both sites. The key considerations were for trainee welfare and that the trust needed to ensure that wellbeing was considered and additionally every effort made to ensure a viable education experience was still had by the trainees. There were almost double the exception reports made by Drs at the Royal Liverpool University Hospital site (113) compared with 59 at the University Hospital Aintree site. The majority of which, at both sites, related to hours of working.

The trust was much worse than comparators for whistleblowing alerts to CQC with 15 reported between September 2020 and 22 May 2021. CQC receives feedback from different sources, including whistleblowing contacts from staff members. During 2020 -2021 we had intermittent contacts and spoke with staff from different services, who have reflected their concerns about culture in the organisation. Included in this have been significant whistleblowing contacts from senior clinical staff, including nursing and medical staff, stating their lack of confidence in trust leadership and the trust's ability to manage risks. These have often related to concerns about communication issues, with the sense that the trust had not been open or listened to their concerns. The perception was of a culture that has been based on blame rather than learning from experiences. During inspection, we saw examples of collaborative teamworking. It was evident that there was variation in positive culture and staff experience at all levels of the organisation.

Inclusion and Diversity

Whilst the trust promoted equality and diversity in daily work and mainly provided opportunities for career development, not all staff from multicultural backgrounds felt they were provided with opportunities for career development and there was a higher percentage who experienced discrimination, harassment and bullying.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce. The trust WRES data for 2020 showed differential experiences of staff from black and minority ethnic backgrounds in comparison with staff from white and unknown ethnic backgrounds. One of the significant indicators showed that approximately 19% of clinical staff at band 5 level were from black and minority ethnic backgrounds, however this reduced to 6.3% of clinical staff at band 7. We also saw in NHS Staff Survey 2020 results that three indicators showed a statistically significant negative difference in score between white and BME staff:

- 28.9% of BME staff experienced harassment, bullying or abuse from staff in the past year which was significantly higher when compared to 21.7% of white staff.
- 64.7% of BME staff believed that the trust provided equal opportunities for career progression and promotion which was significantly lower when compared to 85.2% of white staff.
- 17.9% of BME staff experienced discrimination from a colleague or manager in the past year which was significantly higher when compared to 5.8% of white staff.

The trust's WRES action plan included improvement actions in recruitment processes, appraisals, training and leadership development.

An Associate Director for Equality, Diversity and Inclusion had recently been appointed in the trust and there was an expectation that this role and the surrounding support would help to improve standards and awareness in this area. A programme of support for ethnic minority leadership and development was being identified, focusing on three key elements: Experience, Exposure, and Education. This '3 Es' programme provided secondment placements to a higher

grade for individual employees from ethnic minority backgrounds; with opportunity for skills development and support for learning. Plans were also in development for an equality, diversity and inclusion strategy, through engagement with staff diversity networks, managers and stakeholders. This was anticipated to be finalised and for implementation in 2022.

Governance

Leaders did not always operate effective governance processes, throughout the trust and with partner organisations. Most staff were clear about their roles and accountabilities although some, including some staff at senior levels were not. Staff had regular opportunities to meet and discuss the performance of the services but did not always learn from this. Overall responsibilities, roles and systems of accountability to support good governance continued to be unclear and management processes were not always timely.

Systems for accountability to support delivery of good quality sustainable services were unclear and there was a lack of effective accountability, governance and management at all levels of the trust. Care groups and divisional leadership teams had limited autonomy in respect of governance and oversight arrangements. Key information regarding service quality and emerging risks was not always clearly and effectively communicated for the trust board to be able to respond to with actions. At senior level, there was a reliance on reassurance rather than assurance in board level processes. This was acknowledged by a number of board members during interview.

During the last inspection in September 2020 we identified concerns about the effectiveness of governance systems and lack of clear systems of accountability at the trust. Prior to the current inspection, an NHS England/ Improvement quality governance review had been completed. Initial high-level feedback, detailing five key priorities, was shared with the trust's leaders at the end of March 2021. The final report, which was received on 27 May 2021, provided further information and outlined 12 recommendations to the trust for improvement. Of these, five were identified to the trust as immediate priorities:

- Priority 1: Review the reporting line for Divisional Directors of Nursing
- Priority 2: Be clear about the kind of governance the Trust wants?
- Priority 3: Define what safe, effective care looks like
- Priority 4: Improve reporting at divisional level
- Priority 5: Improve the role and functioning of the Trust's Quality of Care meeting

At the time of the inspection, the trust board was not fully engaged and had not fully responded to the Improvement quality governance review, nor had there been sufficient focus for the immediate priorities identified in this review and the actions which needed to be taken. We were told initial work was progressed against the key priorities, and some were marked as complete. However, the initial details of the governance review were not shared with the trust Chair and NEDs until several weeks later, in early June 2021. During our interviews with key senior leaders, there was a lack of clarity on what actions had been taken following the initial feedback of the governance review outcomes and how this had been progressed through to board sign off and oversight.

Following the inspection, the trust shared an update on the its response to the five immediate priorities recommended in the governance review as the following:

Our findings

- Priority 1: Divisional governance posts were being appointed to support the ownership and accountability for governance at divisional level with strengthened professional reporting line through Deputy Chief Nurse. This included the introduction of a weekly Chief Nurse safety huddle from the 10th June 2021.
- Priority 2: Revised governance system in development with implementation due to complete by September 2021. This included external support on risk management. There was a plan to review the actions put in place through an external Well Led review during quarter four in 2022.
- Priority 3: A Quality & Safety Strategy was being developed with external consultancy support that would have clear outcome measures to deliver Great Care. We were told this was due for approval in July 2021.
- Priority 4: Implementation from May 2021 of new Trust, Divisional, Care Group and service level Quality Governance Dashboards. However, there was recognition of further work to undertake on improving data analysis
- Priority 5: Revised cycle of business to be introduced in July 2021 with continued development over coming months with focus on improvements to dashboards

The medical director described having a shared responsibility with the Executive chief nurse for clinical effectiveness through a 'matrix reporting system' from divisional and trust committee structures. Highlighted in the governance review as a concern, and reflecting there had been a degree of complexity in this, the approach was being amended by the trust. However there continued to be a lack of clarity for how embedded this process was. The medical director told us the executive team was trying to move into a more strategic oversight space and being less directly involved in operational decision making, encouraging and supporting divisional autonomy. We were told the Executive chief nurse was accountable for quality at Board level, however the split of mixed portfolios between the medical director and executive chief nurse had added confusion to the overall accountability. The Executive chief nurse also did not attend key trust forums and committees, including finance and performance committee, and audit committees. We were told that neither the medical director nor the executive chief nurse attended the weekly patient safety meetings. We had concerns that the trust systems for oversight and assurance of clinical effectiveness together with patient safety, and direct line of reporting, remained unclear.

The director of estates noted that since the establishment of the trust in October 2019 there had been continuing work to align policies trust-wide. However 80% of these were still separate policies. This meant there was confusion for staff working across different sites and an ongoing need to challenge this.

The trust had a committee structure in place to manage the Board's business. We saw there had been several changes in governance structures since the establishment of the new organisation. Audit committee minutes indicated there was mainly routine business conducted in the period for which minutes were provided, and a plan (from March 2021) for carrying out an effectiveness review. The process of regularly reviewing the effectiveness of all committees is a key part of organisational governance to ensure committee schedules or business and governance arrangements are fit for purpose. Following the inspection the trust provided evidence of effectiveness reviews of trust committees that had been completed during April and May 2021. However, it was unclear about what learning or actions were taken as a consequence of these reviews. We noted that the recent external governance review had not formally been through audit committee or board.

Whilst all financial systems and payroll received significant assurance opinions from internal audit, auditors had indicated that work was still outstanding on integrating wider Trust procedures including in clinical areas.

Our findings

We reviewed the Board Assurance Framework (BAF) board papers and found this was a narrative summary of risks rather than an holistic presentation of the risks and associated mitigations. It was difficult to see how risks were being mitigated, what was being assured, what the issues were, and which were being dealt with. One of the senior leaders during our interviews observed that whilst the BAF fulfilled its purpose it did not stimulate a live debate about risk.

Committee reports to board were also of a narrative style which made it more difficult for the reader to identify what assurance was being provided and where key issues were being escalated.

At the time of the inspection, the existing processes were not always effective at identifying and managing patient safety issues. A significant example of this was the lack of oversight and timely action taken to address significant issues in access and flow through both hospital emergency departments into the wider hospital services. This was identified during the inspection of the core services. Due to the concerns we found during this inspection, we used our powers to formally write to the trust asking them to take immediate action to prevent patients being exposed to the risk of harm. These concerns included:

- Lack of effective local oversight, timely provision of safe care and treatment and management of risk in the emergency departments;
- Lack of effective oversight from senior management of performance and risk management in the emergency departments;
- Ineffective medical and surgical in-reach to the emergency departments to ensure time decision making and admissions to wards;
- Delays in assessment and treatment from initial triage meant patients were not receiving timely and appropriate care and treatment based on both clinical need and national performance standards.
- Lack of proactive management and response to immediate risks in relation to patient access and flow through the emergency department including any audits and monitoring data.

As part of these concerns, and following the inspection, the trust has provided planned actions which we will monitor going forward.

In our core service inspection, we found areas of poor performance in audits and unclear governance arrangements. In medical care services the quality matrons carried out regular audits using the Liverpool Quality Assurance (LQA) tool, in order to identify areas where improvements were required. The service provided information which showed monthly quality audits were not consistently completed or performance maintained. For example, the cardiology ward had achieved 94% compliance in these audits in March 2021 but had since declined to 73% in June 2021. The monthly mealtime audit highlighted that the cardiology ward had consistently green ratings (above 90%) since February 2021, yet the short stay ward only appeared to be audited quarterly. The medical assessment unit had been rated red in December 2020, amber in March 2021 and not audited since. Governance processes were operated differently across sites and it was not clear how all meetings fed into each other to ensure clear lines of communication and escalation. Care group meetings had been newly implemented. It was recognised that there was a need to standardise these meetings across sites and to integrate good working practices.

In contrast, we found there were clear lines of communication and accountability between the chief pharmacist and the board. Medicines risks within the trust were identified and escalated as needed via the Medicines Governance Committee. However, whilst we found evidence of effective medicines incident reporting, there were still similar incidents occurring in services.

Our findings

At the time of inspection, we met with the new director of quality improvement who had just started in their role. They had attended a board development workshop prior to their start date; this had included a whole day focus on quality which we were told had not happened previously. The director of quality improvement role saw their role as to have a clear focus on interpreting and analysing the various data and information, to ensure identification of clear actions and outcomes to sustain progress.

Management of Risks, Issues and Performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. They did not always have plans to cope with unexpected events. Staff did not always contribute to decision-making to help avoid operational pressures compromising the quality of care.

The board did not always have oversight of key risks or take timely and appropriate action to respond to mitigate risks. Arrangements for identifying, recording, and managing risks, issues, performance, and mitigating actions were not always clear or well embedded in many areas across the trust. During interviews there was a lack of articulation of short-term mitigations of current risks whilst the bigger more strategic plans were put in place. Whilst the main elements of an effective risk management system were in place; risk management strategy, BAF and risk register reviews, interviewees indicated that the system was not fully embedded and sometimes felt like “box ticking”. We were told that the chief executive was leading a refresh of the Trust approach to risk management.

From our discussions with senior leaders and staff, a review of the board assurance framework, quality outcomes committee and board meetings, we could see there was inconsistent alignment between the recorded risks, what we heard from staff and what we identified as risks during the inspection and prior to the inspection. Different reporting structures and systems were in place and we saw a lack of co-ordinated approach in providing assurance to the board. Committee reports to board were often in narrative form and did not identify key risks for the board to have oversight or be able to identify mitigating actions to take/taken. We saw there was a transactional approach to risk and a lack of control over key areas of risk, such as patient access and flow through the hospital.

There was a director of patient safety who reported to the medical director and was supported by a deputy director of patient safety, who came into post January 2021. At the time of inspection, a head of patient safety learning was being appointed, to support an improved focus on embedding a patient safety culture in the trust.

One of the key challenges the trust faced was in implementing service integration programmes and preparing for moving to the new hospital building on the Royal Liverpool University Hospital site. We were told that due to the impact of the Covid-19 pandemic, limited progress had been made with the planned organisational and service integration, and consequentially there was limited realisation of the identified efficiencies.

The board and senior leadership team told us they were aware of the importance of the service integration programmes to align trust wide systems and processes across the hospitals and to prepare for the move of services into the new hospital in 2022; they felt they were sighted on the priorities for this. However, we were not assured that the board had effective oversight of these programmes and the new hospital; there was a lack of pace, urgency and grip of these significant changes to service provision.

We were told that the new hospital would reach practical completion by end of March 2022, at which point the management of the estate would be handed to the trust. When asked who would be the Senior Responsible Officer (SRO) for this, we were told of three different named individuals. There was a lack of clarity regarding who was

accountable and responsible for key decisions. We were told that operational planning had commenced, and plans had been identified, incorporating a six phased approach. The first phase had aimed to identify structures and governance, with phase two a review of the previous plans that had been sent to the divisions and were now complete. We were told that phase three was reviewing any changes to the plans and this was 80/90% completed, with phase four due to complete in September/ October 2021. All six phases were due to be completed by March 2022.

Whilst the trust had continued to work closely with external parties to manage the risks associated with the construction phase, one of the most significant risks now facing the organisation was the transition to the new hospital. The Trust had a significant amount of work to do ahead of the transition to the new hospital and the new models of care, with a fast approaching handover date for the new hospital. Although this work had commenced as part of the New Hospital Board, service integration plans were not fully co-ordinated and there were gaps in overall scrutiny and assurance. There was a lack of clarity around the cost of the new operating model and transition to the new hospital. Three different figures were suggested by different executive leaders as cost exposure to the hospital, ranging from cost neutral, to £700.000, to £5 million.

The trust corporate risk register, identified its top three clinical risks in relation to patient safety, with specific concerns around specific areas. These included gastro-enterology services; maintenance of safe staffing; and the move to the new hospital. Earlier in 2021, we had escalated concerns about the backlog of gastro-enterology patients and had asked the trust for assurances re clinical prioritisation of patients and timeliness of the interventions to reduce the risk and the backlog. This was being monitored and improvements were being made.

We identified significant clinical risks to patient safety whilst on site that the trust had either not identified or was not addressing in a timely and effective way. There had been continuing deterioration in the performance of the emergency departments over time and significant problems with flow through the departments into the wider hospital services and discharge. Staff also expressed a degree of frustration in their having identified risks and areas which needed to improve and possible actions for this, however, these had not been progressed. We were told that leads were identified to support patient discharge across the trust. A patient review app had been implemented to provide live information for wards and discharge teams to access with the intention of providing improved oversight of any delayed discharges.

The trust had responded to manage the infection prevention and control (IPC) risks during COVID-19. The Infection Prevention and Control committee was a formal sub-committee of the board quality committee, with an executive chair. A monthly infection prevention and control report was reviewed by the quality committee, this included details of COVID-19 patient admissions and any incidences of hospital acquired COVID-19 infections. A tactical control group had been established and met daily to ensure any new guidance was implemented. However, during inspection we saw not all staff were adhering to the trust's infection prevention and control policy in the use of personal protective equipment, at all times and in all areas. In addition, there was no process in place at the Royal Liverpool University Hospital emergency department to immediately identify which patients, when entering the department, may potentially have COVID-19.

From core service inspections we found there was variability in oversight of risks. Although the accident and emergency departments had a risk register, there was no overarching action plan for the department to mitigate the risks and manage priorities. Leaders we spoke with were not always clear on the top risks for the service and could not describe actions to mitigate the risks.

We also identified areas of poor practice on the acute medical unit which we raised with the senior leadership team. From this, we found leaders did not have oversight of patients in this area or the discharge lounge.

Our findings

There was a multidisciplinary medicines safety team which had a process for identifying risks, for example, the number of incidents relating to gentamicin and the risk of duplicate prescriptions and missed levels. The Trust did not have a seven-day pharmacy service. Therefore, at weekends, pharmacy staff focus was limited to areas of risk such as gentamicin prescribing on the electronic prescription system to check whether levels had been completed. However, the risk was not fully mitigated as this did not capture gentamicin prescribed on handwritten charts.

Information Management

The trust did not always collect reliable data, analyse and use it to make improvements. Staff accessed data on multiple electronic and paper platforms. This meant that, for some services, information was difficult to access promptly. The information systems were secure. Data or notifications were submitted to external organisations as required.

Although information technology systems were used to monitor the quality of care, this information was not always used to drive improvement where needed.

The trust used electronic systems including an electronic patient record (EPR), monitoring of early warning scores, medicines management and incident management systems. Some information was in paper format and staff often needed to navigate multiple systems to view information. We saw during inspection that a new electronic record system had recently been introduced in the emergency department at University Hospital Aintree; this was complex and time consuming for staff to be able to effectively use, particularly when needing to urgently respond to patient needs. We saw that although staff completed routine comfort checks for patients in the emergency department, these had not been updated in electronic records due to the challenges of navigating the system. We also saw that staff in the emergency department at Royal Liverpool University Hospital used a different prescribing system from the rest of the hospital and that staff did not always follow systems and processes when administering and recording medications given. This presented a risk to patient safety.

Leaders did not always have access to clear data in order to provide an understanding of service performance. Several directors acknowledged this and said there needed to be further work to improve business intelligence systems, observing ‘there was a lot of data, and a lot of narrative which said nothing, and wasn’t driving performance currently’. This was identified as a key challenge, with one of the main issues being the separate systems used.

Interviews indicated that committee reporting tended towards reassurance rather than assurance, with some papers being more narrative than critical analysis of the issues and recommendations.

There was concern at committee level about the robustness of non-financial data, and a number of actions were being taken forward to improve this. Internal audit provided a limited assurance on business intelligence.

There were established arrangements to ensure data and notifications were consistently submitted to external organisations as required. There were arrangements for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems. However, we saw during the core service inspection that records were not always stored securely in some areas.

Engagement

Our findings

Leaders told us that they engaged with patients, staff, equality groups, and the public, although we frequently heard from staff that leaders were not visible. The trust was participating in the developing new health and social care landscape of the ICS. There was a limited range of collaboration otherwise with partner organisations to help improve services for patients.

The trust had engaged with staff in identifying their strategy, however we heard varied experiences from staff of how they had been able to participate in this development. During the core service inspections, we frequently heard from staff that senior leaders were not always visible in services. The trust acknowledged there was more work to do in staff engagement, particularly with regard to the move to the new hospital and the related proposed service changes.

Actions had been identified to support staff during the COVID-19 pandemic, with a strong emphasis on staff well-being. Staff were encouraged to access a range of available support, including occupational health services, risk assessments, counselling and different therapies.

The patient experience team had a database for trust wide activity and engagement with different patient groups; some particular examples included service users from black and minority ethnic groups; patients who had a learning disability; and patients with autism. A toolkit had been developed for use when contacting patient groups to support staff in making new contacts with different groups. Of these, the priority was for development of provision for patients who were living with dementia, and their families. Scores for dementia in patient-led assessments of the care environment (PLACE) were, Aintree 90%, Royal 70%, Broadgreen 65%. At the time of inspection, the trust data for Friends and Family Test showed 92% of patients would recommend their services.

Patient stories had recently been introduced as a routine part of board meetings. This had supported the board's direct awareness of patient experience, and of individuals' experience of care at the trust. The patient experience team recognised the importance of evidencing patient experience outcomes and of how this linked with good care. There were plans to develop a dashboard report for patient experience as part of board and quality reporting. Patient experience was now a pillar of the new trust strategy, which was recognised as an enabler for overall development in this area.

We saw that trust governors had a limited role in talking to the public and to date there had been minimal engagement by governors within the integrated care system. Engagement work to capture the voice of patients or carers was scheduled to begin in August or September 2021, with a view to the trust moving to the new hospital in 2022.

The guardian of safe working hours attended quarterly board meetings, accompanied by junior doctors. This allowed the voice and views of junior medical staff to be directly heard.

There was no identified NED for patient experience at board level. Following the inspection the trust confirmed that rather than having a single identified NED for patient experience at board level the trust allocated responsibility for patient experience to its Quality Committee, which is chaired by a NED.

Learning, continuous improvement and Innovation

Whilst the trust had systems in place to identify learning from incidents, deaths and complaints; these were not always effective or delivered in a timely way, which delayed any required improvements to patient care. Staff we spoke with were committed to continually learning and improving services. They used quality improvement methods and had the skills to use them. Leaders encouraged innovation and participation in research.

Our findings

From our review of the trust's systems and processes for managing incidents, we identified some concerns about the timely and effective management of incidents and the learning from these. We were told there was a process for reviewing Serious Incidents (SIs) at weekly trust and divisional quality and safety meetings. And, that there had been a move to declaring more SIs recognising a lower threshold when considering the need to report these. We were told this was a robust process and this could involve robust challenge. However, we heard from others during our well led interviews that issues were not always clearly articulated.

We reviewed eight SI investigation reports and found that there was variable quality in terms of the reports and the level of investigation undertaken. Completed SI reports were reviewed at the trust's oversight group, however the dates on which the reports went to the oversight group were not always documented. Also, from the varying quality of the reports it was not clear whether there was any challenge at this point regarding the depth and completeness of investigation. We saw that some key issues were not explored and subsequently, related learning was not identified. Whilst reports indicated reference to sharing learning, there was no evidence of this having been completed, or what process was in place to ensure any learning was embedded. We saw reports which appeared to be in various stages or progress, where some actions were completed, with others stated as ongoing, however no new date was identified or added even when the completion date has passed. It was not clear how any actions that were marked as ongoing after the completed date had passed, were being monitored. In some reports we saw actions being completed more than 12 months from completion of the report.

In our overall review of these incidents, we identified several themes, including poor documentation relating to both inaccurate and incomplete reports, and different report templates in use. There was poor communication of the report findings; it was not clear how any learning from thematic analysis would be shared and embedded across the organisation.

The trust reported information about Never Events in the NHS England strategic executive information system (*StEIS*). There had been six never events reported in relation to the surgical services at the Royal Liverpool University Hospital between April 2020 and June 2021. The service reported two never events relating to retained foreign objects in October 2020 and February 2021 and had implemented remedial actions. We found that whilst these incidents had been investigated and learning had been identified, the remedial actions taken had not been effective as the service reported two further never events in June 2021 relating to retained foreign objects (swabs) following surgery. Ongoing actions to address these latest incidents included increased auditing of Local Safety Standards for Invasive Procedures (LocSSIPS), communications to staff, and visits to theatres by the medical director.

In addition, the trust reported three surgical invasive incidents during February 2021 and May 2021. These were not initially reported as never events, but the trust later identified at least one of these as meeting the criteria for reporting as a never event. The delayed decision-making showed the trust did not have an effective process in place for identifying and reporting never events. The others were reviewed by the trust and additional learning implemented.

Of the serious incidents reviewed, we found that duty of candour had been applied. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw that duty of candour was addressed in most reports with a record of a conversation and a follow up letter. In some cases, feedback from the family was included in the report, but this was an inconsistent approach. At the time of inspection when we reviewed serious incident reports, we saw no documentation of whether any contact was made with families after the investigation was completed, or whether a copy of the report was shared. However, we saw the initial part of

the duty of candour process was implemented. Following the inspection, the trust provided information to confirm the full duty of candour process had been completed. The trust invited service users to present 'patient stories' as part of this approach. During the inspection we also heard some concerns from leaders about the timeliness of duty of candour, and acknowledgement that there was work to do in this area.

Incident reports relating to medicines were reviewed by the medicines safety officer (MSO) and reviewed with divisional pharmacists, as well as being discussed at weekly medicine safety and divisional meetings.

The trust had a process for integrated mortality reviews and consultant review for individual patient deaths, and we saw that structured Judgement Reviews (SJR) had been completed for patients, where these were identified. We reviewed six SJR reports and saw these were completed to an acceptable standard; however different systems were used between University Hospital Aintree and Royal Liverpool University Hospital sites for these and there were delays in completion, with some reports taking over 100 days. It was also unclear how any action/learning suggested by the SJR reviewer had been carried out or where this would be correlated. The medical examiner process was in place with an emphasis on prioritising deaths that were identified as requiring further review and we saw the trust followed appropriate procedures for medical examiner review.

Trusts are monitored for mortality in two NHS England national indicators: The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio. The Trust reported 105.34 for SHMI (Summary Hospital-level Mortality Indicator) as at Oct 2020. For HSMR (Hospital Standardised Mortality Ratio), the Trust reported 97.84 as at Dec 2020. The trust was within expected parameters for both mortality indicators.

During the inspection, CQC reviewed a sample of complaints. All complaints were acknowledged by the Patient Advice and Liaison Service (PALS) and contact made with the complainant. All complaint responses were signed by the Chief Executive.

We found the overall quality of the complaint responses was poor and provided limited details for individuals who were raising a complaint. The complaint investigation report was included in the complaints response and this primarily was the process for addressing the issues of concern that had been raised. Full investigation reports were produced for each complaint, however there was some variable quality in the standard of these. Response letters confirmed details of the individual who had completed the investigation report and we saw this was always completed by relevant persons. However, since the complaint investigation reports were written as an internal trust report, this also raised questions of how the appropriateness of sharing some of this detail was being considered.

We observed the tone of the accompanying complaint response letters was lacking in empathy and understanding, with a somewhat impersonal approach. Complaints were not responded to in a timely manner and from the information shared it was not clear whether the response timeframe would be negotiated or discussed with the complainant. The trust's 'Policy for the Management of Complaints, Concerns and Compliments' included the requirement of completion of complaints in 35 working days unless an extension has been agreed to the complex nature of a complaint.

The letters included advice on next steps and signposting both internally and externally if not satisfied with the outcome or response provided. However, the timeframes for a response were not always achieved and the examples reviewed had taken between six and 12 months to complete. We observed from our review that whilst similar concerns were identified in several complaints, there appeared to be no changes in practice, or process for sharing this learning.

Our findings

The trust had actively participated in 48 COVID-19 research programmes, recruiting 8,179 people for this study. The trust was also the lead NHS Site for the phase I AGILE COVID-19 platform study and had attracted £7.27million research income. The trust's critical care buddying system was now accredited as an advanced learning element in Higher Education Institutes. In medical care the joint respiratory clinics held with the speech and language therapy teams and respiratory consultants meant better care for respiratory patients with the aim of providing better outcome for patients.

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Notes on ratings tables on the following pages

In the table on page 31 headed 'Ratings for acute services/acute trust', the overall trust ratings in the bottom row do NOT take into account ratings for Broadgreen Hospital or Liverpool University Dental Hospital that come from when those hospitals were managed by a different trust. The overall rating for well-led comes from our inspection of trust-wide leadership rather than an aggregation of well-led at service level.

The ratings tables on page 32 for Broadgreen Hospital and Liverpool University Dental Hospital show ratings from when they were managed by a different trust.

On the same page, the ratings table for Royal Liverpool University Hospital shows ratings from this inspection and from when the hospital was run by a different trust. We have not rated the hospital overall at this inspection.

For more information, please see the explanation at the start of the Overall summary on page 2.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Oct 2021	Requires Improvement ↓ Oct 2021	Good ➔➔ Oct 2021	Requires Improvement ↓ Oct 2021	Inadequate ↓↓ Oct 2021	Requires Improvement ↓ Oct 2021

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
University Hospital Aintree	Requires Improvement → ← Oct 2021	Requires Improvement ↓ Oct 2021	Good → ← Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement → ← Oct 2021	Requires Improvement → ← Oct 2021
Broadgreen Hospital	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Liverpool University Dental Hospital	Good Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019	Requires improvement Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019
Royal Liverpool University Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement → ← Oct 2021	Requires Improvement ↓ Oct 2021	Good → ← Oct 2021	Requires Improvement ↓ Oct 2021	Inadequate ↓↓ Oct 2021	Requires Improvement ↓ Oct 2021

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for University Hospital Aintree

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Oct 2021	Requires Improvement ↓ Oct 2021	Good ↓ Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement ↓ Oct 2021
Critical care	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014
End of life care	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Outpatients and diagnostic imaging	Good May 2014	Not rated	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Surgery	Requires Improvement → ← Oct 2021	Good → ← Oct 2021	Good → ← Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement → ← Oct 2021	Requires Improvement → ← Oct 2021
Urgent and emergency services	Inadequate ↓ Oct 2021	Requires Improvement ↓ Oct 2021	Good → ← Oct 2021	Inadequate ↓ Oct 2021	Inadequate ↓ Oct 2021	Inadequate ↓ Oct 2021
Overall	Requires Improvement → ← Oct 2021	Requires Improvement ↓ Oct 2021	Good → ← Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement → ← Oct 2021	Requires Improvement → ← Oct 2021

Rating for Broadgreen Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Outpatients and diagnostic imaging	Good Jul 2016	Not rated	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Surgery	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Overall	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016

Rating for Liverpool University Dental Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019	Requires improvement Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019
Overall	Good Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019	Requires improvement Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019

Rating for Royal Liverpool University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Oct 2021	Good ↑ Oct 2021	Good → ← Oct 2021	Requires Improvement → ← Oct 2021	Requires Improvement → ← Oct 2021	Requires Improvement → ← Oct 2021
Critical care	Good Jul 2016	Good Jul 2016	Good Jul 2016	Requires improvement Jul 2016	Good Jul 2016	Good Jul 2016
End of life care	Good Jul 2016	Good Jul 2016	Outstanding Jul 2016	Outstanding Jul 2016	Outstanding Jul 2016	Outstanding Jul 2016
Outpatients and diagnostic imaging	Good Jul 2016	Not rated	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Surgery	Requires Improvement → ← Oct 2021	Good → ← Oct 2021	Good → ← Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement ↓ Oct 2021
Urgent and emergency services	Inadequate ↓ Oct 2021	Requires Improvement → ← Oct 2021	Good → ← Oct 2021	Inadequate ↓ Oct 2021	Inadequate ↓↓ Oct 2021	Inadequate ↓ Oct 2021
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

New Royal Liverpool University

Prescot Street
Liverpool
L7 8XP
Tel: 01517062000

Description of this hospital

We visited Royal Liverpool University Hospital as part of our unannounced inspection from 29 June 2021 to 1 July 2021. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Emergency department

- Medical staffs mandatory training compliance was low. Staff did not always have the correct level of training on how to recognise and report abuse. The service did not control infection risk well. Staff did not always manage clinical waste well. Staff did not always recognise or respond appropriately to signs of deteriorating health or medical emergencies, exposing patients to the risk of harm. The service could not always demonstrate that staff had the right qualifications, skills, training and experience to keep patients safe. Patient notes were not always stored securely. The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not always recognise and report incidents and near misses. Action plans to improve care and treatment were not evident. The service did not always manage patient safety incidents well and did not always share lessons learned with the whole team.
- Staff did not always provide care and treatment based on national guidance and evidence-based practice. Fluid documentation was not always accurate and complete. Staff could not demonstrate that they monitored the effectiveness of care and treatment. They could not demonstrate they used the findings to make improvements and achieved good outcomes for patients. Staff did not always assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way. The service did not always make sure staff were competent for their roles. There were gaps in management and support arrangements for staff. We observed staff and it was not clear that discussion of patient care and treatment were taking place, oversight was not clear. Staff did not always give patients practical support and advice to lead healthier lives.
- Staff did not always respect patient's privacy and dignity and did not always keep care confidential.
- There were ineffective processes in relation to access and flow of patients into and through the emergency department. These were creating and contributing to significant delays in admitting patients onto wards. This meant they did not always receive timely and appropriate care and treatment. The service did not always plan and provide care in a way that met the needs of the local people and the communities served. The service did not make it clear if reasonable adjustments were in place to help patients access services. The service did not always demonstrate managing patient safety incidents well, and learning was not always put into practice to improve care and treatment.
- Senior leaders were not always visible and approachable. Senior leaders did not always have a clear understanding of the risks, issues and challenges. They did not always act in a timely manner to address risks and issues. Senior leaders did not have a clear strategy to turn their vision into action. Staff did not always feel respected, supported and valued by the wider hospital and senior managers. Leaders were not always focused on the needs of patients receiving care.

Our findings

Leaders did not always operate effective governance processes, throughout the service, across both sites and with partner organisations. They did not always have regular opportunities to meet, discuss and learn from the performance. Leaders and teams did not always use systems to manage and understand performance effectively in order to make decisions and improvements. The information systems were not integrated. Paper records were not always stored securely. We saw limited examples of continual learning and improving services.

However:

- Overall, nursing staff mandatory training compliance was above the trust target. Staff understood how to protect patients from abuse. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The department was well designed in the major's area with individual rooms with glass sliding doors.
- The service had up-to-date policies. Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other needs. Doctors, nurses and other healthcare professionals held regular effective multidisciplinary meetings to discuss patients and improve their care. Key services were available seven days a week to support timely patient care. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent and supported patients who lacked capacity or were experiencing mental ill health.
- Staff treated patients with compassion and kindness and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service worked with others in the wider system and local organisations to plan care. The service was inclusive and took account of patients' individual needs and preferences.
- Departmental leaders were visible, approachable and had oversight of the challenges in the service. The service had plans to cope with unexpected events. Senior leaders collaborated with partner organisations to help improve services for patients. Local leaders were seen in the department and supported staff throughout the unprecedented attendances and throughout the pandemic.

Surgical services

- Whilst leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact, they did not use systems to manage performance effectively. We identified poor performance in key processes such as mandatory training, patient access and flow, patient outcomes and complaint management. We were not assured the surgical services had implemented suitable remedial actions to demonstrate an improvement in key performance and compliance measures.
- The service did not always manage patient safety incidents well. Whilst managers investigated never events, lessons learned were not always shared with the whole team and remedial actions taken did not minimise the risk of reoccurrence. We were not assured that the service had effective systems in place for identifying and reporting never events.
- Whilst staff monitored the effectiveness of care and treatment, most clinical audit outcomes were worse than expected national standards. The service also had a had a higher than expected risk of readmission when compared to the England average.

Our findings

- Not all patients could access the service when they needed it and receive the right care promptly. The services performed worse than the national average for the percentage of cancer patients treated within 62 days. The average length of patient stay was worse than the national average. The total number of patients on the waiting list continued to increase since January 2021. Whilst the service did not achieve national standards for waiting times from referral to treatment; they performed better than the average when compared with other trusts in the region.
- The environment across the surgical wards and theatre areas was not always dementia friendly.
- Mandatory training compliance was below trust targets for a number of training modules, such as paediatric life support and higher level resuscitation training.
- The number of staff that had completed the higher level of adult and children's safeguarding training did not meet trust targets.
- Whilst there had been improvements in nurse staffing levels, not all surgical wards had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Complaints were not always responded to within the timescales specified in the trust complaints policy.
- An effective work culture focused on patient safety had not been fully embedded across the surgical teams in theatres.

However:

- The service had enough medical staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well, collected safety information and used it to improve the service.
- Staff gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. The service planned care to meet the needs of local people and took account of patients' individual needs.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Medical services

- The service did not always have enough staff to care for patients and keep them safe. Staff did not always have training in key skills and safeguarding. The service did not always control infection risk well. They did not always prescribe and administer medicines in line with requirements.
- We could not be assured that staff received a regular review of their performance or were supported with regular supervision. Key services were not always available seven days a week.
- People could not always access the service when they needed it and flow in and out of the hospital was poor.

Our findings

- The service did not have clear governance structures in place and did not always manage risk issues and performance well.

However:

- Staff understood how to protect patients from abuse, and managed safety well.
- Staff assessed risks to patients, acted on them and kept good care records.
- The service managed safety incidents well and learned lessons from them
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well and supported staff to develop their skills. Staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with staff were committed to improving services continually.

Urgent and emergency services

Inadequate 

Is the service safe?

Inadequate 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as inadequate.

Mandatory training

Not all staff were compliant with mandatory training. Whilst the service provided training in key skills, not all had completed it. Managers monitored mandatory training but did not always make sure everyone completed it. Some staff told us they did not always receive protected time to complete their training.

Managers were unable to provide accurate training figures during the inspection. We requested these after our inspection and the information received was unclear. Managers told us this was due to problems with the electronic system being inaccurate. At the last inspection we told the service it should consider establishing an effective system to monitor compliance with mandatory training, this had not been improved.

At the time of this inspection, overall mandatory training compliance was 85%. This is in line with the trust target. However, whilst the overall compliance for nursing staff was 90%, for medical staff it was 71%.

Medical staff were below trust compliance targets in 19 of the 22 training courses, including 0% for moving and handling people. Nursing staff were below compliance targets in two of the 15 courses.

Medical staff training compliance rates for yearly level two resuscitation training was 24%. Adult advanced life support (ALS) training, every four years, was 80%.

Compliance for paediatric basic life support (PBLS) was 89% for nursing staff. However, 57% of medical staff were non-compliant. In addition, 52% of medical staff were non-compliant for Advanced Paediatric Life Support (APLS).

Safeguarding

Staff did not always have the correct level of training on how to recognise and report abuse. However, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

At the last inspection we told the service it should ensure safeguarding training was improved. At this inspection, level three safeguarding adults training compliance was 51% and children's safeguarding training was at 47%.

However, staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them.

On inspection staff were aware of how to identify specific safeguarding concerns, such as female genital mutilation (FGM).

Staff knew how to make a safeguarding referral and knew who to inform if they had concerns.

Staff were able to explain the process of referring to the safeguarding team on the online referral system. Nursing staff stated they would escalate any safeguarding concerns to the nurse in charge and complete an incident report. However, not all staff were clear on who was the lead for safeguarding.

Cleanliness, infection control and hygiene

There was a lack of robust systems in place to manage and mitigate risks in relation to infection prevention and control measures within the emergency department. The service did not control infection risk well. Staff did not always use personal protective equipment (PPE) and control measures to protect patients, themselves and others from infection. The department was not always visibly clean.

All areas were not always clean and well-maintained. We saw dirty sinks, and blood stains on the floor in reception and on sharps bins. The resuscitation area was cluttered and dusty. However, there was building work in progress.

The three main waiting rooms and ambulance admissions area were overcrowded which did not allow for appropriate social distancing. During our inspection of the Royal Liverpool University Hospital we observed that the ambulance admission area, which could accommodate 10 patients, was frequently full so patients were held on trolleys in other areas. For example, on the 01 July 2021 there was an additional five patients in the ambulance reception on trolleys without the correct social distancing. These patients were side by side with less than 15cm between the trolleys.

Cleaning records were not always up-to-date and did not cover all areas. However, it did include specific equipment.

Checking of specialist equipment to ensure it was in date, sterile and safe to use was not always completed. We found seven pieces of equipment in the resuscitation room that were out of date for sterilisation purposes, this included internal defibrillation paddles and thoracotomy equipment.

Staff did not always follow infection control principles including the use of PPE and hand hygiene. At the Royal Liverpool University Hospital, inspectors observed staff and patients not wearing face masks correctly. We observed poor staff compliance with hand hygiene measures in-between patient contact. Inspectors completed a hand hygiene observation audit on 30 June 2021 which identified five of six staff not adhering to hand hygiene procedures. There was a lack of an effective system of triage at the front door regarding screening for potential Covid-19 positive patients. Staff were not asking Covid-19 screening questions at triage or reception at the Royal Liverpool University Hospital. Patients will or may be exposed to the risk of harm if Covid-19 screening questions are not asked. This is because there is a risk of transmission if patients with Covid-19 are not screened and are allowed to wait with other patients.

In the emergency department at the Royal Liverpool University Hospital on 01 July 2021, there were three Covid-19 positive patients who were seen in side-rooms with doors open. The corridor where the side rooms were located, was still being used as a thoroughfare and was not isolated to prevent the transmission of Covid-19.

However, staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

Urgent and emergency services

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well.

The environment did not always support staff to provide safe and effective care.

The estate was old and not always well maintained. For example, we saw trolleys blocking the corridor and a patient's cubicle. This could delay treatment in the event of an emergency. In addition, we saw damaged flooring marked with tape.

General and high-level signage for fire exits were not always clearly visible.

Areas of the department were cluttered with equipment which could have caused delays in the event of an emergency.

Staff did not always carry out daily safety checks of specialist equipment. We looked at the checks of the hypoglycaemia emergency drug box and found that this had not been checked on 12 out of 30 days.

Staff did not always use dispose of clinical waste safely. We saw three sharps bins to the fill line without the temporary closure in place. This could cause needle stick injuries to staff or visitors.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. There was a risk that staff did not always recognise or respond appropriately to signs of deteriorating health or medical emergencies. Opportunities to prevent or minimise harm were missed.

Staff did not always complete assessments, including appropriate investigations, in a timely manner. We saw four patients that had delays in assessment, investigations and treatment from triage; there were delays in having echocardiograms (ECG) and neurological assessments. There was no system in place to prioritise patients with chest pain for triage, they waited in the queue.

Staff did not always recognise patients with deteriorating health or medical emergencies. Five patients were seen at Royal Liverpool University Hospital with delays to treatment including recognising and responding to rising troponin levels. In one case, the inspectors onsite escalated the patient's condition to staff, as this had not been recognised by staff.

The department accepted adult patients only, however in an emergency staff should have the training to recognise any unwell patient including children. Senior nursing staff could not explain the red flags for recognising a sick child

The waiting rooms were not visible to staff. This was a risk to patient safety as deterioration could not always be seen and acted upon in a timely way. We were told two hourly rounding was in place to check on patients, but we did not see these taking place. We saw a slumped patient in the waiting area; staff had not seen this person and we had to escalate our concerns.

Despite using recognised tools, such as the national early warning score and recognition of sepsis, staff did not always follow all systems that were in place to act where patients were at risk of deterioration. Staff, at both hospital sites, did not always reassess national early warning score (NEWS) scores in line with the NEWS escalation guidance version two (as developed by The Royal College of Physicians). In one patient record, we saw reassessment occurred nine hours after

their initial observations. According to national guidance patients with a NEWS score of one should have their observations reassessed between four and six hourly. We saw in two patient records a NEWS score of three in one parameter and the frequency of monitoring was between two and four hours. According to national guidance patients with a NEWS score of three in one parameter should have their observations reassessed hourly.

Patients did not always receive care and treatment in a timely way, exposing them to the risk of harm. We reviewed 11 patient records who attended the emergency department between the 29 June 2021 and 01 July 2021. These patients were all identified as having possible sepsis. Nine of these patients had delays in receiving their first dose of antibiotics ranging between two hours and nine hours 23 minutes.

The service took part in a regional sepsis audit. It showed that the Royal Liverpool University Hospital was below the target of 80% in six of the seven domains from January to March 2021. We were provided with a forward plan however it was unclear how the service would achieve these plans.

Risk assessments, at both sites, were not always completed in a timely manner. In two patient records we saw risk assessments completed at least 10 hours after their arrival. Psychosocial risk assessments were not always completed when required.

Shift changes and handovers did not always include necessary key information to keep patients safe. The handover to other wards was not always documented. Communication between nursing and medical staff was not always clear. During the time of the inspection we did not see evidence of board rounds other than at 8am.

Nurse staffing

The service had enough nursing staff and support staff. Managers regularly reviewed staffing levels. However, the service could not always demonstrate that nursing staff had the right specialist skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff. However, the service could not always demonstrate that staff had the right level of specialist experience, skills and knowledge, especially in recognising the deteriorating patient and how to keep patients safe from avoidable harm. We were told staff were given the Royal College of Nursing's national curriculum and competency framework for emergency nursing. However, competency frameworks had not been routinely completed and returned.

The service was over established compared to the planned number of posts for registered and unregistered nursing staff. The emergency department fill rates were above 85% between April and July 2021. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance.

The department manager adjusted staffing levels throughout the day according to the needs of service. Staff would move flexibly within the department to support the area with the highest acuity level of patients when required. However, there were unfilled shifts to staffing levels seen on site. .

The emergency department had low turnover rates. Turnover rates were rated at 4.53% for nursing staffing across the division. The department had low and reducing vacancy rates for the division.

Medical staffing

Urgent and emergency services

The service did not always have enough medical staff. Although managers regularly reviewed staffing levels. The service could not always demonstrate that medical staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep patients safe. There was no clear information provided regarding the mitigation for the shortfall in full time equivalents.

The division had 81% full time equivalent medical staffing. It was not clear what the establishment of medical staffing should be.

Medical staffing fill rates, for the division, varied from 60% to 85% during the last two weeks of July 2021.

There were emergency medicine and trauma consultants in the department 16 hours per day from 8am to 2am, which is in line with RCEM guidance. Outside of these hours there were consultants on call.

The service could not always demonstrate medical staff had the right qualifications, skills, training and experience. Mandatory training figures were discussed in a previous section of the report.

However, the service had low turnover rates for medical staff at 8%.

Staff felt there were inequities in terms of medical staffing across both sites. We were told that University Hospital Aintree were allocated eight foundation year 2 doctors per four months and Royal Liverpool University Hospital were allocated 14.

The vacancy rate across the division was 22%. Staff told us there was an over reliance on junior doctors. We were told that the divisional clinical director was preparing a business case for 12 additional doctors.

A tactical coordinating group meeting was held daily to review staffing and access and flow issues.

The sickness rate for medical staff was low at 2%.

Managers made sure medical staff had a full day of induction to the service before they started work. Junior medical staff stated that they received good informal clinical supervision and felt well supported by senior colleagues and consultants. Medical staff in training were allocated protected time for training and told us this was very rarely cancelled.

Records

There was poor documentation in patient records and on clinical systems across the emergency department and medical wards throughout the trust. Staff did not always keep detailed records of patients' care and treatment. Staff do not always have all the information they needed before providing care, treatment and support. Staff had to duplicate information due to the confusion of paper and electronic records. Records were not always clear to support the treatment given due to the confusion of paper and electronic systems. Patient notes were not always stored securely.

Urgent and emergency services

There is a risk to patient safety and the continuity of care with the two different prescribing systems at the Royal Liverpool University Hospital. Staff in the emergency department use the casualty (CAS) card to give the first dose of medications. However, the rest of the hospital used an electronic prescribing system.

There is a risk that paper notes are not always handed over to other areas effectively. The paper notes (CAS cards) are photocopied and later scanned into a patient electronic record which was different to the rest of the hospital. However, other hospital medical staff do not have access to the emergency care patient electronic record, they used the hospital online notes storage system.

The use of two systems to record medication (across both the sites we inspected) caused a risk to effective treatment in at least 23 gentamicin incidents identified from the National Reporting and Learning System (NRLS) between September 2020 and April 2021. Concerns were also identified from discussions on site with staff about the use of the multiple recording systems and lack of robust handovers. In addition, eight of the 23 incidents did not have gentamicin levels prescribed in accordance with the policy. A consultant told us that gentamicin levels need to be prescribed eight to twelve hours after the first dose of gentamicin antibiotics are given by the initial prescriber as per trust policy. The gentamicin blood level test that was required was not always recorded on the inpatient system to alert other staff members that the patient had been given gentamicin. This causes a risk to patient safety as patients would not always get treatment in a timely manner or would get second doses given without the required spacing between doses. Staff did not always follow systems and processes when administering and recording medications given.

In the last inspection report, we told the service it should ensure patient records are maintained securely. This has not improved. Paper records were seen spread over the desks and in unlocked filing cabinets. However, computer screens not in use were seen closed and locked.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. The service did not always follow relevant national guidelines around storing emergency medicines. People were at risk because staff did not always administer medicines safely and patients did not receive them as prescribed.

Staff in the emergency department used the paper CAS card to give the first dose of medications. However, the rest of the hospital use an electronic prescribing system. There was a risk that paper notes were not always handed over to other service areas effectively. There was no formal documentation in the handover process, leading to a risk that critical medications could be missed.

We saw that the use of the two systems caused a risk to effective treatment in at least 23 of the 39 gentamicin incidents identified from the National Reporting and Learning System (NRLS) from September 2020 to April 2021. There was a risk to patient safety and continuity of care with the two different prescribing systems.

Staff did not always follow systems and processes when safely prescribing. Incorrect prescribing, including wrong dose and wrong frequency, accounted for 10 of the 39 gentamicin incidents on NRLS. Safety precautions to check for patient harm after antibiotics were not always initiated. In eight of these 23 incidents gentamicin levels were not prescribed as per the trust's policy.

Urgent and emergency services

At the Royal Liverpool University Hospital, staff did not always follow 'The Code'. This is the Nursing and Midwifery councils' professional standards of practice and behaviour for nurses, midwives and nursing associates. Records were not always completed fully and there were gaps including dates, time, frequency and signatures. We reviewed one patient notes in the emergency department with omissions in recording intravenous fluid administration on the prescription charts.

Across the trust medicines management training for nursing staff was 35% compliance against the trust target of 85% and medicines management for medical staff was 30%.

Staff did not always store and manage medicines in line with the trust's policy. We saw emergency medications left on trays on the desk instead of being in a tamper evident storage container. We found eight different unattended medications on desks, trolleys and in unlocked cabinets.

Medications within the resuscitation room were not always stored in clean "grab" bags. Inspectors saw emergency drugs stored in a soiled yellow bag, with blood stains. Staff did not always ensure that clean utility rooms were secure. We saw the clean utility room door in majors, with intravenous fluids stored inside, propped open with a bin.

Controlled Drugs (CD) were not always checked daily. Compliance rates for CD checking in the resuscitation area were below the target of 90% in four of the last six months.

However, fridges were found locked and the checks had been completed.

Incidents

Staff did not always recognise and report incidents and near misses. Action plans to improve care and treatment was not evident. Managers investigated incidents and shared lessons learned with the whole team.

Staff did not always know what to report as an incident. Staff did not always recognise and report incidents of poor practice which could put patients at risk. On inspection, we observed staff moving an elderly patient using the patient's upper back and knees to cradle the patient and lift them up the bed. Staff did not know this was not recognised safe practice which was reflected in the moving and handling policy. It was not clear how the department monitored staff compliance for moving and handling. However, whilst not at the trust target, moving and handling training was at 77% for nursing staff.

Inspectors observed 14 patients in the ambulance assessment area, this was over the maximum capacity of 10 patients. Staff we spoke with, did not feel that an incident report was required when the maximum capacity of patients was met. The risk is that staff would not be able to safely provide care and treatment to all patients. If incidents weren't reported senior leaders would not be able to assess the severity of the issues.

Managers told us they shared learning with staff about never events through "the new message of the week", monthly newsletters, the medical directors' newsletter and the communications notice board. However, clear action plans to improve care and treatment was not evident.

Safety Thermometer

Staff did not always collect safety information and did not always share it with staff, patients and visitors. It was not clear if the service used monitoring results to improve safety.

Urgent and emergency services

The service did not always continually monitor safety performance through audits.

Audit data was displayed on a “how are we doing” board in the Majors department for staff and patients to see. The audit data included controlled drugs checks, multifactorial risk assessments (MFRA), Waterlow scores and fluid balance chart were all 100% compliant for the previous quarter March 2021 to May 2021. National Early Warning Scores completion was at 74.4%.

Is the service effective?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated effective as requires improvement.

Evidence-based care and treatment

The service had up-to-date policies based on national guidance and evidence-based practice. However, staff did not always provide care and treatment based on their trust policies. Staff protected the rights of patients subject to the Mental Health Act 1983.

Pathways and policies were based on guidelines and standards.

Staff protected the rights of patients subject to the Mental Health Act. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients’ religious, cultural and other needs. However, fluid documentation was not always accurate and complete.

Inspectors observed regular food and drinks offered throughout the day. Options of drinks and meals were available, hot meals were accessible if requested. Staff offering food and drinks would check with nursing staff to see if any patient had any specialist requirements such as being nil by mouth.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

However, staff did not always fully and accurately complete patients’ fluid charts where needed.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Urgent and emergency services

Patients did not always receive pain relief soon after it was identified they needed it or they requested it. Four out of five patients we spoke with had not been asked about pain relief. However, if asked there was evidence in notes that pain relief was administered.

Nursing staff at triage had the ability to give ibuprofen and paracetamol by the way of the patient group directive If any patient required stronger pain relief a prescription from a doctor was needed. The triage nurse left the triage area to find a doctor which delayed triage nurses in seeing other patients.

Patient outcomes

Staff could not demonstrate that they monitored the effectiveness of care and treatment. They could not demonstrate that they used the findings to make improvements and achieved good outcomes for patients.

We were told by the senior leadership team for the service, during an interview, that national audit submissions, such as Trauma Audit and Research Network (TARN) and the Royal College of Emergency Medicine (RCEM) audit had been suspended during the COVID-19 pandemic. However, following our inspection we did receive some audit data. No internal compliance processes had continued for any of the national audit standards. Therefore, there was limited oversight of the department's performance and opportunity to improve the service provided.

From the audit data we received, we noted that the TARN data from October to December 2021 showed that in 86% of cases National Institute for Health and Clinical Excellence (NICE) head injury guidance was not followed. In addition, 84% of patients did not receive a CT scan in less than 60 minutes of arrival at trauma unit. The leadership told us that an action plan to evidence how they intend to improve this was not required.

The RCEM audit results for fractured neck of femur patients that was undertaken in 2020/2021 showed that 92% of patient had effective initial assessment of pain scores at triage. Three of the five patients with moderate to severe pain had pain relief within 30 minutes and 82% of patients had an Xray within 90 minutes. However, staff did not re-evaluate pain scores 30 minutes after giving pain relief. The service recognised pain scores were not being reassessed but had no clear plans or learning to improve this.

Competent staff

The service did not always make sure staff were competent for their roles. There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development.

The service could not demonstrate that all staff had the right experience, qualifications, skills and knowledge to meet the needs of patients.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. We were told that 64% of staff had not had a recent appraisal.

Managers identified training needs of staff but did not always give them the time and opportunity to develop their skills and knowledge. Nursing staff told us they were required to complete mandatory training in their own time.

Managers did not make sure all staff received specialist training for their role. Some support workers told us they "felt like they had been de-skilled" since the acquisition.

However, all new staff a full induction tailored to their role before they started working in the department.

Multidisciplinary working

Doctors, nurses and other healthcare professionals held regular effective multidisciplinary meetings to discuss patients and improve their care. However, we did not always see staff discuss patients and care requirements.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We observed instances of good multidisciplinary team working and staff supporting each other to provide good care for patients within the department.

We observed nursing staff working well with physiotherapy staff, learning disabilities nurses and police to review patients within the emergency department.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors, diagnostic services and other disciplines, including mental health services and stroke specialist nurses, 24 hours a day, seven days a week.

The emergency department at Royal Liverpool University Hospital had support from four pharmacists and four pharmacy technicians from 8am to 8pm, seven days a week. Pharmacy colleagues helped to ensure the department is fully stocked for the medications required.

Staff had access to an online medicines locator to check where medications are stocked out of hours if it is not in the emergency department. There was also access to an out of hours medication cupboard if required as a last resort.

Health Promotion

Staff did not always give patients practical support and advice to lead healthier lives.

We reviewed six patients notes, none of these had documentation of health promotion and practical support given to patients.

The service did not always have relevant information promoting healthy lifestyles and support in department. We did not see smoking cessation or healthy eating leaflets or posters in the department. However, inspectors saw information leaflets on mental health crisis support, bereavement and keeping yourself safe whilst in hospital.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Urgent and emergency services

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We observed staff making sure patients consented to treatment based on all the information available.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

There was forms available when assessing whether a patient required detention under section 136 of the Mental Health Act. Mental health nurses were easily accessible in the trust to support with Mental Health Act decision making.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. However, training compliance for safeguarding was low as discussed within safe.

Is the service caring?

Good 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. However, staff did not always respect patient's privacy and dignity and did not always keep care confidential.

Staff took time to interact with patients in a respectful and considerate way. Patients told us the care was good and the staff were kind despite being under significant pressure.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. The service ensured designated staff had a separate area call the hub to care for patients with mental health needs. Staff were seen appropriately and compassionately discussing the care for a patient detained under the Mental Health Act.

However, staff did not always follow policy to keep patient care and treatment confidential. Privacy and dignity were not always respected. We observed a doctor taking clinical history of a patient in the corridor of the ambulance assessment area with other patients nearby. However, the doctor did move into a consultation room to examine the patient. Data from the acute and emergency medicine survey showed 11% of patients felt they were not given enough privacy and dignity.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Urgent and emergency services

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff talked to patients in a way they could understand, using communication aids where necessary. Staff supported patients to make informed decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The acute and emergency medicine survey showed 81% of patients felt involved in decisions about their care and treatment. The feedback from the Emergency department survey test was positive.

Is the service responsive?

Inadequate 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated responsive as inadequate.

Service delivery to meet the needs of local people

The service did not always plan and provide care and treatment in a timely way that met the needs of local people and the communities served. The department was not well signposted. However, it worked with others in the wider system and local organisations to plan care.

The service did not always plan and provide care in a way that met the needs of local people and the communities served. Patients could not always access care and treatment in a timely manner. During our inspection there were challenges with the number of patients arriving at the department for the emergency department but we heard limited examples about how the service was working with other stakeholders for system level solutions.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. However, it was not clear if staff made reasonable adjustments to help patients access services.

Urgent and emergency services

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had the mental health hub area designated for patients with mental health problems. Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The service had systems to help care for patients in need of additional support or specialist intervention.

The trust had introduced a dementia team which, at the time of inspection, were developing the service. Staff supported patients with dementia and learning disabilities by using 'This is me' documents and patient passports.

However, we did not see information leaflets available in different languages on display. In addition, we did not see information displayed to support people whose first language was not English or may need support with communication.

Access and flow

Ineffective processes in relation to access and flow of patients into and through the emergency department were creating and contributing to significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients were not always receiving appropriate care and treatment in a timely way, exposing them to the risk of harm. Waiting times were not in line with national standards.

Managers monitored waiting times but did not always make sure patients could access emergency services when needed. Patients did not always receive care and treatment in a timely manner, within agreed timeframes and national targets.

Overcrowding was seen in the emergency departments at both sites resulting in limited flow through the department for patients to discharge or admission.

National targets were that hospitals should receive handover of patients from ambulances within 15 minutes of arrival. Ambulance handovers at Royal Liverpool University Hospital was better the regional and England average for handover delays 30 – 60 minutes. This has deteriorated since the end of June 2021.

Although the wait for ambulance handovers was lower than national standards, there were significant delays for patients accessing care and treatment once in the emergency department. The longest wait for a patient to get into the main emergency department at the Royal Liverpool University Hospital from the ambulance assessment area was 10 hours. The ambulance admission area had a six bedded area and consulting rooms, it had space for 10 patients. The six bedded bay and consulting rooms were full, with five further patients in the corridor on beds without sufficient social distancing being maintained. Overall, the percentage of patients treated within 60 minutes across both sites at the end of May 2021 was around 10% compared to around 25% for the region as a whole and 40% nationally. In June 2021 and July 2021, the percentage of patients treated within 60 minutes across both sites was 8.3% compared to 24.2% regionally and 32% nationally. We observed waits of up six hours 26 minutes to be seen by a doctor and subsequent treatment.

In addition, the national standards state that patients should not stay longer than 12 hours after the decision to admit (DTA) is made. The service provided data that showed 81% of patients did not get a DTA within three hours from arrival in the department. We observed patients waiting over 22 hours and 22 minutes for a DTA decision.

The decision maker was declared as a hospital speciality senior doctor, rather than a doctor from the emergency department. Staff told us there was a limited in reach for medical and surgical specialities which effected the timeliness of decision making for admissions.

During our inspection we found the patient flow team did not look for a bed until a decision to admit had been inputted into the electronic system. This meant there were additional delays which resulted in patients being in the emergency department longer than necessary. This put those patients at risk of their care needs not being met. The provider shared information to say that 10% of patients stay within the emergency department for over 12 hours from DTA.

The median total time patients have spent in the emergency departments at LUHFT has been longer than the national average for every month since May 2020. In May 2021, patients attending LUHFT emergency departments spent a total of 216 minutes on average compared with the national average of 170 minutes.

Managers monitored patient transfer to an inpatient bed but did not always meet the national standards that state patient should be admitted, transferred or discharged within four hours of arrival. Managers and staff did not always work to make sure patients did not stay longer than they needed to. The longest attendances in the department was 23 hours 48 minutes on the 1 July 2021.

In addition to the access and flow within the emergency department, there was supplementary pressures put onto the emergency department from the GP Unit and acute medical unit (AMU). There were staffing issues in the emergency department and the GP unit. The lack of beds on the 29 June 2021, meant that patients were staying on the AMU on average for three to four days instead of the maximum recommended time of 24 hours before they could be transferred to appropriately staffed wards and available beds. This was causing extended lengths of stay on the GP unit and AMU.

We were told by staff that on the 29 June 2021 the AMU was full, and a patient was sent to the emergency department and added to the electronic reporting system as a red flag as they could not be treated in AMU. We were also told that patients would be sent to AMU from the emergency department if they were at risk of breaching the timed clock standard in the emergency department as staff told us the clock stops when the patient is in AMU. This meant that patients in AMU had delayed admissions because patients in the emergency department would be prioritised for beds when they became available.

There was no enhanced care in AMU. This meant that patients who were a direct referral into AMU by their GP for assessment could not always have their care and treatment needs met. These patients were discharged from AMU into the emergency department as a new attendance. On the 29 June 2021 there was at least a four hour wait to be seen in the emergency department at Royal Liverpool University Hospital. This meant there were significant delays to diagnosis and treatment for these patients

The service had not formalised a patient flow pathway from admission to discharge throughout the emergency department. Meaning that there were significant delays throughout the patient pathway putting patients' care and treatment at risk of harm.

We requested additional data from the trust to provide assurance on the timeliness of access and flow in the emergency departments and through pathways to inpatient discharges. This included details of length of stay in the departments including patients who had waited 12 hours from arrival on 20 July 2021. This was due back by close of business on the 23 July 2021 and has not been provided to date. We are not assured that senior leaders have oversight over the systems in place or appropriate audit systems in place, as evidenced by the failure to provide such data.

Urgent and emergency services

Learning from complaints and concerns

It was not clear if it was easy for people to give feedback and raise concerns about care received. It was not demonstrated that learning was put into practice to improve the service.

The service did not clearly display information about how to raise a concern.

Managers investigated 23 complaints and identified eight themes for the division of acute and emergency medicine, in the first quarter of 2021/2022. The service responded to complaints within the response deadlines as per trust policy.

Managers shared learning through key messages of the week, monthly newsletters, communication boards and the clinical governance meeting. However, not all the learning was embedded within the department. For example, in response to an identified theme, a two hourly waiting room audit had been introduced to ensure patients were safe and supported, especially at time of surge. No evidence was seen of this audit happening during our inspection. In addition, no data for this was provided by the service.

Is the service well-led?

Inadequate 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated well led as inadequate.

Leadership

Senior leaders were not always visible and approachable in the service. Senior leaders did not always have a clear understanding of the risks, issues and challenges in the service. They did not always act in a timely manner to address them. Leaders did not always support staff to develop their skills and take on more senior roles. However, departmental leaders were not always visible, approachable or have oversight of the challenges in the service.

The emergency department was a part the Division of Acute and Emergency Medicine.

There was a triumvirate leadership team for the division, this being a divisional medical director, deputy divisional director of operations and divisional nursing director.

At department level, the emergency department was led by a clinical director, a deputy head of operations, who worked across both sites, and three matrons on the Royal Liverpool University Hospital site. The senior leaders were not visible, however local departmental ones were.

We observed the department when it was busy and we were concerned that there was a lack of local leadership. At times the department felt chaotic and we had concerns about the lack of management and oversight of activity.

Urgent and emergency services

We were particularly concerned that there were unknown risks to patients due to a lack of robust communication and lines of responsibility. Senior consultants in the department could not describe who had the responsibility and oversight for the patients. This raised significant concerns about the safety of patients.

Vision and Strategy

Senior leaders had a vision for what they wanted to achieve within the division but did not have a clear strategy to turn it into action. We were not assured local leaders and staff understood the vision and knew how to apply and monitor its progress.

Senior leaders told us that their values aligned with the trust vision, and ensuring the values were implemented was work in progress. The two emergency departments within the trust were not aligned, we observed differences to training requirements cross site and differences in care patients were receiving. Leaders did not articulate a clear strategy regarding to how they would align the two sites and achieve their vision.

We were told about the civility and kindness work, getting it right first time (GIRFT), communication, getting away from corridor care and recovery. GIRFT is a national programme designed to improve treatment and care of patients through in-depth review of services, benchmarking and presenting a data-driven evidence base to support change. We were told this was work in progress which was evident from the inspection.

Since our inspection, in July 2021, the trust launched a new trust-wide strategy for 2021 to 2024, Our Future Together. This was aligned to support the One Liverpool Plan which was a city-wide plan. The trusts vision was: “healthier, happier, fairer lives”.

The vision of the trust focused on providing high standards of compassionate care and listening to patients, staff and partners. There were four strategic priorities: great care, great people, great research and innovation and great ambitions. These were not displayed in the department.

Culture

Staff did not always feel respected, supported and valued by the wider hospital and senior managers. The service did not always have an open culture where patients, their families and staff could raise concerns without fear. Leaders were not always focused on the needs of patients receiving care.

Staff said they felt concerns they raised were not always heard. Therefore, they would not always record these in the form of an incident. Staff felt that senior leaders within the trust did not have oversight of the flow issues.

Staff told us they were not supported by other teams within the wider hospital. It was perceived by the rest of the hospital that the flow issues were the emergency department problems. Staff told us that there was a lack effective support provided from the wider hospital.

Staff of all levels felt they were valued and respected by their colleagues and local managers within the department. We asked staff about the morale of the department and they all said it was generally good, despite the challenges in the department. However, some staff did become emotional when they told us about how the overcrowding challenges impacted the level of care they would like to provide. Despite these concerns, they said they worked as a team and supported each other during busy periods with limited resources. We were told local managers were visible within the department to assist when it was busy.

Urgent and emergency services

Local leaders were focussed on the flow and performance figures within the department rather than focusing on the needs of the patients receiving care.

There was a desire from all staff to provide good care and treatment to patients but they had limited resources when the department was busy. We saw staff working extremely hard, in challenging situations. Staff were working additional shifts to help the service manage the pressures. There was a risk this passion and drive to work extra to keep the department afloat was not sustainable in the longer term and could lead to staff burn out.

Governance

Leaders did not always operate effective governance processes, throughout the service, across both sites and with partner organisations. They did not always have regular opportunities to meet, discuss and learning from the performance of the service was not clear.

Senior leaders told us that governance across both sites needed to be updated and aligned. We did not see any evidence that plans were in place to achieve this despite the two sites being part of the same trust for 22 months.

At the triumvirate meeting we were not assured by the senior leaders that they were fully sighted on the activity and performance in the emergency department. They were unable to demonstrate having appropriate audit systems in place.

From our observations and discussions with staff there were missed opportunities for sharing information and learning with staff. Information was not always displayed on notice boards. Information was shared through key messages at handovers, newsletters and a mobile telephone applications.

There was not a clear focus on development and training for staff to support them in their roles. This was supported by low training and appraisal figures. There had been trajectories created but no clear action plan to achieve appropriate compliance figures.

Whilst staff were generally aware of their individual roles and responsibilities. When the department became busy, this became unclear. We were concerned when staff described ‘near misses’ and potential safety incidents that they said they had not reported.

However, the service had governance leads who attended a cross site quality group to update and align audit plans, NICE guidance, and standard operating procedures.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalated relevant risks and issues. They did not always identify actions to reduce their impact. However, they had plans to cope with unexpected events.

The departmental clinical leaders were sighted on the main issues facing the department. However, there was no overarching action plan for the department to mitigate the risks and manage priorities.

We requested the risk register for this site. From our discussions with the leaders they were not always clear on the top risks for the service. They talked about nurse staffing, provision for mental health patients and access and flow. We were not provided with robust plans and mitigating actions to address the risks. We saw lists of controls in place which included using the pit-stop model for assessing patients requiring urgent treatment but we did not see this in action.

Whilst these risks reflected what we found during our inspection. We identified additional specific risks which had not been identified. These related predominantly to oversight of risk in terms of patient conditions within the department.

Performance was measured against National standards and by the outcomes of RCEM audits. The submission to the RCEM standards had not been fully maintained during the pandemic. Where data was collated and results were poor, we did not see action plans developed to support the improvements needed. In addition, we did not see evidence of improvements from local audit activity.

Senior leaders could not demonstrate clear oversight of what was contributing to the access and flow issues. They reacted by reviewing the information technology systems and comparing the trusts monitoring standards against the Clinical Commissioning Group (CCG). This demonstrated they were not fully aware of the problem so were unable to mitigate any of the risks.

Senior leaders did not have assurance that waiting rooms were safe following initial triage. It was also unclear if managers were fully aware if the department was safe for patients during busy times. We were informed the department was safe. However, during our inspection an internal major incident was activated. This appeared to be in response to the inspection team escalating their concerns regarding deteriorating patients.

Similarly, leaders were aware that incident reports were not always submitted to escalate when the numbers of patients in the department corridor reached the maximum level. Staff did not feel that the department's capacity and overcrowding was listened to by senior managers. Therefore, they had stopped reporting these type of incidents.

Staff told us that the escalation plan was not effective when the department was overcrowded. Senior leaders were made aware of overcrowding and flow issues however it was unclear whether the mitigating actions to ensure patient safety were effective.

Information Management

The service did not always collect the data to enable them to make positive changes to improve the service for patients and staff. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated. Paper records were not always stored securely.

Staff did not always receive training on information governance. The trust had multiple electronic systems that were not effective including records and medication management. This poses a risk to patient safety.

There was poor documentation in patient records and on clinical systems across the emergency department and medical wards throughout the trust.

Urgent and emergency services

There is a risk to patient safety and the continuity of care with the two different prescribing systems at the Royal Liverpool University Hospital, as discussed in safe. This causes a risk to patient safety as patients would not always get treatment in a timely manner or would get second doses given without the required spacing between doses. Staff did not always follow systems and processes when administering and recording medications given.

However, staff accessed information relating to polices and guidance electronically. The system was easy to navigate.

Engagement

Leaders and staff did not always actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not always collaborate with partner organisations to help improve services for patients. However, local leaders were seen in the department and supported staff throughout the throughout the pandemic.

During our inspection it was highlighted to us that there was limited engagement by most of the senior leadership team with some staff. Staff told us they felt that the board did not respond to the concerns and risks they raised. Senior leaders told us they communicated with front line staff through weekly and monthly newsletters, through a group on a mobile phone application, and Microsoft Teams meetings.

Senior leaders relied on staff surveys and updates from meetings. Senior leaders we spoke with were not clear when they last visited the department to see for themselves how staff on the front line were managing. This meant senior leaders might not have effective oversight of each department and their staff.

The head of operations attended the daily tactical meetings to hear any concerns from staff. The division held a divisional core meeting each week, they discussed staff feedback and results from the staff surveys. However, the senior leadership team could not demonstrate how they used this information to develop action plans to improve care and treatment.

The department participated in the friends and family test and CQC surveys but had not carried out any local surveys, recently in relation to the quality of urgent and emergency care services. The CQC Survey had been undertaken from October to March 2021, however results had not been published. Friends and family test results, in May 2021, showed 70% of patients recommended the emergency department to friends and family.

However, nursing staff felt supported to cover breaks to ensure patients were safe. The service supported staff welfare through the COVID pandemic by creating a separate room decorated in a non-hospital style with bean bags, mood lights and a diffuser. Staff felt that this had a positive impact to their welfare and mental health during the challenges faced.

Learning, continuous improvement and innovation

We saw limited examples of continual learning and improving services. Leaders stated that they encouraged innovation and participation in research but we did not see evidence of this.

The trust vision included innovations and great ambitions. Some staff had been involved in the creation of the mental health hub to improve care and treatment for those suffering with mental health crisis'. Staff told us how proud they were of the improvements' they made in the mental health hub.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement → ←

This is the first time we have rated safe for this service. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, mandatory training compliance was below trust targets for a number of training modules, such as paediatric life support and higher level resuscitation training.

Staff received mandatory training. Mandatory training was delivered through e-learning modules with some face to face training modules. Training was completed on induction and then updated every one to three years depending on the training module. The mandatory training was comprehensive and met the needs of patients and staff.

An electronic system prompted staff when their mandatory training was due or had expired. Managers monitored mandatory training and alerted staff when they needed to update their training.

Training data specific to this hospital was not provided. However, records for July 2021 showed the overall trust-wide training compliance was 84.9% in the division of surgery and 87% for the division of anaesthetics, critical care, head & neck and theatres. The trust target for mandatory training compliance was 85%.

Staff told us the availability of some training modules that included face to face training had been impacted by the Covid-19 pandemic.

The records for all staff groups across the division of surgery showed that training compliance was below the trust target of 85% for a number of training modules. This included paediatric basic life support (39%), adult resuscitation level 1 (81%), adult resuscitation level 2 (57%), adult resuscitation level 3 (47%), infection prevention and control level 2 (64%) and moving and handling (69%).

The records for all staff groups across the division of anaesthetics, critical care, head & neck and theatres also showed that training compliance was below the trust target of 85% for a number of training modules. This included paediatric basic life support (34%), adult resuscitation level 1 (78%), adult resuscitation level 2 (50%), adult resuscitation level 3 (52%), infection prevention and control level 2 (70%) and moving and handling (68%).

This showed most staff within the surgical services had completed their mandatory training but the hospital's internal target of 85% training completion had not been achieved across all the mandatory training modules.

Safeguarding

Surgery

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the number of staff that had completed the higher level of adult and children's safeguarding training did not meet trust targets.

Staff received training specific for their role on how to recognise and report abuse. Training data specific to this hospital was not provided. However, trust-wide records for July 2021 showed that safeguarding training compliance within the division of surgery was; level 1 adults safeguarding (88%), level 2 adults safeguarding (87%), level 3 adults safeguarding (44%), level 1 children's safeguarding (88%), level 2 children's safeguarding (79%) and level 3 children's safeguarding (47%).

The safeguarding training compliance within the division of surgery and the division of anaesthetics, critical care, head & neck and theatres was; level 1 adults safeguarding (92%), level 2 adults safeguarding (86%), level 3 adults safeguarding (57%), level 1 children's safeguarding (91%), level 2 children's safeguarding (87%) and level 3 children's safeguarding (41%).

This showed the majority of staff in the surgical services had completed mandatory training in the safeguarding of vulnerable adults and children. However, training compliance for the level 3 (higher level) adults and children's training was below the trust target of 85%.

Staff told us access to safeguarding level 3 training was impacted by the Covid-19 pandemic and the trust had developed e-learning modules for this training to improve compliance.

Staff also received training in the prevent (anti-radicalisation) strategy, child sexual exploitation and female genital mutilation as part of their safeguarding training and staff we spoke with had a good understating of how to identify these.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information on how to report adult and children's safeguarding concerns was displayed on notice boards in the areas we inspected.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff used an electronic system to report safeguarding concerns,

The trust had safeguarding policies available to support staff and these could be accessed on the trust intranet. Staff were aware of how they could seek advice and support from the trust-wide safeguarding team.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Surgery

There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Staff disposed of clinical waste safely. There were enough hand wash sinks and hand gels. The majority of staff we observed followed hand hygiene and 'bare below the elbow' guidance. Staff and visitors were encouraged to wash their hands.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was clear guidance displayed on how to minimises risk of spread of Covid-19 and we saw staff and patients adhere to social distancing guidelines across the ward and theatre areas. The majority of staff we observed wore suitable personal protective equipment, such as gloves, aprons and visors while delivering care. Gowning procedures were adhered to in the theatre areas.

Patients identified with an infection were isolated in side-rooms. We saw that appropriate signage was used to protect staff and patients. Staff also told us they could also seek advice and support from the trust-wide infection prevention and control team if required.

Staff told us cleanliness of the environment and equipment and hand hygiene compliance was monitored as part of routine monthly and three-monthly audits. Hand hygiene audit compliance in the surgical wards ranged between 91% and 100% between January 2021 and March 2021, which was in line with the trust target of 90% compliance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. Whilst the, the main theatre corridors were not well maintained or in a good state of repair.

The design of the environment followed national guidance. The ward and theatre areas were well maintained and free from clutter. Whilst the environment and equipment in the theatre areas was well maintained, we found the main theatre corridor area was visibly dusty, worn and aged.

The theatre manager told us this had been reported to the estates team and the theatre corridor was regularly cleaned. The theatre manager told us the dust was caused by crumbling walls and whilst there was an estates maintenance programme in place, there were no plans for large scale refurbishment due to the planned move in 2022 to the new hospital site.

Access to the surgical wards was secure and the ward and theatre areas required key code access for entry. Patients could reach call bells and staff responded quickly when called. We saw that there was a call bell alert system next to the ward nurses' stations that identified the room and level of alert that had been raised. There were three levels of alert on the call bells, one of which was an emergency response call.

All the ward areas had sufficient shower and bathing facilities. The ward areas were free from clutter and we saw that equipment and consumable items were stored appropriately.

Staff told us equipment was routinely checked and cleaned in between use. The majority of equipment (such as hoists and blood pressure monitoring machines) we saw were visibly clean. Single-use, sterile instruments and consumable items were stored appropriately and were within their expiry dates.

Surgery

The service had enough suitable equipment to help them to safely care for patients. Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. Ward staff also told us they did not have any difficulty obtaining any equipment. Equipment was serviced by the trust's medical engineering team under a planned preventive maintenance schedule. Staff told us they received good and timely support if a fault was reported.

Emergency resuscitation equipment was available in all the areas we inspected, and this was checked on a daily basis by staff. We saw that daily and weekly equipment check logs were complete and up to date in the areas we inspected.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks.

Managers told us that the pre-operative checklist for patients was very thoroughly checked and the patient was unable to leave the ward for surgery unless the checklist had been validated as correct.

All patients over 65 years of age, or if they met the criteria, were given a falls risk assessment. There was a specialist falls nurse who could help with this. Those patients on a falls risk care plan were given a wrist band to identify them and were supported by the falls team.

Patients identified as high risk were placed on care pathways and care plans were put in place, so they received the right level of care. Staff carried out 'intentional rounding' observations at least every four hours so any changes to the patient's medical condition could be promptly identified. Patient records we looked at showed that patients were reviewed regularly and escalated appropriately when required.

Staff knew about and dealt with any specific risk issues. Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.

Staff were aware of the NEWS score escalation process so that patients with a NEWS score over five were seen and assessed by medical staff as soon as possible. Patients with a NEWS score of seven or above triggered a call to the medical emergency team. Staff were encouraged to use clinical judgement so that if a patient's observations were not triggering an escalation, but the patient did not look well they could still escalate and make a medical emergency team call.

Staff followed appropriate guidelines, pathways and screening tools, based on national guidelines for the management of patients with sepsis. Staff we spoke with understood how to identify the signs of sepsis and management of sepsis in line with national guidelines. Nursing staff had received training and used a sepsis kit on the ward for those patients displaying signs of sepsis, this included antibiotics and fluids. If the sepsis pathway was triggered, patients were treated within the hour.

Surgery

The theatre teams followed the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist. There was a monthly audit to check staff compliance against the safer surgery checklist across the theatre areas. This included an observational audit to observe staff practice and a review of completed checklist records. The monthly audit results for the period between December 2020 and June 2021 showed high levels of staff compliance in the use of the checklist and the theatre teams at this hospital consistently achieved 100% compliance throughout this period. The audit results did not reflect our findings during the inspection, as the services reported a number of never events during the past 12 months, including at least four never events relating to retained foreign objects.

Nurse staffing

Whilst there had been improvements in nurse staffing levels, not all surgical wards had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. There was a monthly safe staffing spreadsheet produced and a six-monthly acuity audit on staffing levels to establish whether adjustments to ward staffing were required.

The expected and actual staffing levels were displayed on notice boards in each area we inspected.

There were 115.8 full time equivalent vacancies for registered nurses (all bands) within the surgical services across the trust in July 2021. The surgical services also reported a 4.2 full time equivalent over establishment for healthcare staff.

The surgical wards we inspected had nurse staffing vacancies. We found that recruitment was on-going, and some vacant posts had been filled through the appointment externally recruited and newly recruited nurses. Whilst we found some improvements had been made to nurse staffing levels through recruitment activities, the majority of these new starters were not due to start until at least September 2021.

The shift fill rate records for May 2021 showed most surgical wards had sufficient levels of nursing and healthcare staff and there was an over-establishment of healthcare staff on some wards to balance lower nurse staff numbers. However, records showed that ward 9y (breast, endocrine and ophthalmology) had an average shift fill rate of 66% for nursing staff and 70% for healthcare staff during the days and 90% nursing staff and 54% for healthcare staff on nights. This meant the ward did not have always have sufficient numbers of staff. We also found instances where this ward had been closed due to staff shortages and patients had been transferred to other wards, which could have an impact on their health and well-being.

The senior nurses and ward managers carried out daily staff monitoring and escalated staffing shortfalls to the matrons due to unplanned sickness or leave. Managers told us that if the ward was not staffed safely, they would escalate this by using the red flag system so that additional staff could be found, or beds were closed.

Staffing levels were maintained through the use of bank staff, agency staff or existing staff working additional hours. Staff could also be redeployed from other surgical wards if required.

Staff participated in huddles at the start of each day and nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues.

The theatre manager told us they had not used bank staff for 18 months and used their first agency nurse in 18 months last week.

There was a shortage of operating department practitioners (ODPs) and anaesthetic practitioners in theatres but some staff were going through training and recruitment drives were underway. Three nurses were due to complete an anaesthetics course in September 2021.

At the time of our inspection there were 12 vacancies in theatres for ODP's, scrub practitioners and recovery practitioners. All the posts were out to advert and there were joint recruitment events run with University Hospital Aintree. The theatre manager told us a number of ODP's had been recruited and were due to start in September 2021 upon completion of their university course.

Operating theatres were staffed in line with national guidelines, such as the association of perioperative practice (AfPP) guidelines for safer staffing. The theatre manager told us the staffing in the hybrid theatre was above AfPP guidance levels with two scrub nurses, two healthcare assistants, one ODP and the surgical team.

There had been a recent review of staffing and skill mix in theatres. Unit managers planned the skill mix in theatres and fed this to the theatre manager. Operations were cancelled on occasion where the skill mix could not be fulfilled.

Staff were moved between the Royal Liverpool University Hospital and Broadgreen Hospital to meet skill mix requirements. The theatre manager told us there had been at least two occasions where theatre staff had been asked to support the theatre teams at University Hospital Aintree and when this happened, they had been sent there the day before for an induction and orientation.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. There were separate medical rotas in place to cover specific specialties, such as for general surgery and urology. There was at least one junior doctor, middle grade and consultant on call for each specialty 24 hours per day.

The service always had a consultant on call during evenings and weekends. There was sufficient on-site and on-call consultant cover over a 24-hour period including cover outside of normal working hours and at weekends. There was an onsite consultant presence during normal working hours across seven days and daily consultant-led ward rounds took place across the surgical wards seven days per week.

There were 2.5 full time equivalent vacancies for consultants and 22.6 full time equivalent vacancies across other medical roles in the division of surgery across the trust.

Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Managers could access locums when they needed additional medical staff. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.

Surgery

The junior doctors we spoke with told us they received good support and could easily access middle grade or consultant support if needed. The majority of doctors we spoke with told us the workload was manageable and they were able to provide timely care and treatment during busy periods.

Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. Staff used electronic patient records for recording risk assessments, care plans and for medical and nursing notes, care plans and patient assessments. When patients transferred to a new team, there were no delays in staff accessing their records.

Staff used electronic records for standardised nursing activities, such as daily observations and nutritional care. We saw that observations were well recorded, and the observation times were dependent on the level of care needed by the patient.

We looked at the records for 10 patients. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly. Patient risk assessments were reviewed and updated on a regular basis. We found that patient's care plans were person-centred and were completed to a good standard. Multidisciplinary staff interventions were recorded in daily notes and these were up to date.

Patient records were checked for accuracy and completeness as part of routine audits, such as the routine weekly and monthly quality audits undertaken by ward managers or matrons.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. We looked at a sample of controlled drugs and found the stock levels were correct, and the controlled drug registers were completed correctly.

We saw that medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. Fridge temperature logs showed that these were checked daily and the medicines we checked were stored at the correct temperatures. Log sheets also showed that staff monitored the temperature of the clinic rooms in the surgical wards and theatres on a daily basis.

There was a system in place for staff to notify the maintenance team and the pharmacy department where medicine fridge or treatment room temperatures exceeded the maximum temperature range.

Surgery

The Trust used an electronic prescribing and medicines administration recording system. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw that medicines containing potassium were stored in drawers marked with a red dot so that they were easily identifiable.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out daily reviews either on the wards or remotely by reviewing the electronic records.

The trust had reported a number of incidents relating to the administration of Gentamicin. We did not identify any concerns relating to the prescribing or administration of Gentamicin in the surgical wards we inspected. We found that staff across the surgical wards carried out checks on whether a patient had received a dose of Gentamicin prior to admission to the surgical wards to minimise the risk of Gentamicin overdose.

Incidents

The service did not always manage patient safety incidents well. Whilst managers investigated never events, lessons learned were not always shared with the whole team and remedial actions taken did not minimise the risk of reoccurrence. We were not assured that the service had effective systems in place for identifying and reporting never events.

Staff raised concerns and reported incidents and near misses in line with trust policy. Incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.

Information reported on the strategic executive information system (StEIS) showed there had been six never events reported in relation to the surgical services at this hospital between April 2020 and June 2021.

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

The service reported two never events relating to retained foreign objects in October 2020 and February 2021. Remedial actions taken following these included trialling new surgical stock and the use of wall mounted sponge/swab boards as part of the counting process.

We found that whilst these incidents had been investigated and learning had been identified, the remedial actions taken had not been effective as the service reported two further never events in June 2021 relating to retained foreign objects (swabs) following surgery. The retained swabs were removed and there was no patient harm in both these cases. Immediate lessons learnt following these incidents included creating a culture where challenging staff for not adhering to the policy is routine and accepted and shared learning around potential communication and situational awareness issues.

Staff told us learning from incidents was shared trough safety huddles, routine staff meetings and through trust-wide newsletters and bulletins. We received a mixed response from theatre staff in relation to sharing of learning from never events. Some of the staff we spoke with were not able to describe any learning from never events or whether learning had been shared with the wider team.

Surgery

Records between March 2020 and May 2021 showed there had been 12 serious incidents reported in relation to the surgical services across the trust. The most frequent type of incidents were treatment delays (three incidents), surgical invasive incidents (three incidents) and slips, trips and falls (two incidents).

The service reported three surgical invasive incidents during February 2021 and May 2021. These were not initially reported as never events, but the trust later identified at least one of these as meeting the criteria for reporting as a never event. The delayed decision-making showed the trust did not have an effective process in place for identifying and reporting never events.

The service reported a surgical invasive incident May 2021 in relation to a colostomy procedure that was incorrectly performed. The trust did not report the incident as a never event and this was questioned by the clinical commissioning group and NHSE/I who advised the incident met the criteria to be reported as a never event.

The service reported an incident in May 2021 where a metallic surgical thumbtack marker used in a partial sacrectomy procedure was post-operatively found in the patient's abdomen. The trust did not initially report the incident as a never event as it was determined by the trust to be exempt due to the thumbtacks not being part of the surgical count. The trust subsequently reviewed the use of these thumbtacks and agreed to include them in the surgical count.

The service reported an incident in February 2021 where a retained swab was found in the throat of a patient after a rhinectomy (removal of nose) procedure. The swab had been retained following a Bonfils intubation. The trust reported all staff were made aware of the incident and to follow good practice in relation to visually inspect the airway at the end of the procedure. The incident had not been reported as a never event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when they identified things that went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Records showed the surgical services across the trust achieved 100% for patient safety alert compliance between October 2020 and May 2021.

Patient deaths were reviewed by individual consultants within their specialty area. These were also presented and reviewed at mortality and morbidity meetings. This was a joint meeting between the two surgical divisions and included all clinical leads and patient safety representatives.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see.

The safety thermometer showed the service had reduced the incidence of harm within the reporting period. Staff used the safety thermometer data to further improve services.

Surgery

Is the service effective?

Good  

This is the first time we have rated effective for this service. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, such as from The National Institute for Health and Care Excellence (NICE) and the Royal Colleges' standards.

We reviewed care pathways for a number of surgical procedures, including colorectal surgery and general surgery, and found these were based on best practice guidance. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidelines.

The 2021/22 clinical audit forward plan identified 19 audits planned to be undertaken by the division of surgery and 10 clinical audits planned for the division of anaesthesia, critical care, head and neck and theatres. Findings from clinical audits were reviewed during routine speciality (care group) clinical governance meetings and any changes to guidance and the impact that it would have on their practice was discussed.

Staff used specific care plans when providing care and treatment for patients with mental ill health, which included additional measures such as enhanced one to one monitoring and supervision. Staff could also seek support and advice from the trust-wide safeguarding team and mental health liaison teams from another trust when providing care for these patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used the Malnutrition Universal Screening Tool (MUST), which was a nationally recognised screening tool to monitor patients at risk of malnutrition. Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians was available for patients who needed it. The patient records we looked at showed that there was regular dietitian involvement with patients that were identified as being at risk. Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff. Patients with difficulties eating and drinking were placed on special diets.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. Optional menus were available for patients with specific requirements. We saw patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used an appropriate pain scale for patients that were unable to communicate effectively, such as those living with dementia or a learning disability. Acute pain symptoms were managed by the surgical consultants.

Pain scores were recorded electronically. Staff prescribed, administered and recorded pain relief accurately. The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.

Patients received pain relief soon after requesting it. The majority of patients we spoke with told us staff gave them pain relief medicines when needed and their pain symptoms were managed appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. However, the service had a higher than expected risk of patient readmissions when compared to the England average.

Hospital episode statistics (HES) data showed that all patients at this hospital had a higher than expected risk of readmission for elective admissions and non-elective admissions when compared to the England average between March 2020 to February 2021.

During this period, the ophthalmology, urology and vascular surgery patients all had a higher than expected risk of readmission for elective admissions when compared to the England average. The general surgery, colorectal surgery and urology patients all had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

The senior leadership team told us they did not have any specific concerns in relation patient readmissions. We were told this was due to data quality in relation to the reporting of patient readmission rates due to the inclusion of planned re-attendances being included in the data.

The surgical services reported a number of actions taken to reduce patient readmissions. The vascular surgery specialty had consultant ward rounds and daily discharge consultant reviews and a daily 'hot slot' clinic to review patient concerns and to assist in avoiding accident and emergency presentations.

The urology services reported patients had a primary ureteroscopy and laser in emergency theatre, where they would previously have had stent inserted and been added to a waiting list for the procedure at a later date. Urology patients

could also be booked into a review clinic on the surgical assessment unit prior to being discharged. The urology service also ran hot clinics and patients could be directly referred to the service from the emergency department if they required advice and support. The renal transplant services reported that most patients were expected to be readmitted at some time due to the complex nature of their treatment. The services had support mechanisms in place such as access to on-call teams and virtual follow ups to reduce accident and emergency presentations.

The trauma and orthopaedic departments for Royal Liverpool University Hospital and University Hospital Aintree were reconfigured in November 2019, with elective services delivered at the Broadgreen Hospital site and trauma services at University Hospital Aintree. Therefore, we cannot report on clinical audit outcomes for the national hip fracture audit for this hospital.

The surgical services at this hospital participated in the national emergency laparotomy audit (NELA). The services reported the risk-adjusted 30-day mortality rate at this hospital was 7.3% and this was better than the regional average of 8.8% (when compared against 12 trusts in the North West region).

Records for the period between January 2021 and March 2021 showed there had also been improvements in a number of NELA audit indicators compared to the previous published annual NELA audit report (2018).

During this period, the surgical services reported 93% compliance in the indicator for consultant surgeon and anaesthetist presence in theatre for patients with more than 5% mortality predicted. This had improved from 63% compliance reported in 2018.

The compliance for the case ascertainment indicator (98% against 68.9% in 2018) and the proportion of high risk patients admitted to critical care post-operatively (88% against 81% in 2018) also showed there had been recent improved compliance.

The surgical services reported that there had been a number of actions taken to improve compliance with the NELA audit. This included regular updates sent to consultants and anaesthetists to aid learning and awareness in relation to the annual NELA report findings and estimations for the next year. The services also reported improvements in the case ascertainment indicator through additional monitoring of emergency theatre lists and checks by named consultants to add patients fitting the NELA criteria where they have not been entered onto the system already.

The national joint registry data 2020 showed this hospital performed similar to expected in all six standards when compared to national averages. The surgical services participated in patient reported outcome measures (PROMs); however, there was insufficient data reported by the trust in order to compare outcomes against the England average.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. Newly appointed staff had an induction and their competency was assessed before working unsupervised. Bank and locum staff also had inductions before starting work.

Surgery

Managers made sure staff received any specialist training for their role. The staff we spoke with told us they routinely received competency-based training in their specialty area and felt confident to do their role. Staff received role-specific training in areas such as venepuncture, cannulation, acute kidney injury, aseptic non-touch technique, dementia, falls prevention, nasogastric awareness, pain management, palliative care, safe use of insulin, sepsis awareness and NEWS2.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Competency-based assessments and training support was provided by the managers and practice-based educators based in the ward and theatre areas.

Junior nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management. They told us they could access routine training sessions and were supported to attend these. The theatre manager told us there had been 10 student nurses in the department since January 2021. The theatre manager had sought feedback and told us nine of the student nurses gave 100% positive feedback for the support they had received, and one gave 91% positive feedback.

Staff told us they routinely received regular supervision and annual appraisals. Appraisals were completed on a rolling annual plan with three-monthly trajectory targets and an overall completion target of 80% by March 2022. Records for staff at this hospital from July 2021 showed 30.9% of staff in the division of surgery and 45.7% of staff in the division of anaesthesia, critical care, head and neck and theatres had completed their appraisal. The surgical services reported staff were on target to achieve the end of year trajectory target.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective daily communication between multidisciplinary teams within the surgical wards 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.

The ward staff told us they had a good relationship with consultants and ward-based doctors. We saw there was effective team working and communication between the theatre teams.

Staff worked across health care disciplines and with other agencies when required to care for patients. Specialty multidisciplinary (MDT) meetings took place on a weekly basis with input from medical, nursing and allied health professional staff as well as staff from other hospitals within the trust or external hospitals where patients received care and treatment from more than one healthcare organisation. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

The ward and theatre staff told us they received good support from pharmacists, dietitians, physiotherapists, occupational therapists as well as diagnostic support such as for x-rays and scans.

Seven-day services

Key services were available seven days a week to support timely patient care.

Surgery

Records showed nursing and medical staff levels were sufficiently maintained outside normal working hours and at weekends across most of ward and theatre areas based at this hospital.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. There was sufficient out-of-hours medical cover provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover. There was on-site consultant presence across most surgical specialties on weekends along with on-call cover and consultant-led ward rounds taking place seven days per week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Ward staff told us on-site physiotherapy and occupational therapy support was available on weekends and the support offered had improved. Microbiology, imaging (such as x-rays), physiotherapy, occupational therapy and pharmacy support was available on-call outside of normal working hours and at weekends. The pharmacy was also open for a limited number of hours on Saturdays and Sundays.

The ward and theatre staff we spoke with told us they received good support outside normal working hours and at weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Information leaflets were readily available for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients identified with weight concerns were referred to dietitians for advice and support. Patients with addiction to alcohol and drugs could be offered treatment and provided with support from specialist trust-wide liaison teams.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Patient records we looked at showed that patient consent had been obtained and that planned care was delivered with their agreement.

Staff made sure patients consented to treatment based on all the information available. Staff told us the risks and benefits of the specified surgical procedure were documented and explained to the patient.

Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Mental Capacity Act and Deprivation of Liberty training was incorporated into the adult safeguarding training.

Surgery

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. A range of multidisciplinary staff were trained to carry mental capacity assessments (such as nurses and medical staff) and capacity assessments were documented in the electronic patient records.

We did not identify patients with Deprivation of Liberty Safeguards (DoLS) orders place within the surgical wards we visited. However, ward staff were able to demonstrate a good understanding of DoLS processes.

If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that could legally make decisions on the patient's behalf. Where this was not possible, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff could seek support from the trust-wide mental health liaison team and the safeguarding team for advice and guidance on mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications.

Is the service caring?

Good 

This is the first time we have rated caring for this service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that patients were treated with dignity, compassion and empathy. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff followed policy to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.

Patients transferred between the ward and theatre areas were given dressing gowns and their dignity was maintained. Patients calling for assistance and call bells were answered in a timely manner across the wards we visited.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients said staff treated them well and with kindness. We spoke with 12 patients during the inspection. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: "staff are really helpful and been great" and "all care has been good so far".

Surgery

The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between January 2021 and June 2021 showed the average monthly satisfaction score across surgical wards at this hospital ranged between 82% and 93%. The average monthly response rate ranged between 25% and 32%. This indicated the majority of patients were positive about recommending the hospital's surgical wards to friends and family.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing reassurance and comfort to patients.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties.

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs. Staff told us they could contact the hospital's palliative (end of life care) team for support and advice during bereavement.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff speaking with patients clearly in a way they could understand.

Staff supported patients to make informed decisions about their care. Patients told us the nursing and medical staff fully explained the care and treatment options to them and allowed them to make informed decisions. Patient comments included "I have had treatment explained fully, feel involved in discussions on the next steps and any actions" and "I have had a lot of investigations and have been given a lot of information on the next steps".

The trust had restricted visiting due to the Covid-19 pandemic; however, staff told us they allowed patients' relatives or carers to visit if this was seen to be in their best interest or there were exceptional circumstances, such as if the patient was living with dementia or learning disabilities or receiving end of life care. Patients with mental ill health and who were distressed were also allowed a visitor for one hour on the surgical wards.

Is the service responsive?

Requires Improvement 

Surgery

This is the first time we have rated responsive for this service. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so that they met the needs of the local population. There were daily meetings with the bed management team so patient flow could be monitored and maintained and to identify and resolve any issues relating to the admission or discharge of patients. Staff were aware of how to escalate key risks that could affect staffing and bed capacity constraints and there was daily involvement by the matrons and ward managers to address these risks.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The areas we inspected were compliant with same-sex accommodation guidelines: we observed that male patients were cared for in separate areas to female patients.

The hospital provided a range of elective and unplanned surgical services for the communities it served. This included general surgery, gastroenterology and colorectal surgery, ophthalmology, urology and vascular surgery.

Some surgical specialities had been transferred to other hospitals within the trust as part of service configuration following the formation of the new trust. This included the transfer of trauma and orthopaedics (including emergency trauma) services to University Hospital Aintree and elective orthopaedics and gastroenterology day case to Broadgreen Hospital.

The emergency surgical assessment unit (ESAU) admitted unplanned general practitioner (GP) referrals as well as patients from urgent and emergency care. A nurse practitioner (band 7) managed direct GP referrals from Monday to Friday 8am-6pm. The rest of the ESAU was open 24 hours a day, seven days a week.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, the environment across the surgical wards and theatre areas was not always dementia friendly.

The service had information leaflets available in the areas we inspected. These could be provided in different formats or in languages spoken by the patients and local community if required. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff completed training in dementia awareness. Staff used specific care plans when providing care and treatment for patients with a learning disability or those living with dementia. We saw evidence of these care plans in use in the records we looked at and they included reasonable adjustments and additional support and advice for patients and their carers.

We observed during our inspection that the environment across the surgical wards and theatre areas was not always dementia friendly.

Surgery

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff also used a 'passport' document for patients admitted to the hospital with dementia or a learning disability. Staff could contact dementia or learning disability specialist nurses for advice and support in relation to caring for patients living with dementia or a learning disability.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they could contact the mental health liaison team for further support and guidance if required.

Access and flow

Not all patients could access the service when they needed it and receive the right care promptly. The services performed worse than the national average for the percentage of cancer patients treated with 62 days. The average length of patient stay was worse than the national average. The total number of patients on the waiting list continued to increase since January 2021. Whilst the service did not achieve national standards for waiting times from referral to treatment; they performed better than the average when compared with other similar sized trusts .

Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, through accident and emergency or through GP referral. Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

From March 2020 to February 2021, the average length of stay for patients having elective and non-elective surgery at this hospital was worse than the England average across all surgical specialties except for non-elective ophthalmology and colorectal surgery.

The average length of stay for patients having elective surgery at this hospital was 5.2 days. The average for England was 4.0 days. The average length of stay for patients having non-elective surgery at this hospital was 4.3 days. The average for England was 4.2 days.

NHS England data showed there had been an increase in the total number of patients on the referral to treatment pathway across the trust, from approximately 46.000 patients in January 2021 to approximately 58,000 patients in June 2021. In June 2021, there were 17,433 new referrals and only 9,677 pathways completed. This meant there were nearly twice as many new referral pathways than those that had been completed.

NHS England showed the trust treated 78.9% of patients within 18 weeks of referral in April 2021 and 76.1% in June 2021, which showed there was a slightly worsening trend in performance. However, the trust performed similar to the average in the North West region (75.5%) in June 2021 and had consistently been ranked in the middle when their 18-week referral to treatment performance was compared with other trusts across the North West region. The trust performance was also similar to or better when compared to other similar sized trusts nationally. The trust's rank had ranged between 36th in April 2021 and 60th in June 2021 (out of 139 trusts nationally).

NHS England data showed the proportion of patients on the waiting list that had waited more than 52 weeks was in the bottom 25% of all trusts nationally (7.1% in June 2021). However, there had been an improving trend since February 2021. This indicated there had been a focus on reducing new referrals as well as the number of patients waiting more than 52 weeks. The trust had the lowest numbers of patients waiting more than 52 weeks when compared to other similar sized trusts nationally.

Surgery

NHS England data for March 2021 showed the trust performed better than the England average for the cancer two week waiting time standard (from GP referral) and the cancer 31 day waiting time standard (from decision to treat). However, the trust performed worse than the England average for the percentage of patients treated within 62 days (66.5% compared to the England average of 73.9%). The trust failed to achieve the 62 day standard across all specialties. except breast surgery.

The trust had an elective recovery plan that included proposed trajectories for reducing waiting lists for cancer patients, elective inpatient and day case patients and those waiting over 52 weeks.

Performance against the recovery plan was monitored as part of weekly elective recovery delivery forum meetings. Meeting minutes from May and June 2021 showed there was an improving trend in performance and meeting planned trajectories.

The services reported elective surgery capacity had increased recently following a reduction of restrictions applied during the Covid-19 pandemic; however, overcoming the referral to treatment backlog position continued to impact on the sustainable recovery of elective access standards.

To maintain patient safety, available capacity was allocated based on clinical need and patients were managed in order of clinical priority. This also applied to patients not on an active referral to treatment pathway (such as surveillance and long-term follow-up patients).

The surgical services reported that a standardised approach to harm reviews had also been developed and applied to patients on waiting lists that carried the potential for unintended harm as a result of time degenerative conditions. The process was implemented for orthopaedics and gastroenterology from 1 June 2021 and planned be extended to cover all surgical specialities.

A number of actions had been undertaken or were planned to improve referral to treatment waiting time performance. This included financial support has been given to address gaps in theatre staffing and increase capacity and a plan to utilise unused theatre space through insourcing from an external contractor.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Complaints were not always responded to within the timescales specified in the trust complaints policy.

The service clearly displayed information about how to raise a concern in patient areas. The ward and theatre areas had information leaflets displayed showing how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.

Staff understood the policy on complaints and knew how to handle them. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was discussed during daily ‘safety huddles’ and at routine team meetings to aid future learning.

Surgery

The trust complaints policy stated that complaints would be acknowledged and responded to within 35 working days for routine formal complaints and within 60 working days for complex complaints.

From July 2020 to July 2021 there were 43 complaints about the surgical services at this hospital and the trust reported 30% of were responded to within the timescales specified in the trust complaints policy.

The trust reported the delays in responding to concerns were mainly due to a large number of complex complaints that required more time to investigate and this was also impacted by staffing pressures during the Covid-19 pandemic.

Is the service well-led?

Requires Improvement 

This is the first time we have rated well-led for this service since the acquisition. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The surgical services at the hospital were incorporated into two divisions; the division of surgery and the division of anaesthetics, critical care, head & neck and theatres.

Each division was led by a divisional medical director, divisional nurse director and divisional director of operations. The services had leads and deputies in place that had responsibility at hospital-level and surgical specialty level.

The surgical specialties were structured as care groups that included a clinical, nursing and operational lead. The care groups had medical and nursing leads in place. The surgical wards were managed by a team of matrons and ward managers. The theatre manager (matron) was responsible for overseeing the services at this hospital as well as the theatres at Broadgreen Hospital.

The majority of staff spoke positively about the leadership and organisation structure. The theatres and ward-based staff told us they understood their departmental reporting structures clearly and described their line managers as approachable, visible and who provided them with good support.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Whilst leaders understood and knew how to apply the strategic objectives and monitor progress, not all staff had a good understanding of these.

Surgery

The trust vision was 'healthier, happier, fairer lives.' The trust mission was 'by working together we will deliver outstanding healthcare'. The trust vision and mission statement were underpinned by four strategic priorities: great care, great people, great research and innovation and great ambitions.

The division of surgery 'divisional strategy 2020-25' outlined the strategic objectives for the surgical services, and was based on the overall trust vision, mission and four strategic priorities.

The divisional strategy set out a number of objectives that were revised on an annual basis. This included; for 'great care' - the implementation of ward accreditation, mortality and morbidity review meetings and timely access to surgical services following the Covid-19 pandemic. For 'great staff' - improving staff recruitment, retention, development and engagement. For 'great innovation' – to implement and embed a culture built on research and innovation. For 'great ambition' - effective integration of services, building successful partnerships and maximum use of technology.

Progress against the divisional strategy objectives was monitored as part of divisional executive review meetings every three months.

We received a mixed response from staff in wards and theatre areas in relation to their understanding of the vision and strategy for the surgical services. This meant that the vision and strategy had not been effectively cascaded to staff across the surgical services and not all staff had a good understanding of these.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. However, an effective work culture focussed on patient safety had not been fully embedded across the surgical teams in theatres.

The majority of staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the surgical services. They told us there was a friendly and open culture and that matrons and clinical leads were visible and approachable.

The medical and nursing staff we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers. Junior doctors and nurses told us they received good training and learning opportunities. Most staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared.

The majority of staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed.

Whilst we found a positive culture across most services, we found that the theatres did not have a fully embedded patient safety culture. There had been a number of never events and invasive surgery incidents over the past 12 months and staff errors were a contributory factor in all these incidents.

Surgery

Staff we spoke with felt some surgeons prioritised operational performance over patient safety. Staff gave an example where a surgeon did not behave appropriately when they could not proceed with a surgical procedure, this was escalated to the medical director and the surgeon made a formal apology. Staff told us the medical director had also written to surgeons setting out their expectations around safety and compliance with the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist.

We received a mixed response from staff in relation to embedding a joint-working culture with University Hospital Aintree after the acquisition. Staff spoke positively about new processes introduced following the acquisition, such as electronic patient records. However, some staff we spoke with expressed concerns about having to relocate to University Hospital Aintree as part of on-going service configurations. They told us communications around relocation was on-going, but this had been impacted by the Covid-19 pandemic.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The surgical services at the hospital had governance structures in place that provided assurance of oversight and performance against safety measures. There were monthly divisional and care group level governance meetings in place to discuss governance and risk. Each surgical specialty had routine monthly governance meetings and clinical governance meetings.

Meeting minutes showed key discussions took place in relation to workforce, current risks, clinical effectiveness and performance issues in relation to each speciality area.

The surgical wards took part in the Liverpool Quality Assessment (LQA) ward accreditation process that aimed to focus wards in offering excellent care and treatment and highlighting where improvements were needed. Wards that had been assessed were given an overall rating of gold, silver or bronze. The assessment covered items such as general ward environment, infection control, medicines management, information boards, NEWS2 compliance and staff awareness of the freedom to speak up guardian.

The division of surgery executive review report for July 2021 showed 10 surgical wards at this hospital had undergone the accreditation process and four wards achieved 'gold' status, four wards achieved 'silver' status and two wards achieved 'bronze status.

The nursing and medical staff also participated in routine local team meetings to monitor governance, risks and performance and share learning from divisional and care group meetings. Information was also shared through daily staff huddles and newsletters.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. However, they did not use systems to manage performance effectively. We identified poor performance in key processes such as mandatory training, incident management, patient access and flow, patient outcomes and complaint management. We were not assured the surgical services had implemented suitable remedial actions to demonstrate an improvement in key performance and compliance measures.

Surgery

The trust used an electronic risk register system to record and manage key risks. The division of surgery risk register documented key risks to the surgical care services and the divisional register incorporated the individual departmental / ward risks. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Each risk had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to divisional and trust level. Staff were supported by governance leads within each specialty to review open risks and identify mitigations / controls to reduce or eliminate risks.

We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through team meetings, safety huddles, performance dashboards and newsletters.

Whilst the service had risk management and audit processes in place, we were not assured the service managed performance and staff and patient risks effectively. This was because we identified significant shortfalls in key processes such as mandatory training, safeguarding training, management and reporting of never events, nurse staffing, patient readmission rates, clinical audit outcomes, referral to treatment targets, patient length of stay and complaints management processes during the inspection.

We found that performance information relating to these processes was collated and monitored at least monthly. However, the surgical services had not implemented effective actions in order to demonstrate an improvement in performance and compliance measures.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff completed data security awareness training as part of their mandatory training. Records for July 2021 showed 91 % of staff in the division of surgery and 93% of staff in the division of anaesthetics, critical care, head & neck and theatres had completed this training and the trust target of 85% compliance had been achieved.

We did not identify any concerns in relation to the security of patient records during the inspection. The majority of patient records were electronic. We saw that paper-based patient records were kept securely. Staff files and other records (such as audit records, staff rotas, files) held electronically.

Computers were available across the wards and theatre areas and staff access was password protected. Electronic patient records were also password protected. The staff we spoke did not identify any concerns relating to accessing IT systems or any connectivity issues.

The ward and theatre areas had notice boards in place displaying information such as guidance and performance for staff and patients. Information on performance, patient safety and staffing was routinely collated, and dashboards were used to review this information and analyse trends.

Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Surgery

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The majority of staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. The trust also engaged with staff through newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms. One staff member told us that a lot of information was received through email and some staff did not always receive information in a timely way if they were unable to read their emails regularly.

The staff survey results 2020 showed staff in the surgical services scored higher than overall trust score around themes of morale, quality of care, safety culture and staff engagement. The audit identified areas for improvement relating to safe environment – violence and bullying & harassment, health and wellbeing, manager / staff relationships and work / life balance and demands placed upon individuals.

Improvement actions following the staff survey included; completion of individual care group level action plans to address the themes outlined in staff survey, discussions with staff within care groups taking place in order to update on progress, taking a 'you said, we did' approach and the introduction of a “staff brief” online meeting, to allow staff the opportunity to attend and participate in a question and answer session with the senior divisional management team.

Staff were provided with emotional support. For example, clinical supervision and debrief support was put in place to support staff. There was a ‘chillout / wobble’ room for staff who needed to take time out when under pressure.

The medical and nursing staff participated in specific events (such as listening events) and training days that included engagement, training and discussions around improvements to clinical processes. Staff told us there had been regular walk rounds by trust executive team members (such as the chief executive and the medical director) as well senior divisional leads to engage with staff across the surgical wards and theatre areas.

Patients were asked to give feedback about their stay on the ward. Volunteers on the ward gathered patient opinions on an electronic device rather than friends and family test cards. This enabled the collection of fuller and more detailed feedback from patients and issues could be acted on sooner.

Staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family. Feedback from NHS Friends and family survey was mostly positive across the surgical wards.

A number of wards had volunteers in place to gather patient opinions using an electronic device rather than friends and family test cards. Staff told us this enabled the collection of more detailed feedback from patients and allowed for staff to act on issues sooner.

Public engagement had been impacted due to the Covid-19 pandemic; however, staff told us there was still engagement through patient focus groups (such as for colorectal surgery) and general engagement through the trust’s website.

Learning, continuous improvement and innovation

Surgery

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The culture across the surgical services was based on quality improvement. There were a number of quality and cost improvement projects and work streams in place across the surgical services, such as theatre improvement and elective surgery quality improvement programmes.

Staff across the services were involved in research, innovation and clinical trials to improve patient care and treatment. Staff participated in a range of local clinical audits and re-audits to improve the services.

The services planned to integrate and configure a number of services as part of the implementation of the new hospital. This included operational plans submitted for the transfer of all urology inpatient services and complex elective breast surgery services to this hospital.

“React to red” in place to identify potential pressure sores. Patients checked once per shift and mattresses could be put in place quickly.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, however we saw mixed completion rates and we were unable to break the information down into site and compliance information demonstrated areas of poor compliance.

Mandatory training compliance rates were provided at trust level and were not broken down into locations. Mandatory training was split into mandatory training and role specific mandatory training. There was a lack of assurance that the service had a clear oversight of compliance rates for their staff or assurance that staff had received the required training for their role.

We saw that trust level compliance for mandatory training for the division of Specialist Medicine was 86.29% and for role specific mandatory training was 69.88%. The division of acute and emergency medicine division, which the acute medical unit sat in had a mandatory training compliance of 85.46% and role specific mandatory training was 70.38%.

Divisional data showed that on average mandatory and role specific mandatory training compliance for nursing staff at 86.5% and 71.14% was higher than the average compliance for medical staff which was 74.68% and 49.6%.

Divisional data showed poor compliance with some critical training topics such as SEPSIS level two training which had an average compliance rate of 62.6%, resuscitation level 2 and three which had average compliance rates of 52.77% and 55.2% and paediatric basic life support which was on average 29.45% with the compliance rate for the division of specialist medicine being the lowest at 16.76%.

During our inspection we observed mandatory training compliance for four wards these were the frailty unit, 6Y, 6X and the acute medical unit. We saw that training compliance was mixed with an average compliance of 85.5%, the compliance ranged from 74.06% on ward 6Y to 98% on the acute medical unit.

The mandatory training was comprehensive and met the needs of patients and staff. We saw that there was specific mandatory training topics identified for staff in the divisions these covered a range of topics including COVID-19, conflict, infection prevention and control, data security awareness and resuscitation training.

Clinical staff completed training on recognising and responding to dementia. The divisional compliance rates for dementia training were 92.73% and 90.59% for level 1 and 81.20% and 84.30% for level two. During our inspection we saw that staff compliance for dementia training on the frailty unit was 82%.

Staff received prompts via the electronic system when their training was due to be updated. Staff told us they were allocated time within working hours to complete their mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, training compliance rates could not be broken down into site or staff group and we saw low compliance rates for level three training for children and adults.

Safeguarding training was part of the role specific mandatory training for staff, the requirements for the service was that clinical staff received training up to level three for children and adults.

Compliance rates for the division of acute and emergency medicine and the division of specialist medicine demonstrated that level two training for children and adults met with the trusts target and were on average 84.7%. for children and 85.6% for adults. However, the rates for the level three training for children and adults were low and below the trusts target with the division for specialist medicine having a compliance of 64.04% for children and 55.4% for adults and the division of acute and emergency medicine having a compliance of 45.5% for children and 51.30% for adults.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that there was good access to the safeguarding team who provided the required support.

Staff raised safeguarding alerts via and electronic system, they told us if they were unsure, they could telephone the safeguarding team for support.

Cleanliness, infection control and hygiene

The service had measures in place to control infection risk. However, staff did not always use equipment and follow control measures to protect patients, themselves and others from infection and not all premises were visibly clean.

Ward areas were not all clean or well maintained. The environment on the acute medical unit was cluttered looked visibly unclean and was poorly maintained. Walls and door frames throughout the unit contained chipped paint, there was exposed wood on the wall bumpers and floor coverings were torn.

On ward 3A we observed chipped paint on the walls around the nurses station and bits of blue tack stuck to the wall.

This posed an infection risk to patients as walls floors and surfaces could not be easily cleaned.

We observed that staff did not always follow appropriate infection control principles including the use of personal protective equipment. We observed staff did not always wash their hands in line with hand hygiene principles, and we saw some staff not wearing their mask appropriately with them positioned under their nose.

The service carried out a number of different monthly audits in relation to infection prevention and control which were overseen by the matrons. Close monitoring of infection prevention and control practices had been implemented across the trust following concerns identified at the last inspection, in relation to IPC and COVID-19. We saw that the audits covered general practice and environment, COVID-19 and hand hygiene.

Audit data provided by the trust indicated that they generally performed well for environment cleanliness and hand hygiene audits. However, our review of the audit data provided by the trust showed that not all wards were consistently audited each month. COVID-19 audits in the main were below 90% compliant and classed as amber and red.

Staff cleaned equipment after patient contact.

All patients admitted to the hospital were tested for COVID-19. We were told that the trust could provide results within 10 minutes.

Wards were classified as either ‘red or ‘green’ dependant on the COVID-19 status of the patients. ‘red’ wards were for patients who had tested positive for COVID-19. Patients awaiting a swab result were placed on red wards in isolation cubicles. Patients with a negative result were cared for on ‘green’ wards. However, during our inspection we observed some confusion about patients COVID-19 status and saw a patient admitted to a green ward who had not received a result and subsequently tested positive. Ward staff acted appropriately when they realised this and sought assistance from the infection prevention and control team.

Patients requiring aerosol generating procedures were cared for in allocated side rooms on the respiratory enhanced care unit.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The environment on ward 3A and the acute medical unit was aging and did not look well maintained.

The Stroke unit had narrow corridors, we observed it was difficult for staff to quickly move down corridors with patients on trolleys.

The frailty unit had been relocated and the area being used was noted to not provided a dementia friendly environment. We were told that there were plans to move the unit back to its original location, however we saw this area was poorly maintained.

The AMU did not provide enhanced care beds with close monitoring such as cardiac monitoring. This meant patients requiring enhanced cardiac monitoring had to be transferred and cared for in the emergency department.

We observed that patients could reach call bells, however we saw that staff did not always respond quickly when called.

The service had enough suitable equipment to help them to safely care for patients. We observed equipment had been recently serviced and were within re-test date.

Resuscitation equipment was available in all areas that we visited. We checked the trolleys on three wards and found that the daily checks had been completed and that equipment and sundries were intact and within manufacturers expiry dates.

There was clear signage in place. However, we saw posters and information displayed on ward 3A which were out of date, some were from 2016.

Staff disposed of clinical waste safely. We saw that sharps bins were appropriately labelled and stored. However, on the main corridor on the acute medical unit we observed two large open bins containing clinical waste which remined on the corridor for a number of hours unattended. There was a risk of contamination for patients on the unit.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. National early warning scores were used help staff identify when patients were deteriorating or at risk of deterioration. Observations were recorded on an electronic system which flagged high risk patients. We were told that the system had a flow chart which directed staff to the escalation action they needed to take in response to patient risk. The system also sent risk flags to the medical teams when patients were alerting on the system. Nursing staff documented actions taken in the nursing notes.

The system alerted staff when observations were due, patients on the dashboard turned amber five to ten minutes prior to observations being due and highlighted them as red once they were overdue.

Staff stated that doctors were usually present on the wards or available 24 hours a day seven days a week for escalation, however, they knew how to escalate to the medicine emergency team or critical care outreach team if necessary. We were told that patient transfers to critical care happened smoothly.

There were monthly audits in place for the completion of national early warning scores. We reviewed audit data for May 2021 for the division of specialist medicine at the Royal Liverpool University Hospital location and found that performance was mostly above 80% compliant.

Staff completed risk assessments for each patient on admission, using recognised tools, and reviewed them regularly. Staff knew about and dealt with any specific risk issues.

The admission pathway had eight required risk assessments which had to be completed on admission. The assessments covered malnutrition universal scoring tool, moving and handling, pressure area, social, discharge planning, MDT discharge plan, falls assessment and care plan, significant events and incidents.

However, staff on the acute medical unit did not follow the same admission risk assessment process. We were told that staff chose the assessments that they felt were relevant to complete, the rationale was because it was an assessment area only not a ward.

The matron was unable to provide clarification about the frequency of risk assessment completion on the acute medical unit and could not advise the timescales in which risk assessments should be completed following admission. We were told that this was not formalised in any policy or protocol.

Audits for risk assessments were carried out weekly covering falls, water low, nutrition and body maps. We were told that on the stroke unit there were no concerns flagging as a result of the audits.

There were five risk assessments which required a weekly review these included falls, mouthcare, pressure areas, moving and handling and nutrition.

Our review of patient records demonstrated that in the main risk assessments were completed for patients, observations were taken regularly, and we saw evidence of additional care plans were in place and escalation of SEPSIS where required.

Patients who presented to the emergency department who were diagnosed with a stroke, and if deemed appropriate, were given thrombolysis in the emergency department and then transferred to the stroke unit. Standardised nursing assessments (SNOBs) were completed for patients who had undergone thrombolysis, these patients had enhanced observations taken hourly for a 24-hour period.

If any of the booked patients booked to be seen in the ambulatory care unit did not attend their appointment, they were added to the virtual review list to be followed up.

Patients who received non-invasive ventilation in the community were directed to a dedicated unit for any care needs.

The service used a process called ‘bay tagging’ to provide close observation to patients at risk of falls. We saw that signage was in used to indicate that bay tagging was in place outside of bays so that people were aware that staff were observing patients to limit disturbances. On the stroke ward we saw specific staff had been allocated to this duty.

The service had access to mental health liaison and specialist mental health support. However, staff on the medical assessment unit told us it often took a long time for patients to be reviewed which caused them additional distress.

Shift changes and handovers included all necessary key information to keep patients safe. We observed that this covered risk factors such as falls and safeguarding. However, we were told that there were issues with handovers between wards and specialities.

Safety huddles took place twice a day. We observed a safety huddle on ward 2S. There were risk scores assigned to each room number. We saw that risks were discussed and requirements such as critical medication were discussed as part of the safety huddle as was staffing. However, actions required as a result of the risks were not always discussed. Information on the safety huddle documentation referenced deadlines for appraisals and mandatory training which were April 2021 and so was out of date at the time of our inspection. During our observation of a safety huddle, we did not see any evidence of sharing incidents or learning.

Nurse staffing

Medical care (including older people's care)

The service did not always have enough nursing and support staff. However, staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff an induction.

The service did not always have enough nursing and support staff to keep patients safe. Staffing was under pressure in most areas we visited but this was a particular risk on the acute stroke unit where safe staffing was not always met. We could not be sure that the unit always complied with the standards set out by British Association of Stroke Physicians (BASP 2014) for nurse to patient ratios. This was because on the day of the inspection there were four acute patients on the ward and four registered nursing staff. In order to meet the ratio of one nurse to two acute patients, this would have left a ratio of one nurse to eleven patients for the rest of the ward. We found a red flag had been raised in respect of this dates staffing.

We were told that seven nurses had left the stroke unit since November 2020. Staff told us that morale was low because of the staffing shortages. The staffing levels for the stroke unit were on the risk register.

Leaders told us that safe staffing levels were also being breached at night on the cardiology unit ward 3A. Staff on ward 3A who worked nights told us that there was significant risk on nights with unfilled shifts and no senior nurse cover. Our review of shifts for March to May 2021 we saw that average fill rates for registered nurses at night was 87.33% with the lowest fill rate being 82% in May 2021.

We were told that patients were kept on AMU longer as staff on other wards were unable to cope with the acuity of the patients due to limited staffing. Staff did not always feel supported to provide care for the acuity of patients. Staff on AMU described needing additional support to look after patients who required one to one care and that this wasn't always provided.

During our inspection we observed that actual staffing did not meet the planned staffing numbers for four of the wards we visited.

We reviewed fill rates for nursing staff across medicine for March to May 2021, we saw that the average day shift fill rate was 92.2% and the average night shift fill rate was 93.05%. Average nursing fill rates for the daytime shift on the stroke unit in April 2021 was 86%. Ward 9 HDU consistently had the lowest fill rates across day and night shifts we saw that the average fill rates were reported at 73 and 72% in April and May 2021. Ward 9X reported an average fill rate of 83% for day shifts in April 2021. We did see evidence that non-registered staffing had been increased when nursing fill rates were low.

Trainee nursing associates supported the healthcare assistant rotas and were not included within the registered nurse numbers. Nursing associates were registered with the NMC and so supported nursing rotas and were included within the numbers.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Rosters were created using an electronic system with built in staffing rules based on the nationally recognised safer care staffing tool. The acuity of the ward patients was assessed to determine the required staff for that day and adjustments to numbers were made accordingly.

Staff could raise a red flag against the ward if they felt that staffing was unsafe. We were told that any staff member could raise a red flag, however it was asked that any red flags were escalated to the sister in charge prior to raising these. When a red flag was raised staff contacted the duty manager via a bleep system who would provide support.

Medical care (including older people's care)

Staffing was reviewed twice daily at the ward safety huddles, which were rag rated dependant on the staffing figures. Requests for additional staff were escalated to the matrons for approval.

There were no staffing meetings held at the weekend. Staff had access to a duty manager on a Saturday and a matron on a Sunday to escalate staffing concerns.

Nurse staffing was one of the top risks for the service and was on the risk register.

We were not assured that the service had low or reducing rates for sickness and staff turnover. The service provided information on sickness and turnover rates for the medical division for the whole trust. Therefore, we do not have rates specifically for medical care at Royal Liverpool University Hospital. However, the information provided showed the service overall had high turnover and high sickness rates. Sickness absence had increased to 7% in May 2021 from 6% in April which was higher than the overall trust sickness rate of 6% in May 2021. The turnover rate for the service was 27%.

The leadership team had recently undertaken a review of nursing and healthcare assistant establishments across the service. We were told that the review had identified and increase in the number of staff but had not yet been to the trust board for sign off.

Staff told us that turnover rates were high because staff were stressed.

The leadership team identified the need to have a focus on the retention of staff and so a number of initiatives had been put in place to support this. The service had in the last couple of months recruited 51 nurses from overseas for the division of specialist medicine. At the time of our inspection we were told that the majority of these nurses were now in post and had completed their conversion course.

They had introduced an initiative called the ‘golden ticket’ for third year student nurses this gave wards the opportunity to request a student nurse to join their team once they had qualified and gave student nurses a guaranteed position.

There had been a focus on providing staff with family friendly contracts. There had been a revisit to engagement with nursing staff about the shift lengths to ensure that shifts reflected how staff preferred to work.

The service was developing staff to become nurses and offering additional support roles such as nurse associates and assistant nurse practitioners. The service planned to start a nursing apprenticeship programme from Autumn.

The service had access to bank and agency nurses used on the wards. We were told that agency staff were accessed as a last resort.

There was a temporary staff induction checklist in place for managers to complete with staff. We saw that the checklist covered identification checks, policies and procedures to be read and an orientation to the ward. We did not see any completed checklists during our inspection.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and used bank and agency staff where required.

Medical care (including older people's care)

The service had enough medical staff to keep patients safe. The service had a consultant on call during evenings and weekends. Most wards across medicine followed the consultant of the week model of care. This provided seven-day cover. However, we were told that it may not always be the same consultant at the weekends.

We were told that there was a low threshold for contacting consultants out of hours who were on call.

We were told that telemedicine monitoring for stroke patients out of hours kept the service safe.

Managers could access locums when they needed additional medical staff. We were told that respiratory and geriatric medicine had additional locums over their establishment to provide additional support as they were high pressure areas. This had been introduced in response to the COVID-19 pandemic. The service block booked locum staff to provide continuity.

We were told that there were two registrars on site 24 hours a day seven days a week to provide cover for the acute medical unit and medical wards plus an additional twilight shift.

Subspecialty rotas were in place for respiratory, gastroenterology, infectious diseases and nephrology. Some of these were cancelled during the peak of the COVID-19 pandemic to maintain safety and cover, but we were told these were back up and running at the time of our inspection.

On wards 6X and 6Y medical staffing was supported by physician associates, there was one allocated to each ward. We were told that one could prescribe the other was working towards being able to prescribe.

Surge rotas had been put in place which planned for 33% medical staffing sickness; however, we were told that these were not implemented.

However, were told that cardiology was the biggest challenge to recruit to and that it was being covered by a mix of locum and staff doing extra shifts.

We were not assured that the service had low or reducing turnover rates for medical staff or that the sickness rates for medical staff were low or reducing. The service provided information on sickness and turnover rates for the specialist medical division for the whole trust. Therefore, we do not have rates specifically for medical care at Royal Liverpool University Hospital. However, the information provided showed the service overall had high turnover rates and high sickness rates. Sickness absence had increased to 6.95% in May 2021 from 6.3% in April. This was higher than the overall trust sickness rate of 5.97% in May 2021. The turnover rate for the service was 26.76%.

We were told that there were 'itchy feet' conversations taking place with medical staff to support retention. The new clinical director for the division of specialist medicine had identified the need to focus on supporting staff training and development.

It was recognised that there was a national shortage of orthogeriatricians and so the service was reviewing job plans to attract recruitment into these roles.

We saw evidence in patient records that patients were reviewed daily by the medical teams and that there was input from senior clinicians. All patients had been seen on the post take ward round within 12 hours of admission

Records

Medical care (including older people's care)

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely. However, staff on the stroke unit reported concerns in accessing electronic records due to issues with the technology and we found that not all paper records were complete.

Patient records were comprehensive and stored securely. Records consisted of a mixture of electronic and paper records. Staff had individual login codes to access electronic records so that information was protected.

During our inspection we looked at 23 patient records and found that they were mostly complete. However, we found that not all paper documentation was fully completed, and we found issues with documented dates and staff signatures and printed names.

Admission documentation was completed for all patients. However, there was not a standardised approach of the required admission documentation for the acute medical unit. Admission documentation was audited weekly for compliance with their completion. We requested evidence of audit results for patient records, however these were not provided by the trust.

Some patient records were electronic, and staff used computers for accessing and completing notes for patients. On the stroke unit we were unable to access patient records on two of the computers because there was no internet connection. Staff told us this was a regular issue and they found it frustrating as it delayed access to patient records

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, not all staff followed these correctly.

The service used an electronic system for prescription charts this meant that all documentation in relation to the prescribing and administration of medicines was legible, automatically saved, signed and time and date stamped.

During our inspection we reviewed eight prescription charts we found four occasions where time critical medicines had not been administered in accordance with the prescription chart. Three of these medicines were antibiotics and once was medication to control the effects of Parkinson's disease. An example of a delay we saw was antibiotics which had exceeded their administration time by three hours for a patient who was on the SEPSIS pathway.

We saw three occasions where there were issues with communication from the emergency department about the continuation of antibiotics. There were two occasions where patients who had been prescribed an antibiotic called Gentamicin in the emergency department who required close monitoring, that had not been done and one antibiotic which had not been given. Ward staff told us that they were unaware of the requirements for these patients as it had not been handed over when the patients were transferred to the ward. We were told that there was no formal documentation for the handover of patients from the emergency department and it was all verbal.

We found an example of an antibiotic which had not been prescribed in accordance with guidance for unknown SEPSIS and an antibiotic which had been prescribed with no indication.

Medical care (including older people's care)

In Medical care between September 2020 and April 2021 the trust had a total of 51 incidents linked to midazolam or gentamicin, with the highest number of incidents reported in April 2021 (16). Seven of these were linked to gentamicin, one of which caused low harm and the remaining six incidents caused no harm. Nine of these were linked to midazolam, all of which caused no harm.

The pharmacy team were aware of the risks with antibiotic prescribing particularly in relation to Gentamicin. To mitigate the risk pharmacists at the weekend checked patients who had been prescribed gentamicin to ensure that the appropriate monitoring had taken place. However, we were told that this is only for those who have been prescribed the medication on their regular prescription and there was no way of identifying patients who had been prescribed the antibiotic as a one-off dose.

There were audits of antibiotic prescribing carried out by the pharmacy team, however we were told that this did not look at whether they were prescribed in line with local formulary. Following the inspection, the trust informed us that point prevalence audits are completed to confirm whether antibiotics were prescribed in line with local formulary. These are reviewed at the antimicrobial group and then on to the Medicines Management Group.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled drug stock balance checks were online for ward stock. However, the system did not account for patients own controlled drugs or accept decimal points which made balances for liquids inaccurate. Our check of controlled drugs found that balances and documentation was accurate, and we observed that medicines were stored securely in the areas we visited.

Pharmacy teams provided cover to medical wards five days a week. There was a dedicated pharmacy team for the emergency department and the acute medical unit who provided a service 8 am to 8 pm seven days a week.

The acute medicine pharmacy team had developed a portal to review all the patients in the department. This had been designed by a pharmacist and it prioritised patients on the unit by medication risk. For example, patients on medication for epilepsy or diabetes. We were told that the system was being regularly updated as suggestions for improvement were made.

Pharmacy teams felt that the greatest risk was the lack of a seven day service across all wards. We were told that medicines reconciliation figures were around the 80% in the week, but it dropped dramatically at the weekend. This meant there was a risk that patients were not prescribed their medication in line with their usual prescription.

Audits were completed by the pharmacy team these covered, controlled drugs audits, antibiotic audits and discharge medication turnaround times.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. The trust used an electronic system.

Staff raised concerns and reported incidents and near misses in line with trust policy and we were told they were encouraged to report incidents.

Medical care (including older people's care)

From May 2020 to April 2021, there were 22 serious incidents reported in Medicine. 50% of these were slips/trips/falls (11). 14% were treatment delays (3) and 9% were HCAI/Infection control incident (2).

There was one never event in July 2020 which was a blood product/transfusion incident when patient give the wrong blood type and had subsequent reaction.

From 1 June 2020 to 1 May 2021, as with other services across the trust, there was an increase in incidents reported.

From 1 June 2020 to 1 May 2021, the top three incident types were 'Patient accident' (23%), 'Medication' (11%), and 'Implementation of care and ongoing monitoring/review' (10%).

We were told that there had been three falls on the stoke unit which had resulted in significant harm. As a result of serious incidents from falls on the stroke unit the service had introduced falls wristbands to indicate patients who are at risk of falls, slipper socks, support was implemented from the falls team, falls alarms were in use on beds and on chairs and there was a list of patients at risk of falling kept at the nurse's station for oversight.

Staff received feedback from investigation of incidents, both internal and external to the service and they met to discuss the feedback and look at improvements to patient care.

Learning from incidents was shared with staff across the service and divisions through matron, ward manager and care group meetings. Staff told us that incidents and learning were discussed during handovers and safety huddles.

Safety governance emails were shared with staff weekly to inform them of any incidents or safety issues. The emails were discussed in weekly team meetings. We saw that notice boards in staff areas displayed information about recent incidents with areas of concern identified and lessons learnt shared.

Staff gave examples of incidents that had been shared. Staff were positive about the incident reporting process. We were told incidents were discussed with individuals involved and a supportive approach was adopted. Staff felt informed of incidents and supported in the process to identify learning as a result.

There was evidence that changes had been made as a result of feedback. We were told that health care assistant staffing had been increased on the frailty unit due to patient falls at night.

Falls resulting in patient harm had been identified as an area of concern across the medicine core service and across the hospital sites. As a result, the service had implemented a working group who had developed a 12 point action plan to make improvements and protect patients. The working group had representation from the multidisciplinary team who met monthly. We were told that the plan included actions such as implementation of red Zimmer frames to highlight falls risks, strengthened the approach to bay tagging, the implementation of tabards to identify staff who were undertaking a bay tagging roles and the implantation of yellow wristbands to highlight patients at risk of falls. We were told that the group was also undertaking some analysis work about the times of falls to identify spikes and take appropriate actions, at the time of our inspection this work was in its infancy.

Safety Thermometer

Staff collected safety information and shared it with staff, patients and visitors. However, we found that information displayed was not always up to date.

Medical care (including older people's care)

Safety performance data was displayed on the wards we visited for staff and patients to see. These were presented as quality dashboards which looked at a range of safety and quality indicators which included falls, pressure damage, infection rates, matron quality audit compliance and complaints.

Our review of the board on the acute medical unit found the data to be out of date and covered October to December 2020. The information showed that falls had improved as had the matron quality audits from 72.30 to 79.90%. COVID-19 ward assurance had decreased from 97.20-95.30%.

Is the service effective?

Good  

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The frailty unit used a clinical frailty framework to assess patients admitted to the frailty unit.

The respiratory unit followed the British Thoracic Guidelines for non-invasive ventilation Non-invasive ventilation (NIV). NIV refers to supporting a person with their breathing without using an invasive artificial airway which is placed into the throat.

Patients who were thought to be having a stroke were assessed by the specialist stroke nurses in A&E or on the ward where they were admitted. Once they had been assessed if a stroke was confirmed they went onto the stroke pathway and were automatically referred to therapy teams which included speech and language therapy, occupational therapy and physiotherapy.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw that handover meetings considered physical, social and emotional needs of patients and plans included referral to additional services such as mental health teams to support patients.

We were told that the respiratory service was currently using procedures for the Royal Liverpool University Hospital site, however, they were working towards developing procedures that would be used across site.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The service had protected meals times in place. They used a red tray system to highlight patients who required support eating with eating their meals.

The stroke unit had white boards above the patient beds, these were used to identify if patients had any specific dietary needs such as modified diets. If diet requirements were changed during the day the nurses alerted the kitchen who would make the necessary changes to patients' meals.

Specialist support from staff such as dietitians and speech and language therapists for patients who needed it.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. These were completed during the admission process; however, we were told that they were sometimes delayed if the patient was admitted during the night. High must scores triggered an automatic referral to the dietetics team.

Speech and language therapy teams were not available seven days a week. Specialist stroke nurses had been trained in undertaking swallowing assessments for patients so they could do this out of hours. However, if a patient failed the nurse screening they were placed on nil by mouth until they could be reviewed by the speech and language therapy team. We were told that there had been an increase in the number of patients being identified as nil by mouth at the weekend as a result the service was implementing seven day speech and language therapy services.

Consultants could suggest NG tube feeding for nil by mouth patients during the weekend, there was a feeding protocol in pace for staff to follow for nasogastric feeding so that there was no delay to the patient.

The speech and language therapy team used naso-endoscopes to assess patients swallowing this involved the use of a camera. This is considered to be good practice. They had implemented a new policy which spanned across all three sites and they were working towards the standardisation of policies trust wide.

The trust had implemented a Nutrition and hydration collaborative in June 2020 which had five workstreams. The nutrition and hydration operational subgroup meet monthly to monitor progress which is overseen by the Patient and Family Experience Functional group. Completion of must scores was monitored closely, and a monthly report produced. Feedback was given monthly to the matrons who ensured that improvement plans were in place for each ward.

Staff mostly completed patients' fluid and nutrition charts where needed.

However, we saw an example of a patient who was nil by mouth ahead of a procedure that was a type two diabetic who required medication, this was not considered in the plan. We raised this as a concern at the time of our inspection.

We observed one patient with food and drink out of reach the patient required help eating we observed that this was not given.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain was assessed during each observation by nursing or health care assistant staff.

Staff told us that they used visual prompts to identify if a patient was in pain who could not tell them verbally. We were told that staff had access to communication aids provided by the speech and language team to support those who could not verbally communicate to do so, this included the use of whiteboards. We did not observe these in use during our inspection.

Patients received pain relief soon after requesting it and staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

We were not assured that staff monitored the effectiveness of care and treatment. As such we are unable to report whether they used the findings to make improvements and achieved good outcomes for patients.

We were only able to report on audits that had been carried out after the new trust was formed in 2019. Many national audits were put on hold due to the COVID-19 pandemic. As such, the service was only able to supply us with limited audit data.

Outcomes for patients were not always positive, consistent and met expectations, such as national standards. In the most recent time period submitted by the trust January to March 2021 the overall patient centred SSNAP level is B (on a scale of A-E) which is an improvement from the previous quarter where the trust had scored a C. For team centred indicators the trust maintained a score of C. On both patient and team centred indicators the Stroke Unit has been rated as E which is the worst. That is based on three indicators: Percentage of patients directly admitted to a stroke unit within 4 hours of clock start, Median time between clock start and arrival on stroke unit and Percentage of patients who spent at least 90% of their stay on stroke unit.

This indicated that there were some issues with flow for patients getting onto the unit, with patients taking on average, nearly five hours longer than the national average to get onto the unit. This then has the impact on the percentage of patients spending at least 90% of their stay on the unit.

From January 2020 to December 2020, patients at the trust had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Overall, the trust was rated better than comparators for emergency readmissions for acute bronchitis. However non elective emergency readmissions for respiratory medicine were higher at both hospitals.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an annual audit programme which consisted of a wide range of audits covering clinical audits, service evaluation and re-audits. We saw evidence that action plans for improvement were monitored.

Competent staff

Medical care (including older people's care)

The service made sure staff were competent for their roles. However, we could not be assured that managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were competencies that staff had to complete when working on the wards. Staff were given three months to complete the competencies relevant to their roles. Competencies were overseen by specialist nurses.

Managers gave all new staff a full induction tailored to their role before they started work. New starters were allocated a buddy for support and were overseen by a band six nurse on the wards.

There was a preceptorship programme for newly qualified nursing staff, staff on the programme were allocated a mentor to support them in their role.

Managers made sure staff received any specialist training for their role. Staff working on the respiratory wards were given a competency pack for non-invasive ventilation. The competency pack had been developed by the COPD team and included theory and practical sessions to assist their learning. Senior nursing staff in respiratory enhanced care unit were responsible for the assessment of staff against the competencies. At the time of our inspection there were 24 staff who had been trained and 12 who were in the process of completing their competencies.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were able to request attendance of additional training and told us they were supported to attend.

We were not assured that managers supported staff to develop through yearly, constructive appraisals of their work. The trust reset the appraisals data to zero at the beginning of April each year. We requested current appraisal compliance for the service, data supplied covered all staff in the medicines department across all sites. The data provided demonstrated that the appraisal rate for all staff across the specialist medicine division was 29.2%, there was no further data provide to confirm if staff had received an appraisal in the last 12 months. However, during our inspection, we saw that the frailty unit appraisal rate was 93%.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The stroke ward held daily multidisciplinary meetings which involved all staff on the unit including nurses', doctors, therapy and pharmacy staff. Social worker staff have been working remotely throughout the pandemic, but we were told that they attended the meetings remotely using video calls. We were told that there had been some concerns about the social workers not being ward based and so a new ward clerk role had been implemented on the stroke unit to bridge the gap.

On ward 3A we saw staff using prompt sheets during multidisciplinary team meetings to ensure that all relevant agencies were involved in patient discharges.

Staff worked across health care disciplines and with other agencies when required to care for patients. frailty unit had and multidisciplinary approach and worked closely with community staff. Medical staff on the unit also worked in the community setting.

There were automatic referrals to therapy teams for patients who had suffered a stroke. Staff on other wards could refer patients to therapy teams for input and support.

Staff described a highly supportive multidisciplinary working approach to patient care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. However, Staff on the acute medical unit had concerns about the speed that patients requiring mental health review were seen.

Patients had their care pathway reviewed by relevant consultants. The frailty unit was consultant led.

However, we were told that patients in the emergency department were not always seen by the relevant speciality doctor and so were sometimes admitted unnecessarily.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway.

Staff could call for support from doctors 24 hours a day.

Occupational therapy and physiotherapy were seven-day services.

Speech and language therapy teams were available five days a week. There were plans for the speech and language therapy teams to increase the service to seven days a week, this was due to an increase in patients being admitted and identified as nil by mouth on a Friday.

Specialist stroke nurses provided a seven service to provide support and advice to staff and patients on wards or awaiting admission in the emergency department.

Pharmacy services for the acute medicine unit were provided seven days a week. However, they were not available to provide a clinical service for all remaining medical wards at the weekend. The pharmacy department felt this was a risk. A seven-day service was added to the business case, however we were told that this was not approved.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. The electronic system automatically promoted referrals to other services dependant on the information inputted by staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We were told that the majority of capacity and deprivation of liberty safeguards assessments were completed by nursing staff. Nursing staff completed deprivation of liberty safeguards applications and medical staff supported the completion of the mental capacity assessment.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Deprivation of liberty safeguards applications were completed on the electronic system. Staff described the process that they completed at ward level which was sent to the safeguarding team who passed the application to the local authority.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw evidence of three patients with deprivation of liberty safeguards in place. We saw evidence that appropriate documentation had been completed this included capacity assessments and referrals to the safeguarding team.

Do not attempt cardiopulmonary resuscitation decisions were discussed with patients and their families. Where a patient could not make this decision for themselves patient's families were consulted, and healthcare professionals were included prior to a best interest decision being made. We saw evidence of this during our review of patient records.

Staff received training in the Mental Capacity Act. Training compliance data provided by the trust was not broken down into location or staff group. Training compliance reported for the division of specialist medicine for July 2021 was low at 65.31% and below the trusts target.

Is the service caring?

Good 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated caring as good.

Compassionate care

Medical care (including older people's care)

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. They maintained patient privacy by closing doors and curtains when attending to patients' needs. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a relative was not happy with a course of action being taken, the doctor took time in privacy to explain the clinical decision to the patient and the relative. We saw in different areas and situations doctors, nurses and healthcare assistants speaking to patients when carrying out care, explaining why certain decisions had been made, and updating them on their care plan.

Patients said staff treated them well and with kindness. We spoke with patients in different areas and feedback was positive. Patients said staff introduced themselves and treated them with kindness and respect. Patients said their confidentiality had been respected and privacy maintained.

Staff followed policy to keep patient care and treatment confidential. Staff had individual login codes to access electronic care and treatment plans so that information was protected, and most staff logged out of the system before leaving a workstation. However, we saw that one member of staff left patient information on a screen in a corridor when going to speak to a patient in a bay area. There were clear processes to protect personal information. The trust undertook monthly data protection impact assessments to help the organisation identify and minimise data risks.

We observed one staff handover, held by the nurses' station to maintain safe social distancing. Patients were not referred to by name and staff had a paper copy of the details required for each patient that was coded. Handovers normally took place in the office dependent on the number of staff present.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. For example, we observed staff supported a patient on the acute medical unit who had mental health needs and was experiencing distress.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The chaplaincy team worked as part of the overall healthcare team. Other faith or spiritual ministers were available if patients requested them. This was not confined to emergency situations or moments of crisis but to meet every day spiritual needs. Special food, such as kosher, was available to patients with specific cultural and religious needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it and supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

On several occasions we saw that staff supported patients who became distressed and sought a room to give them privacy. A recently bereaved family on one ward were shown to the staff room to give them privacy to grieve, and staff made sure they were not interrupted.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment and talked with patients, families and carers in a way they could understand, using communication aids where necessary.

There was communication support for patients who had a learning disability. Patients with a learning disability were allowed a family member or carer to stay with them on the ward.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was clear guidance on how to give feedback about the service both on the trust website and at ward level. Patients and relatives were encouraged to talk to the ward manager or matron about any concerns. Additional information was provided on how to contact the Patient Advice and Complaints Team at Royal Liverpool University Hospital for information, advice and support.

Staff supported patients to make advanced decisions about their care. Staff told us that patients were consulted about making advanced decisions about their care such as 'do not attempt resuscitation', which was evidenced in care records. Appropriate discussions were had with family members and best interest decisions were made for those who did not have capacity to make the decision for themselves.

Patients gave feedback about the service. Results for the Friends and Family Test from January to June 2021 showed 86% satisfaction with medical care. Figures for wards ranged from 70% to 100% satisfaction.' Benchmarking against national performance was not available as publication from National Health Service England that collates the information has not yet been published at the time of writing this report due to Covid-19. Data at ward level was available with satisfaction scores for ward 4Y palliative care at 100%, ward 2X frailty unit 96% and ward 4B urology an overall satisfaction score of 93% between January 2021 and June 20201. Other areas we visited such as 2Y the acute stroke unit had average satisfaction scores for the same period of 83%. The acute medical unit had an average satisfaction score of 83% and ward 3A 70%.

Is the service responsive?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated responsive as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service worked with another trust to improve links between hospitals, community and social care to address delays in the discharge process for patients who had no fixed abode.

Medical care (including older people's care)

During the pandemic, the service used phone and video consultations for outpatient appointments, for patients who did not need to be seen in person. The service planned to continue to offer this service.

Staff in the speech and language team ran a specialist respiratory clinic for asthma that was one of only three in the country. Staff were trained to detect 'inducible laryngeal obstruction' (ILO), which is an inappropriate, transient, reversible narrowing of the larynx in response to external triggers. ILO causes a variety of respiratory symptoms and can mimic asthma. Tests helped to identify whether the patient had asthma and ensured appropriate care and treatment was provided. The clinic was led by a respiratory consultant, specialist occupational therapist, and speech and language therapist

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Wards 6X and 6Y were mixed sex but men and women were in separate bays with their own bathrooms. Between May 2020 and May 2021, the service reported no mixed sex breeches.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The service had systems to help care for patients in need of additional support or specialist intervention.

On admission patients in need of additional support were said to be identified and referrals made using the risk assessment check lists. We were told that specialist nurses were trained to identify and support patients who may need specialist intervention. These included a specialist nurse for elderly and frail who visited the emergency department and ambulatory care unit to identify frail elderly patients early. They used a clinical frailty scale framework to assess their needs and there was an inclusion criteria to escalate their care treatment pathways. This was said to enhance flow to either admit or discharge following review by appropriate specialities.

Speech and language therapists did not work at weekends. However, specialist stroke nurses could assess whether a patient who had suffered a stroke could swallow well enough to eat and drink safely.

If not, a consultant would decide whether the patient was suitable for nasogastric feeding, which involves passing a tube through the patient's nose and into their stomach to give them liquid feed.

When available, a speech and language therapist would decide what consistency of food and drink the patient could take safely'.

Specialist stroke nurses provided a seven-day service to provide support and advice to staff and patients on wards or awaiting admission in the emergency department.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. If patients booked for an assessment in ambulatory care did not attend their appointment the triage nurse contacted them directly.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences and they coordinated care with other services and providers. However, Staff did not always make reasonable adjustments to help patients access services.

Medical care (including older people's care)

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could access help and support from the learning disability team. The learning disability team provided support and training to staff for people with a learning disability and autism. Staff told us that the learning disability team would come to the ward to advise on support needs. However, staff told us that it was difficult to obtain support from the dementia lead out of hours.

During the pandemic the service made reasonable adjustments to allow visiting for some patients for example those in the last hours of their life, or who required a carer due to their condition.

Dementia friendly initiatives were noted for example, promoting the use of the dementia symbols to identify patients living with dementia. There was a dementia care pathway in place which was integrated with the delirium and stroke pathway. This ensured that patients identified triggered specific requirements on that pathway. Some staff said they had enough training to effectively support people with dementia and could contact the dementia lead for further support and advice if needed. The dementia lead provided dementia friendly activities for patients on wards when this was requested by staff.

Patient passports were used for people with a learning disability and the learning disability team would help with support and advise. Some staff said they had enough training to effectively support people with dementia but could contact the dementia lead for further support and advise. The dementia lead provided dementia friendly activities for patients on wards when this was requested by staff. We saw evidence of a wide range of information to support patients with a learning disability displayed on noticeboards boards to promote and support staff. For example, information regarding what are 'reasonable adjustments', who and how to access learning disability campions in addition to the lead nurse for learning disability in the trust, the use of health passports, and a guide on how to communicate with someone who has a learning disability.

However, staff did not always support patients living with dementia by using 'This is me' documents. We were told that 'This is me' dementia packs were not routinely completed by staff. We were told that relatives or carers who would normally have completed them prior to restricted visiting due to covid-19. We were told that the dementia lead would support with completing the pack if required. However, we did not see evidence in records that they had been completed for patients living with dementia.

Wards were not always designed to meet the needs of patients living with dementia. Ward 2X which was an elderly frailty ward had been relocated to the gerontology unit on the second floor due to a reconfiguring of services due to covid-19 management. This meant that the ward was not always accessible to people using the service and was not designed for frail elderly patients who may be living with dementia. Some dementia decoration was evident on some wards such as a wall painting of a post box and large clocks on some wards. A small designated room designed as a 'café' was at the entrance of 2X for patients to utilise, but staff were not able to explain how this was used or managed with covid-19 restriction in place. The overall impression was not that of a dementia friendly environment in line with best practice. The ward manager and the trust informed us that the frailty ward will be moved back to the ground floor where it was said to be more compatible with a dementia friendly environment. However, it was noted on inspection that this area decoration and flooring were of a poor quality and did not appear specifically dementia friendly.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Translation services were available on request and staff could also access an online translation service. A text relay service for people who were deaf, hearing impaired or had a speech impediment was provided by the trust and British Sign Language (BSL) interpreter was accessible by arrangement

Medical care (including older people's care)

Access and flow

People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times but did not always ensure patients could access emergency services when needed or receive treatment within agreed timeframes and national targets. The acute medical and ambulatory care units were 24-hour services and the unit for GP referred patients had seven beds for overnight. During our inspection we found some patients had stayed in short stay areas such as the acute medical unit for up to a week before being transferred to a ward or discharged this included confused patients requiring enhanced observation.

Managers and staff did not always work to make sure patients did not stay longer than they needed to. The number of delayed discharges had risen steeply since May 2021 trust wide. The main reason for delays of more than 14 and 21 days was the lack of permanent accommodation in a residential or nursing home

We observed a bed management meeting where they identified that there were seven patients waiting to be admitted from emergency care, there were not enough beds available in the hospital with a further 15 beds required for other admissions. Medical outliers or patients fit for discharge were not discussed in the meeting. The focus of the bed meeting was reducing the four-hour waiting time in emergency department and requesting a review of patients needing admitting to the unit rather than facilitating discharges for medically fit patients.

The service did not always move patients when there was a clear medical reason or in their best interest. There was no enhanced care or monitored beds on the acute medical assessment unit so some conditions, such as low potassium levels, could not be assessed and treated on the unit. Patients who presented through the GP admissions pathway requiring enhanced monitoring were therefore transferred back to the emergency department and waited to be reviewed again. This caused a delay in their treatment.

Patients were not being discharged in a timely manner because of delays in social care assessments and finding appropriate placements in care or nursing homes.

Managers and staff did not always work effectively to ensure that they started discharge planning as early as possible. However, staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Allied professionals who worked across services told us that it was difficult to arrange services with the integrated community reablement assessment service (ICRAS) out of hours.

However, patients who needed non-invasive ventilation or critical care went to dedicated units, with transfers occurring smoothly.

On the frailty unit staff started discharge planning when patients were admitted, identified an estimated date of discharge and worked towards it. Multidisciplinary team meetings took place twice a day and discharge plans were updated. Two consultants also worked in community, which provided good links and continuity.

Medical care (including older people's care)

There were less incidents of delayed discharges from the frailty unit because support was prioritised, and a dedicated social worker supported the unit with discharge planning. This was a model that was particular to the frailty unit. Booking ambulance transport to support timely discharge of patients had sometimes been a problem.

Managers did not always monitor the number of delayed discharges, know which wards had the highest number or take action to prevent them. It was noted in the bed management meeting that there was a focus on emergency care and not ensuring flow throughout the hospital. The discharge lounge which was staffed to support patients waiting for discharge was not utilised effectively with patients waiting to be discharged from wards impacting on bed availability.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Initiatives had been implemented to provide support for patients and families which was called a 'matrons help' phone (Helping to Empower Loved ones and patients) this was introduced in March 2021.

The overall inpatient satisfaction for the whole trust decreased in March 2021 to 92.8% from 93% in February. Responses received for the Royal Liverpool site identified that there had been a 6.4% drop in the satisfaction score on the Royal Liverpool site overall compared with the previous month. It should be noted that these figures included satisfaction data for emergency care and were not specific to the medical care core service. Learning from complaints was shared with staff through emails and staff meetings. We observed notices on staff room doors sharing information from complaints and how to improve service such as, ensuring the district nurse if required was organised which had been identified in a complaint.

The service clearly displayed information about how to raise a concern in patient areas. Patient feedback was collected as part of the ward managers audit which was evident in ambulatory care

Staff understood the policy on complaints and knew how to handle them. The complaints policy was available for all staff.

Managers investigated complaints and identified themes. Wards had now resumed accountability for handling calls from relatives which had been temporally suspended in response to the increased demand in service due to the pandemic.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared with staff through emails and staff meetings. We observed notices on staff room doors sharing information from complaints and how to improve the service such as, ensuring the district nurse if required was organised which had been identified in a complaint.

Is the service well-led?

Requires Improvement 

Medical care (including older people's care)

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated well-led as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership triumvirate for the division of specialist medicine were a relatively new team with the operations manager being in post the longest since August 2020. There were no vacancies in the triumvirate leadership team. There were no matron vacancies and one nursing leadership vacancy which was a new role put in place to strengthen leadership.

Leaders recognised that one of the biggest challenges to the service was the integration of the two trusts, working practices and governance processes.

Staff spoke highly of the leadership support from all levels up to the triumvirate team. The triumvirate team had started walk arounds to meet staff on the wards at both sites and increase visibility.

One of the ward managers had won an award for being the 'ward' manager of the year for the trust, they had been nominated by staff on the respiratory ward.

Staff told us that opportunities for career progression had increased. They stated that there were opportunities to progress into specialist nurse roles within their speciality or critical care. Band six nurses were given greater responsibilities and assigned areas to own such as incidents and complaints, which supported their development.

However, staff felt that the trusts executive team not visible.

Vision and Strategy

The service did not have a fully developed or implemented vision and strategy at the time of our inspection.

At the time of our inspection the new trust wide strategy was being developed.

Leaders told us that the vision for the service aligned to the trust's values and strategy. We were told that the strategy for the service would focus on three key areas these were staff retention and wellbeing, developing a safety culture and the integration of the two trusts and the new hospital site.

Leaders told us that staff were engaged in the development of the trust wide strategy. There were communication streams in place for the communication of the strategy with staff.

We were told that the biggest piece of work was around the integration and the introduction of the new hospital site. There were plans to re-configure how the services worked across all site including the new site.

Culture

Medical care (including older people's care)

Staff did not always feel respected and valued. However, they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff described low morale and feeling under pressure due to limited staffing and the effect of the COVID-19 pandemic. Staff on the stroke unit felt that the high number of patient falls had impacted morale. However, staff described a supportive culture from colleagues and leaders.

Staff had access to a wellbeing hub at the trust which provided supportive services such as counselling. Staff had accessed regular counselling sessions to support their wellbeing throughout the pandemic, staff spoke positively about the impact the support had on them.

Staff were committed to improving care for patients and learning from when things went wrong.

Leaders were proud of the staff's commitment to improve patient care despite working through a pandemic.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service was in the development stages of standardising governance processes across the hospital sites following the formation of the new trust. Governance processes were in the main operated differently across site. It was not clear how all meetings fed into each other to ensure clear lines of communication. There was a weekly matrons meeting, weekly safety meeting which looked at incident and risk escalation which were medically led. Monthly divisional assurance groups looked at quality, safety, risks and incidents. Risks were escalated to trust level via the trust quality committee and risk assurance groups. Staff meetings were held weekly.

Risks were escalated to trust level via the trust quality committee and risk assurance groups.

We reviewed the clinical assurance meeting minutes for February to April 2021. We saw that there were standard agenda items which looked at incidents, risks, staff training compliance and safety dashboard and staffing.

Care group meetings had been newly implemented. It was recognised that there was a need to standardise these meetings across site and integrate good working practices.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact, however they did not regularly review mitigating actions in place.

The leadership team described the top three risks to the service as Nurse Staffing, patient falls and follow up for patients requiring non-invasive ventilation at the University Hospital Aintree site. The leadership team articulated mitigating

actions which were in place with regards to these risks which included a recruitment programme for overseas nurses, retention plans, growing their own staff, shared learning, obtaining support from the falls team, the implementation of a number of falls initiatives, the implementation of a falls working group and a clinical review of waiting lists to identify any potential harm.

Our review of the clinical assurance meetings for February, April and May 2021 showed that the service had a high number of risks on the risk register and there were a large number of risks which were outside of their review date, in February 2021 it was reported that there were 60 risks outside of their review date.

There was an action plan in place for the clinical assurance meetings we saw that these were not regularly updated. This included actions about improvement to national early warning scores documentation compliance, the deep dive into COVID-19 incidents and the implementation of a risk team.

Safeguarding training compliance was discussed at each assurance meeting identifying that improvements needed to be made, however we found that compliance rates were still below the trusts target.

The service had issues with access and flow and delayed discharges, however there was no evidence of work ongoing within the division to make improvements and the leadership team had not identified it as a risk to the service.

Tabletop reviews for incidents where harm had occurred were undertaken within 24 hours of the incident being reported. We were told that this provided an opportunity to ask questions, take any immediate action to mitigate any future risk and to provide support for staff recognising the need to ensure psychological safety.

There was a chair report created monthly for the division which looked at operational performance. The report was taken to the divisional operational performance meetings and looked at referral to treatment times and waiting lists.

The service had recently introduced a fundamentals of care meetings to bring together learning from medicines safety, serious incidents, complaints and performance. The meeting was in its infancy and one meeting had taken place at the time of our inspection. The meetings were chaired by the divisional director of nursing and attended by a representative from each care group. The aim was to bring together duty of candour, safety metrics and close monitoring of improvement work to provide more assurance about the management of performance and risks.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

There were clear processes to protect personal information. The trust undertook monthly data protection impact assessments to help the organisation identify and minimise data risks.

Engagement

Leaders and staff actively and openly engaged with staff and we saw some evidence of engagement with patients during our inspection. They collaborated with partner organisations to help improve services for patients. However, we did not see any evidence of engagement with equality groups, the public and local organisations to plan and manage services.

Senior leaders of the service told us how they had taken learning from other services in the trust that had formed and moved sites to improve engagement throughout the process for their service.

The division had introduced a newsletter which had a key focus each month, it also looked at themes and trends, had a section to meet the leaders and get to know governance structures for staff.

Staff were positive about the engagement and involvement in the development of the trust wide strategy.

At care group level leaders used staff surveys and feedback forms to understand what was important to staff. They gave an example of how they had put in place drinking water stations for staff following feedback.

Online questionnaires were used as a way for staff to share their concerns and ask any questions they may have with regards to the move to the new hospital site.

A divisional mailbox had also been implemented for staff to raise questions and concerns directly with the leadership team. however, we were told that this had not been well utilised.

There was a freedom to speak up guardian for staff to access if they felt they could not raise concerns to leaders.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The speech and language therapy team held joint respiratory clinics with consultants for asthma patients. This was to identify if patients had Asthma or inducible laryngeal obstruction, this meant better treatment plans for patients. We were told that this was only one of four clinics offered across the UK.

The service had recently introduced a fundamentals of care meetings to bring together learning from medicines safety incidents, serious incidents and complaints. The meeting was in its infancy and one meeting had taken place at the time of our inspection. The meetings were chaired by the divisional director of nursing and attended by a representative from each care group. The aim was to bring together duty of candour, safety metrics and close monitoring of improvement work to provide more assurance about the management of performance and risks.

The service had undertaken a thematic review of complaints across the division to identify areas for improvement. The main theme identified was communication which in the main was impacted on by the pandemic and the restrictions on visiting. As a result, the service implemented a system of daily contact by the multidisciplinary team to keep relatives informed.

The service had a quality improvement group who had oversight of improvement projects and supported staff to progress quality improvement work.

We were told that the service worked closely with the research steering group for the trust and had the largest portfolio of research projects in the trust.

University Hospital Aintree

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www.aintreehospitals.nhs.uk

Description of this hospital

We visited University Hospital Aintree as part of our unannounced inspection from 29 June to 1 July 2021. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Emergency department

We rated this service as inadequate because:

- The service did not make sure all staff completed mandatory training in key skills. The design, maintenance, use of facilities, premises and equipment did not always keep people safe. Patients did not always receive appropriate care and treatment in a timely way, exposing them to the risk of harm. Nursing and medical staff did not have the required levels of training to keep patients safe from avoidable harm and to provide the right care and treatment. The service did not always have enough medical staff. Staff did not always keep detailed records of patients' care and treatment. The information needed to plan and deliver effective care, treatment and support was not always available at the right time. The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Staff did not always provide care and treatment based on trust policies. Fluid documentation was not always accurate and complete. Staff could not demonstrate that they monitored the effectiveness of care and treatment. There were gaps in management and support arrangements for staff, such as appraisal and supervision.
- The service did not always plan and provide care and treatment in a timely way that met the needs of local people and the communities served. The service did not always work with others in the wider system and local organisations to plan care. Ineffective access and flow processes were creating and contributing to significant delays in admissions to the wards. Waiting times were not in line with national standards.
- Senior leaders did not always have a clear understanding of the risks, issues and challenges in the service. We were not assured local leaders and staff understood the vision and knew how to apply and monitor its progress. Staff did not always feel respected, supported and valued by the wider hospital and senior managers. The service did not always have an open culture where patients, their families and staff could raise concerns without fear. Leaders did not always operate effective governance processes, throughout the service, across both sites and with partner organisations. Leaders did not always use systems to manage performance effectively. The service used multiple clinical systems which were impacting on patient safety and effective care. The information systems were not integrated. Leaders and staff did not always actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not always collaborate with partner organisations to help improve services for patients.

Our findings

However:

- The service controlled infection risk well and kept equipment and the premises visibly clean. The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff protected the rights of patients subject to the Mental Health Act 1983. Staff gave patients enough food and drink to meet their needs and improve their health. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Frontline nursing and medical leaders were visible and approachable within the service. Staff were focused on the needs of patients receiving care. There were plans to cope with major incidents.

Medical care

We rated this service as requires improvement because:

- The service did not have enough staff to care for patients and keep them safe. Staff did not always have training in key skills or manage safety well. The service did not control infection risk well. Staff did not always assess risks to patients, act on them or keep good care records. They did not always manage medicines well. The service did not always learn lessons from safety incidents.
- Staff did not always give pain relief when people needed it. Managers did not always monitor the effectiveness of the service or make sure staff were competent. Staff did not always have access to good information. Key services were not always available seven days a week.
- The service did not consistently plan care to meet the needs of local people, take account of patients' individual needs or make it easy for people to give feedback. People could not always access the service when they needed it.
- Leaders did not always run services well using reliable information systems and did not consistently support staff to develop their skills. Staff did not understand the service's vision and values. Staff did not always feel respected, supported and valued. The service did not engage with the community to plan and manage services.

However:

- Staff understood how to protect patients from abuse.
- Staff collected some safety information and used it to improve the service. They gave patients enough to eat and drink.

Our findings

- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
- Staff were clear about their roles and accountabilities. They were focused on the needs of patients receiving care.

Surgery services

We rated it as requires improvement because:

- The service did not always manage patient safety incidents well. Whilst managers investigated never events, lessons learned were not always shared with the whole team and remedial actions taken did not minimise the risk of reoccurrence. We were not assured that the service had effective systems in place for identifying and reporting never events.
- Not all patients could access the service when they needed it and receive the right care promptly. The services performed worse than the national average for the percentage of cancer patients treated within 62 days. The average length of patient stay was worse than the national average. The total number of patients on the waiting list continued to increase since January 2021. Whilst the service did not achieve national standards for waiting times from referral to treatment; they performed better than the average when compared with other trusts in the region.
- Mandatory training compliance was below trust targets for a number of training modules, such as paediatric life support and higher level resuscitation training.
- The number of staff that had completed the higher level of adult and children's safeguarding training did not meet trust targets.
- Complaints were not always responded to within the timescales specified in the trust complaints policy.
- Not all patients could access the service when they needed it and receive the right care promptly. The services performed worse than the national average for the percentage of cancer patients treated within 62 days. The average length of patient stay was worse than the national average. Whilst the service did not achieve national standards for waiting times from referral to treatment; they performed better than the average when compared with other trusts in the region.
- An effective work culture focused on patient safety had not been fully embedded across the surgical teams in theatres.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Our findings

- Local leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued by their line managers. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Surgery

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, mandatory training compliance was below trust targets for a number of training modules, such as paediatric life support and higher level resuscitation training.

At our last inspection we told the trust to establish an effective system to monitor compliance for staff mandatory training to ensure all staff have completed their mandatory training. The trust had improved, and all staff received and kept up to date with their mandatory training. The service set a mandatory compliance rate of 85%, however whilst the service met the target for mandatory compliance achieving 84.3%, there were key elements which were significantly below this. Some staff did tell us they did not feel confident in the new system and found it confusing.

Training data specific to this hospital was not provided. However, records for July 2021 showed the overall trust-wide training compliance was 84.9% in the division of surgery and 87% for the division of anaesthetics, critical care, head & neck and theatres. The trust target for mandatory training compliance was 85%.

Staff told us the availability of some training modules that included face to face training had been impacted by the Covid-19 pandemic.

The mandatory training was comprehensive and met the needs of patients and staff. The service set a mandatory compliance rate of 85%, however, we saw that the Trust wide target was 85% and the mandatory training compliance was 84%. Whilst the overall Trust wide target was almost achieved some key areas were well below the service compliance rate for Resuscitation Level 2 - 1 Year, 54%, Resuscitation Level 3 - 1 Year, 53%, Paediatric Basic Life Support was at 33.% and fell below Trust wide target of 85%.

Staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

This showed some staff within the surgical services had completed their mandatory training but the hospital's internal target of 85% training completion had not been achieved across all the mandatory training modules.

Safeguarding

Surgery

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the number of staff that had completed the higher level of adult and children's safeguarding training did not meet trust targets.

At the last inspection not all staff had training on how to recognise and report abuse. The service did not improve overall with some of the safeguarding training and compliance falling below the trust target of 85%. Safeguarding level completion rates had improved since the last inspection. For safeguarding adults' level one training the compliance rate was 92%, Level two 87%, however level three was 44%.

Safeguarding children level one was 91%, however level two was 79% and level three was 47% falling below trust targets.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. During our inspection we saw that the trust had safeguarding policies which were available via the trust's intranet to support staff to raise safeguarding concerns. Staff we spoke to knew how to access safeguarding policies.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke to were aware of the trust's named lead for safeguarding adults and children and provided examples of when they had made a safeguarding referral to raise concerns.

Cleanliness, infection control and hygiene

The service mainly controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward and theatre areas were visibly clean and had suitable furnishings which were clean and well-maintained. However, we did find one controlled drugs cupboard in the surgical assessment unit that was not clean with a sticky residue at the bottom of the controlled drugs cupboard. We checked the resuscitation trolleys which were well-equipped and the daily check records were up to date and complete. However, we noted that one resus trolley we saw was not visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE).
However, we did observe some staff on one ward not following hand hygiene procedures. This was escalated to the ward manager who addressed this with the staff immediately alongside the infection, prevent and control team. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed equipment being cleaned regularly.

The areas we visited had enough supplies of personal protective equipment (PPE) and we saw that staff used this in line with trust policy. There was information displayed at ward entrances about appropriate PPE usage and an area for staff to don and doff PPE with supplies of surgical face masks and aprons and with access to a hand washing sink, hand wash and alcohol gel hand rub.

Cleanliness of the environment and equipment and hand hygiene compliance was monitored as part of routine monthly and three-monthly audits. Hand hygiene audit compliance in the surgical wards ranged between 91% and 100% between January 2021 and March 2021, which was in line with the trust target of 90% compliance.

Surgery

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the hospital environment was difficult to navigate and understand.

Patients could reach call bells and staff responded quickly when called. We saw that there were call bell signs in the bays and toilets which said, 'call don't fall'. Patients we spoke to told us that staff were attentive and responded to call bells and requests for assistance. On the wards there was dementia friendly rooms. However, there was a lack of embedded approach for meeting the needs of patients who had a diagnosis of dementia. The layout and signage of the hospital was difficult to understand and navigate around and would be very confusing for someone with an impairment.

The design of the environment followed national guidance. Staff carried out daily safety checks of specialist equipment including the resus trolley, and all checks were in date and accurately recorded.

The service had enough suitable equipment to help them to safely care for patients. We saw that any issues with equipment were reported and managed by the staff. Any urgent equipment issues can be reported via maintenance bleep. We observed dirty utilities and sluice rooms, no hoarding of waste. They had a variety of different bins (domestic, clinical and sharps bins).

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This was evidenced in the patient records we reviewed. National early warning score system (NEWS2) were recorded accurately. We reviewed 11 patient records and found that staff used this tool in line with the trust's policy relating to the deteriorating patient.

Staff knew about and dealt with any specific risk issues. During our inspection we saw that staff assessed patients' condition to identify any issues promptly that may need to be escalated; issues such as sepsis, VTE, falls and pressure ulcers.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. We attended handover meetings on the wards and theatre briefings where we saw relevant and up to date information be shared.

We observed shift changes and noted that handovers included all necessary key information to keep patients safe.

Nurse staffing

Surgery

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

During our inspection we saw that the wards and theatre areas we visited had enough nursing and support staff to keep patients safe and that the number of nurses and healthcare assistants matched the planned numbers. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers we spoke to told us that they could adjust staffing levels daily according to the needs of patients through the use of bank and agency staff that worked in the services regularly and were familiar with the services policies and processes. Managers told us that they made sure all staff including bank and agency staff had a full induction and understood the service. Staff we spoke to on the wards and in theatres told us that they had a full induction and competency-based training plan and that they felt supported by managers.

We saw that managers had a robust system in place to identify needs and this was used to block book established agency staff. We checked daily rotas and the number of nurses and healthcare assistants matched the planned numbers. The trust had recently recruited a number of newly qualified and international nurses on the surgical wards at this hospital.

Managers limited their use of bank and agency staff and requested staff familiar with the service. We saw that managers made sure all bank and agency staff had a full induction and understood the service.

The service had low vacancy rates for nursing staff despite the service being impacted by the COVID pandemic, sickness and awaiting new starters. The wards used nursing staff with the relevant competencies and the support of junior doctors from other areas when required.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe.

The wards and theatre areas we inspected had sufficient numbers of medical staff with a good skill mix on each shift to ensure that patients were safe. We reviewed a sample of medical staffing rotas and saw that the service always had a consultant, junior doctor and middle grade doctor covering each surgical specialty 24 hours per day, including a separate 24 hour on call rota for evenings and weekends.

All staff could access locums when they needed additional medical staff. Including access to locum medical staff and managers made sure locums had a full induction to the service and were familiar with the hospital's policies and procedures before they started work.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we found that patient records were not always stored securely.

Surgery

At the last inspection we found that the service did not keep good care records. The service had made some improvements in relation to record keeping., We looked at 11 patients' records, and patient notes were comprehensive, and all staff could access them easily. However, we noted on two wards and in a theatre that paper records were not stored securely. We found that staff had to duplicate information on multiple systems, and this was not a fluid or streamlined system.

When patients transferred to a new team, there were no delays in staff accessing the patient's records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

At the last inspection it was identified that there was insufficient action been taken to mitigate risk and to ensure risk assessments are reviewed and updated for patients ensuring they are up to date to mitigate risks to patient safety. This had improved and we saw that staff followed systems and processes when safely prescribing, administering, recording and storing medicines. During our inspection we reviewed nine patients records and saw that staff followed systems and processes when safely prescribing, administering and recording medicine and that staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff stored and managed medicines and prescribing documents in line with the provider's policy. We reviewed nine patient prescriptions and found that these were accurate and in line with trust policy. We reviewed controlled drugs, including gentamicin which is an antibiotic that fights bacteria and prescribed to cover a wide range of bacterial infections. The governance system in place for the management of gentamicin was robust and worked well.

We saw that all medicine on wards were stored in keypad locked rooms and controlled drugs were stored in lockable medicine cupboards and medicine fridges. We reviewed a sample of medicine in the medicine cupboards and found that these were well ordered, tidy and all within expiry date. However, we did find on one ward that a controlled drugs cupboard was not tidy and clean with a sticky residue present.

There was a system for monitoring the medicine fridge temperature ranges as per the trust policy and this was reviewed and recorded accurately.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff followed current national practice to check patients had the correct medicines.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service did not always manage patient safety incidents well. Whilst managers investigated never events, lessons learned were not always shared with the whole team and remedial actions taken did not minimise the risk of reoccurrence. We were not assured that the service had effective systems in place for identifying and reporting never events.

Surgery

We reviewed the services never events. Never Events are serious patient safety incidents that are entirely preventable. Managers we spoke to told us that they shared learning from never events, however staff we spoke with were not aware of a never event and the lessons learned. Staff were also unaware of never events and the lessons learned that occurred at other hospital sites across the trust. Implementation of learning from Never Events was not robust. However, we did see that observational audits were conducted in theatres. This involved a team conducting a WHO observational audit in different theatres.

Staff knew what incidents to report and how to report them. Staff told us they did know how to raise concerns and felt confident to raise any concerns. Staff told us that they reviewed feedback from incidents at weekly team meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when they identified things that went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Records showed the surgical services across the trust achieved 100% for patient safety alert compliance between October 2020 and May 2021.

Patient deaths were reviewed by individual consultants within their specialty area. These were also presented and reviewed at mortality and morbidity meetings. This was a joint meeting between the two surgical divisions and included all clinical leads and patient safety representatives.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

During our inspection we saw displayed on notice boards on each ward and in theatre areas we visited that information relating to patient safety, including pressure ulcers, hospital acquired infections and falls was displayed.

Is the service effective?

Good 

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed policies and clinical pathways and found that these based on best practice guidance such as from the Royal

College of Surgeons and the National Institute for Health and Care Excellence (NICE). Staff accessed policies through the trust's intranet, and we saw that these were within their review date and easily accessible. Care pathways were in place to ensure that best practice was followed, for example, management of sepsis. We observed emphasis was given to sepsis and antibiotic prescriptions on ward rounds. We saw use of robust protocols for the management of sepsis within surgery

Patients waiting to have surgery were not left nil by mouth for long periods. Systems were in place that followed current best practice guidelines to identify patients that were required to fast before surgery.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed handover meeting and staff discussed the mental health of patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. The trust had recently held a nutrition and hydration week on the wards where additional snacks and drinks were purchased to encourage good nutrition and hydration with patients.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We observed mealtimes on the wards and saw that patients who required additional support with their eating and drinking were assisted appropriately by staff. We saw that food and drink was available and in reach of patients. Patients told us that the food and drink available met their needs and that they had adequate choice, and patients were complimentary of the quality of the food. Drinks and snacks were available to patients between mealtimes. Staff told us that specialist support from staff such as speech and language therapists were available for patients who needed it.

We reviewed electronic and paper records for patients and saw that staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used the Malnutrition Universal Screening Tool (MUST) tool, which is a nationally recognised screening tool to identify and monitor patients at risk of malnutrition.

Patients waiting to have surgery were not left nil by mouth for long periods. Systems were in place that followed current best practice guidelines to identify patients that were required to fast before surgery

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Medicine charts showed pain relief had been given in a timely manner when pain score was increased. Pain scores were completed within national early warning sign score (NEWS) and completed an additional pain score chart.

Surgery

Patients received pain relief soon after requesting it. We spoke to six patients who told us that they were offered pain relief when required and the nurse explained the treatment.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. However, the service had a higher than expected risk of patient readmissions when compared to the England average.

Elective admissions

From March 2020 to February 2021, all patients at University Hospital Aintree had a higher than expected risk of readmission for elective admissions when compared to the England average. Oral surgery patients at University Hospital Aintree had a higher than expected risk of readmission for elective admissions when compared to the England average. The senior leadership team told us they did not have any specific concerns in relation readmission of elective admissions. We were told this was due to data quality in relation to the reporting of patient readmission rates due to the inclusion of planned re-attendances being included in the data.

From March 2020 to February 2021 the average length of stay for patients having elective surgery at University Hospital Aintree was 4.6 days. The average for England was 4.0 days.

Ear, nose and throat (ENT) surgery at University Hospital Aintree was 3.3 days. The average for England was 2.6 days. Oral surgery at University Hospital Aintree was 5.9 days. The average for England was 4.1 days. Urology surgery at University Hospital Aintree was 2.2 days. The average for England was 2.4 days.

Non-elective admissions

All patients at University Hospital Aintree had a higher than expected risk of readmission for non-elective admissions when compared to the England average. General surgery patients at University Hospital Aintree had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

The average length of stay for patients having non-elective surgery at University Hospital Aintree was 4.5 days. The average for England was 4.2 days. General surgery at University Hospital Aintree was 3.4 days. The average for England was 3.3 days. Trauma and orthopaedics surgery at University Hospital Aintree was 9.0 days. The average for England was 7.2 days.

Maxillo-Facial surgery at University Hospital Aintree was 1.3 days. The average for England was 1.4 days.

Readmission Rates - Orthopaedics

The trauma and orthopaedic departments for Royal Liverpool and Aintree were reconfigured in November 2019, with elective services delivered at the Broadgreen Hospital site and trauma services at University Hospital Aintree.

Surgery

The surgical services reported that the previous review of data for the legacy Aintree site revealed the readmission reports were incorrectly elevated due to data quality issues, such as the inclusion of scheduled readmissions for ambulatory trauma and due to patients attending as a day case for deep vein thrombosis being recorded as a readmission.

The emergency readmissions for orthopaedic issues and unscheduled returns to theatre were reported in the monthly orthopaedic trauma governance meetings. The service reported there had been low numbers of patients who had been readmitted and required surgical intervention, with no obvious trend or concern to indicate the requirement for a targeted improvement programme.

Hip Fracture Audit

The national hip fracture audit 2020 showed this hospital performed similar to or better than the England and Wales average for four of the six indicators. The hospital performed worse than the England average for perioperative medical assessment within 72 hours rate and for risk-adjusted 30-day mortality rate (8.2% compared to average of 6.1%).

The surgical services reported that compliance with the national hip fracture audit had reduced since the trauma and orthopaedic service reconfiguration in 2019. This was due to the impact of the Covid-19 pandemic on staffing, access to theatre and service oversight and also due to a lack of resource within the ortho-geriatric team (this had been identified as a risk and was being managed through the service's risk register).

The services reported that the increase in mortality identified in the national hip fracture audit had been escalated to the executive team in March 2021 and an action plan had been put in place. Progress against the action plan was reported every three months within the surgical division and the latest report from July 2021 showed the mortality rate had improved and was in line with the national average.

The surgical services had commenced four trauma lists at University Hospital Aintree, which was expected to improve compliance with audit indicator for time to theatre. A designated hip fracture orthopaedic lead was also planned to commence employment in October 2021, reporting to the clinical director of orthopaedic trauma and also planned to chair the existing 'Femoral Fracture Group'.

The senior leadership team told us they did not have any specific concerns in relation patient readmissions. We were told this was due to data quality in relation to the reporting of patient readmission rates due to the inclusion of planned re-attendances being included in the data.

The trauma and orthopaedic departments for Royal Liverpool and Aintree were reconfigured in November 2019, with elective services delivered at the Broadgreen Hospital site and trauma services at University Hospital Aintree. Therefore, we cannot report on clinical audit outcomes for the national hip fracture audit for this hospital.

The surgical services at this hospital participated in the national emergency laparotomy audit (NELA). The services reported the risk-adjusted 30-day mortality rate at this hospital was 9.6% and this was better than the regional average of 12%.

Records for the period between January 2021 and March 2021 showed there had also been improvements in a number of NELA audit indicators compared to the previous published annual NELA audit report (2018).

Surgery

During this period, the surgical services reported 90% compliance in the indicator for consultant surgeon and anaesthetist presence in theatre for patients with more than 5% mortality predicted.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We spoke to a range of qualified staff who all told us that they had regular supervisions and supported staff with their development.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers we spoke to told us that each member of staff had an individual competency and training plan which was linked to the appraisal process. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers gave all new staff a full induction tailored to their role before they started work. We saw that staff had a robust and full induction, so they were clear on their roles and responsibilities.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that this had been a continued area of improvement for the service.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that they felt confident to speak with their managers to discuss areas for improvement and areas of training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We attended the head and neck and skull base multidisciplinary meeting where four cases where discussed and the outcomes and attendance where recorded. Staff discussed cases individually and communicated relevant and important information for each case.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw that Physiotherapist input was considered in the discharge process and specific emphasis was given to sepsis and antibiotic prescription.

Surgery

We observed staff handover meetings on the wards that took place between senior nurses at the times of shift changes to ensure staff were informed of any issues and concerns and updated about patients' care and treatment. We also observed discharge meetings on the wards that were held to discuss patients awaiting discharge that were attended by matrons, senior nurses, wards managers and discharge co-ordinators.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, we did find that some key policies where not adhered to. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke to could explain the process and the policy and procedure in place and were to access them.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff followed national guidance to gain patients consent and we saw that staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. We reviewed 11 patient records and saw that patient consent for care and treatment was recorded.

All staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training compliance was above the trust targets of 85%.

Surgery

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of deprivation of liberty safeguards and made sure staff knew how to complete them. However, on ward 1 there was no record of applications for extensions to the deprivation of liberty safeguards when they had expired. When we asked staff, they told us that when someone wants to leave the ward, they were unable to due to having deprivation of liberty safeguard application in place. We checked the trust policy, and this stated that where a deprivation of liberty safeguard is still required and the seven day emergency authorisation or 28 day authorisation expires, the trust's safeguarding team should contact the local authority to seek an extension. The safeguarding team told us that they would not routinely apply for an extension for any patient with a deprivation of liberty safeguards that expired, and we found no evidence that the local authority had been contacted. Two of the five DoLS applications we reviewed were not renewed for the patients.

Is the service caring?

Good 

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients we spoke to said staff treated them well and with kindness.

Patients we spoke to told us that the staff were available when they needed them and very kind.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We

observed the care of a patient living with dementia on a surgical ward, and saw that staff provided comfort and reassurance to this patient who had become distressed and agitated in a way that maintained the patient's dignity and protected other patients around them from harm and distress. One patient we observed was confused and wanted to leave the hospital. The staff acted calmly with kindness supporting the patient back onto the ward.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients who had undergone surgery told us they were aware of the procedure that had been carried out and they knew their post-operative plan. All the patients we spoke with told us they were aware of what was happening to them and felt involved in their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement ↓

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Managers described the ongoing work planning for the next 12 months that included how they plan to meet the needs of local people in particular reference to the COVID-19 pandemic.

Surgery

Facilities and premises were appropriate for the services being delivered. However, whilst on inspection we observed that hospital signage was inaccurate and not easy to understand, this made it difficult for staff and patients to navigate around the hospital. We observed visitors and patients getting lost and not fully understanding the hospitals maps and signage.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw in patient records that staff used holistic care plans for patients with a complex need such as patients living with dementia or patients with a learning disability. Staff had access to the trust's safeguarding team who provided advice and support for how to meet the needs of patients with complex needs.

Staff supported patients living with dementia and learning disabilities by using 'hospital passport' documents. However, the butterfly scheme was not in place at the time of the inspection and was launched shortly afterwards. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us that patients with a physical disability would be placed in a bay with ceiling hoist or suitable equipment as required.

The service had information leaflets available and we were told that these could be translated into other languages if required. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

Not all patients could access the service when they needed it and receive the right care promptly. The services performed worse than the national average for the percentage of patients treated with 62 days. The average length of patient stay was worse than the national average. Whilst the service did not achieve national standards for waiting times from referral to treatment; they performed better than the average when compared with other trusts in the region.

Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, through accident and emergency or through GP referral. Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

From March 2020 to February 2021, the average length of stay for patients having elective and non-elective surgery at this hospital was worse than the England average across all surgical specialties except for non-elective ophthalmology and colorectal surgery.

The average length of stay for patients having elective surgery at this hospital was 5.2 days. The average for England was 4.0 days. The average length of stay for patients having non-elective surgery at this hospital was 4.3 days. The average for England was 4.2 days.

Surgery

NHS England data for March 2021 showed the total number of patients on the referral to treatment incomplete pathway across the trust was 49,055. There had been a 7% increase in patients on the waiting list for March 2021 compared to March 2020 (46,013).

NHS England data for March 2021 showed the trust had treated 63.% of patients within 18 weeks compared with 77% for the same time last year. However, the proportion of patients waiting 18 weeks from referral to treatment (63%) was better than the average for trusts across the North West region (62%). The proportion of patients waiting over 52 weeks from referral to treatment (10%) was also slightly better than the average for trusts across the North West region (10%). The general surgery, ophthalmology and trauma and orthopaedic specialities had the fewest patients treated within 18 weeks during this period.

NHS England data for March 2021 showed the trust performed better than the England average for the cancer two week waiting time standard (from GP referral) and the cancer 31 day waiting time standard (from decision to treat). However, the trust performed worse than the England average for the percentage of patients treated within 62 days (66% compared to the England average of 73%). The trust failed to achieve the 62 day standard across all specialties. except breast surgery.

The trust had an elective recovery plan that included proposed trajectories for reducing waiting lists for cancer patients, elective inpatient and day case patients and those waiting over 52 weeks. Managers monitored patient transfers and followed national standards. Managers told us that the University Hospital Aintree site had just put in place a new electronic system to support access and flow. The services reported elective surgery capacity had increased recently following a reduction of restrictions applied during the Covid-19 pandemic; however, overcoming the referral to treatment backlog position continued to impact on the sustainable recovery of elective access standards. Managers told us that one of the challenges is access to trauma theatres. The service ran four theatres daily pre pandemic, but still now only back up to two or three per day. The service has been heavily supported by locum staff and they have since left with this having an impact on the service to access. We heard that there was underutilisation of theatres and regular weekly cancellations of a list in trauma and orthopaedics.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. Complaints were not always responded to within the timescales specified in the trust complaints policy.

The service clearly displayed information about how to raise a concern in patient areas. We saw in the ward and theatre areas information leaflets displayed for patients detailing how to raise a complaint with staff and Patient Advice and Liaison Service leaflets (PALS) were also available for patients should they wish to make a formal complaint to the trust. The patients, relatives and carers we spoke to knew how to complain or raise concerns.

Staff we spoke with understood the policy on complaints and knew how to handle them should a patient make a complaint or raise concerns. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was shared in ward handovers and with all staff in the services. Senior leadership told us about sharing the experience of people who have complained when a family member passes away. They have recently brought people back to share their experiences with staff to enable them to identify what they could have done better.

Surgery

The trust complaints policy stated that complaints would be acknowledged and responded to within 35 working days for routine formal complaints and within 60 working days for complex complaints.

From October 2020 to May 2021 there were 63 complaints about the surgical services at this hospital and the trust acknowledged 100%, however 31% were responded to within the timescales specified in the trust complaints policy.

The trust reported the delays in responding to concerns were mainly due to a large number of complex complaints that required more time to investigate and this was also impacted by staffing pressures during the Covid-19 pandemic.

Is the service well-led?

Requires Improvement 

We rated it as requires improvement.

Leadership

Leaders at a local level had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The surgical services at the hospital were incorporated into two divisions; the division of surgery and the division of anaesthetics, critical care, head & neck and theatres.

Each division was led by a divisional medical director, divisional nurse director and divisional director of operations. The services had leads and deputies in place that had responsibility at hospital-level and surgical specialty level.

The surgical specialties were structured as care groups that included a clinical, nursing and operational lead. The care groups had medical and nursing leads in place. The surgical wards were managed by a team of matrons and ward managers.

Not all staff spoke positively about the leadership and organisation structure. The theatres and ward-based staff told us they understood their departmental reporting structures clearly and described their line managers as approachable, visible and who provided them with good support. However, accessing leadership above their line managers was complex and challenging as staff told us did not understand the management structure.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Whilst leaders understood and knew how to apply the strategic objectives and monitor progress, not all staff had a good understanding of these.

Surgery

The trust vision was 'healthier, happier, fairer lives.' The trust mission was 'by working together we will deliver outstanding healthcare'. The trust vision and mission statement were underpinned by four strategic priorities: great care, great people, great research and innovation and great ambitions.

The division of surgery 'divisional strategy 2020-25' outlined the strategic objectives for the surgical services, and was based on the overall trust vision, mission and four strategic priorities.

The divisional strategy set out a number of objectives that were revised on an annual basis. This included; for 'great care' - the implementation of ward accreditation, mortality and morbidity review meetings and timely access to surgical services following the Covid-19 pandemic. For 'great staff' - improving staff recruitment, retention, development and engagement. For 'great innovation' – to implement and embed a culture built on research and innovation. For 'great ambition' - effective integration of services, building successful partnerships and maximum use of technology.

Progress against the divisional strategy objectives was monitored as part of divisional executive review meetings every three months.

We received a mixed response from staff in wards and theatre areas in relation to their understanding of the vision and strategy for the surgical services. This meant that the vision and strategy had not been effectively cascaded to staff across the surgical services and not all staff had a good understanding of these.

Culture

Not all staff felt respected, supported and valued by the managers above matron level particularly during the COVID-19 pandemic. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. However, an effective work culture focussed on patient safety had not been fully embedded across the surgical teams in theatres.

The majority of staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the surgical services. They told us there was a friendly and open culture and that matrons and clinical leads were visible and approachable. Most staff we spoke with felt supported and able to raise concerns. However, staff also told us that above matron level they did not feel valued by the managers during the COVID-19 Pandemic. Staff spoke negatively about managers and told us that they did not believe that managers respected or supported them.

The medical and nursing staff we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers. Junior doctors and nurses told us they received good training and learning opportunities. Most staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared. The majority of staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed. However, not all medical staff we spoke to felt supported and valued. They told us communication and access to the executive team was difficult due to the complexity of management structure.

Whilst we found a positive culture across most services, we found that the theatres did not have a fully embedded patient safety culture. There had been a number of never events and invasive surgery incidents over the past 12 months across the division of surgery and staff errors were a contributory factor in all these incidents. Learning was not effectively shared across sites.

Governance

Surgery

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The surgical services at the hospital had governance structures in place that provided assurance of oversight and performance against safety measures. There were monthly divisional and care group level governance meetings in place to discuss governance and risk. Each surgical specialty had routine monthly governance meetings and clinical governance meetings.

Meeting minutes showed key discussions took place in relation to workforce, current risks, clinical effectiveness and performance issues in relation to each speciality area.

The surgical wards took part in the Liverpool Quality Assessment (LQA) ward accreditation process that aimed to focus wards in offering excellent care and treatment and highlighting where improvements were needed. Wards that had been assessed were given an overall rating of gold, silver or bronze. The assessment covered items such as general ward environment, infection control, medicines management, information boards, NEWS2 compliance and staff awareness of the freedom to speak up guardian.

The division of surgery executive review report for July 2021 showed 11 surgical wards at this hospital had undergone the accreditation process and five wards achieved 'gold' status, five wards achieved 'silver' status and one ward achieved 'bronze status.

The nursing and medical staff also participated in routine local team meetings to monitor governance, risks and performance and share learning from divisional and care group meetings. Information was also shared through daily staff huddles and newsletters.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. However, they did not use systems to manage performance effectively. We identified poor performance in key processes such as mandatory training, incident management, patient access and flow, patient outcomes and complaint management. We were not assured the surgical services had implemented suitable remedial actions to demonstrate an improvement in key performance and compliance measures.

The trust used an electronic risk register system to record and manage key risks. The division of surgery risk register documented key risks to the surgical care services and the divisional register incorporated the individual departmental / ward risks. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Each risk had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to divisional and trust level. Staff were supported by governance leads within each specialty to review open risks and identify mitigations / controls to reduce or eliminate risks.

We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through team meetings, safety huddles, performance dashboards and newsletters.

Surgery

Whilst the service had risk management and audit processes in place, we were not assured the service managed performance and staff and patient risks effectively. This was because we identified significant shortfalls in key processes such as mandatory training, safeguarding training, management and reporting of never events, patient readmission rates, clinical audit outcomes, referral to treatment targets, patient length of stay and complaints management processes during the inspection.

We found that performance information relating to these processes was collated and monitored at least monthly. However, the surgical services had not implemented effective actions in order to demonstrate an improvement in performance and compliance measures.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not all integrated with areas of duplication. Data or notifications were consistently submitted to external organisations as required.

Staff completed data security awareness training as part of their mandatory training. Records for July 2021 showed 91% of staff in the division of surgery and 93% of staff in the division of anaesthetics, critical care, head & neck and theatres had completed this training and the trust target of 85% compliance had been achieved.

We did not identify any concerns in relation to the security of patient records during the inspection. The majority of patient records were electronic. We saw that paper-based patient records were kept securely. Staff files and other records (such as audit records, staff rotas, files) held electronically.

Computers were available across the wards and theatre areas and staff access was password protected. Electronic patient records were also password protected. The staff we spoke told us that they had three electronic systems that required duplication of records between each system, this took away from staffs' time to provide care and treatment.

The ward and theatre areas had notice boards in place displaying information such as guidance and performance for staff and patients. Information on performance, patient safety and staffing was routinely collated, and dashboards were used to review this information and analyse trends.

Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Engagement

Local leaders did not always engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The majority of staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected.

Surgery

The staff survey results 2020 showed staff in the surgical services scored higher than overall trust score around themes of morale, quality of care, safety culture and staff engagement. The audit identified areas for improvement relating to safe environment – violence and bullying & harassment, health and wellbeing, manager / staff relationships and work / life balance and demands placed upon individuals.

Improvement actions following the staff survey included; completion of individual care group level action plans to address the themes outlined in staff survey, discussions with staff within care groups taking place in order to update on progress, taking a 'you said, we did' approach and the introduction of a "staff brief" online meeting, to allow staff the opportunity to attend and participate in a question and answer session with the senior divisional management team.

Staff were provided with emotional support. For example, clinical supervision and debrief support was put in place to support staff. There was a 'chillout / wobble' room for staff who needed to take time out when under pressure.

Staff told us they did not see the trusts executive team members (such as the chief executive and the medical director) on the wards but the local leaders did engage with staff across the surgical wards and theatre areas.

Patients were asked to give feedback about their stay on the ward. Volunteers on the ward gathered patient opinions on an electronic device rather than friends and family test cards. This enabled the collection of fuller and more detailed feedback from patients and issues could be acted on sooner.

Staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family. Feedback from NHS Friends and family survey was mostly positive across the surgical wards.

A number of wards had volunteers in place to gather patient opinions using an electronic device rather than friends and family test cards. Staff told us this enabled the collection of more detailed feedback from patients and allowed for staff to act on issues sooner.

Public engagement had been impacted due to the Covid-19 pandemic.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The culture across the surgical services was based on quality improvement. There were a number of quality and cost improvement projects and work streams in place across the surgical services, such as theatre improvement and elective surgery quality improvement programmes.

Staff across the services were involved in research, innovation and clinical trials to improve patient care and treatment. Staff participated in a range of local clinical audits and re-audits to improve the services.

The services planned to integrate and configure a number of services as part of the implementation of the new hospital. This included operational plans submitted for the transfer of all urology inpatient services and complex elective breast surgery services to this hospital.

Medical care (including older people's care)

Requires Improvement ● ↓

Is the service safe?

Requires Improvement ● →←

Since we last carried out a comprehensive inspection of this service they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as requires improvement.

Mandatory Training

The service did not make sure everyone completed mandatory training in key skills.

Staff did not receive and keep up to date with their mandatory training.

Trust data on all staff in the medicines directorate showed that staff had completed an average of 70% of their mandatory training.

Lower percentages of staff had completed key elements of training, including adult resuscitation level two (54%) and level three (58%), paediatric basic life support (17%), and infection prevention and control (68%)

The service provided training for specific roles, but low percentages of staff had completed this for example, pain management level one and level two (both14%) and level three (6%). The percentage of staff who had done level two sepsis training was 67%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not all have training on how to recognise and report abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. They could give examples of safeguarding referrals made and working with the safeguarding team. Staff described easy access to the trust safeguarding team and said they got good support from them.

However, staff did not all receive training specific for their role on how to recognise and report abuse. The service provided information on staff completion of safeguarding training for the whole trust. It was not broken down by hospital or staff group.

The percentage of staff who had completed safeguarding level two and three training was below 90%, with level three adults the lowest at 53%

However, in July 2021 more than 90% of staff had completed safeguarding training for level one adults and Prevent basic awareness. Prevent training aims to safeguard children, adults and communities from radicalisation and being drawn into terrorism.

Cleanliness, infection control and hygiene

The service did not consistently control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They mostly kept equipment and the premises visibly clean.

Not all staff followed infection control principles including the use of personal protective equipment (PPE).

We saw some members of staff in some clinical areas wearing face masks that were positioned under their noses.

PPE was available at the entrance of all wards and clinical areas we visited and at the entrance of each bay and side room. However, PPE donning and doffing areas were not always clearly signposted.

On ward 25 we observed the door to side room seven was left open, despite their being a sign displayed upon it which stated that it should be kept closed due to infection prevention.

The service carried out specific audits of staff compliance with COVID 19 infection prevention and control measures. This was a snapshot of five staff on each ward which was comprehensive. However, this was not repeated in May 2021 on a ward with low compliance. In June 2021 some wards still showed low compliance. We did not see any associated action plans to rectify this low compliance or raise staff awareness of this.

Staff did not always label equipment to show when it was last cleaned. The service did not have a system to identify all items were cleaned following use. On ward 22 we observed gaps in the commode cleaning checklist.

However, on ward 32 all equipment, computers, intravenous stands and hoists had sterilising wipes attached for staff to clean them before use. On ward 25 we noted that in the March 2021 infection prevention and control Perfect Ward audit they had achieved 95.2% compliance. The cleaning check for May 2021 was 99% compliance.

All patients were swabbed for COVID-19 infection on admission, days three, six and 13 and then every seven days. The swabs taken on days three, six and 13 were done by the swabbing team who then coordinated the swabs and results. Ward 22, the respiratory ward, cared for patients who needed step down NIV (non-invasive ventilation), laryngectomy and tracheostomy. These patients were nursed in side rooms until three negative COVID-19 swabs had been obtained.

Hand washing facilities and sterilising hand gel were sited at all ward entrances. Hand gel was sited at each side room and bay.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff managed clinical waste well.

During our inspection we saw patients could reach call bells and staff responded quickly when called.

However, staff on the frailty assessment unit said an incident had been submitted regarding the patient call bells in the lower part of the unit which could not be heard by staff in other areas. Staff were not aware of any feedback or actions to rectify this issue.

A call bell audit that had been carried out on one ward. However, the audit tool did not require the time taken to respond to the call bell.

Though staff carried out daily safety checks of specialist equipment and the environment, we found some equipment was out of date. We also found some rooms not secured that contained equipment, items or medicines that may pose a risk to patients if used inappropriately.

On ward 25 we found out of date defibrillator pads (two adhesive pads that are attached to the patient's chest in an emergency such as a cardiac arrest to facilitate resuscitation). This was escalated immediately to staff who removed them.

The resuscitation trolley on ward 22 had a suction pump and defibrillator (a device that gives a high energy electric shock to the heart of someone who is in cardiac arrest) both of which were overdue their annual service since June 2021. This was escalated immediately to staff.

On ward 17B we observed a dirty utility room locked with a keycode but the code that we were able to use to open the door was written on the wall. Inside the room we saw a plastic container with floor polish stripper written on the label and spray bottles containing liquid but not labelled. This is meant patients and the public could access potentially harmful substances. In the Frailty Unit the dirty utility room was left unlocked with chemicals left on the side and accessible to unauthorised people. This meant unauthorised people including vulnerable patients could access substances which would be potentially hazardous to health or harmful. We escalated this to staff, and it was then locked.

The service did not always have enough suitable equipment to help them to safely care for patients.

Ward 17B shared some of its environment and equipment with an adjoining surgical ward. Ward 17B did not have its own scales to weigh patients which was an essential requirement prior to administering certain medications. Also, they did not have an ECG (electrocardiograph) machine which was used to record the electrical activity of the heart muscle. This meant equipment was not always available to all staff but staff told us that there were more medical devices such as these on order. They also had to share a treatment room, resuscitation trolley, a sepsis grab bag and stock medications.

The service did not have suitable facilities in all areas to care for patients and their families. On care of the elderly wards no adjustments had been made to the environment to make them 'dementia friendly'.

The environment in some areas appeared cluttered, for example, on ward 22 we observed that the storage cupboard was difficult to access with the door partially blocked.

On ward 22 there was rust in areas of the patient bathrooms and shower gels, soap and towels were left in the bathroom.

There was a decanting programme to refurbish wards and wards were being moved during our inspection. It was not clear if there was a plan for the most challenged wards such as wards 24 and 25.

Staff disposed of clinical waste safely. Sharps bins were dated correctly, and the lids were partially closed as they should be on ward 17B

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used the nationally recognised national early warning scores (NEWS) tool to identify deteriorating patients. NEWS scores were displayed on a screen at the nurses' station on each ward which also showed when they were due to be repeated. This information was updated in 'real time'. If a patient scored a NEWS of seven or above staff escalated the patient to the medical escalation team (MET) team. A score of between five to seven would trigger enhanced monitoring that could be adjusted dependent on individual patient need. Staff said the MET team responded promptly when called.

Each ward had a sepsis 'grab bag' containing everything needed to treat patients suspected of having sepsis quickly.

The electronic records system alerted staff to patients whose observations indicated possible sepsis.

Records showed that staff started patients on the sepsis pathway appropriately. They documented when this was stopped and why.

However, staff told us audits of NEWS compliance were not carried out regularly due to the change to a new electronic system. Data from the trust indicated that six out of 17 wards showed compliance with completion of NEWS of below 80% in audits in May 2021.

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool, nor reviewed them regularly, including after any incident. We found some risk assessments were not consistently completed on some wards. For example, we found that VTE (Venous thromboembolism) assessments had not been completed in 10 out of 20 records we reviewed on wards 14 and 15.

Staff knew about and but did not consistently deal with any specific risk issues. On the stroke ward some patients were being taught to make up drinks with thickeners for when they were discharged home. Thickeners were added to drinks of patients to reduce the risk of aspiration and choking. However, there was insufficient lockable storage for patients to securely store thickeners and no risk assessment process to determine which patients could do this.

However, staff did know about and deal with some specific risk issues. For example, on ward 25 there was a plan to give a member of staff additional responsibility for improving patient safety.

Staff could access support from the tissue viability team and falls nurses and they were visible on the ward and responsive to requests. Ward 25 staff were working with the tissue viability nurse to look at trends for HAPU (hospital acquired pressure ulcers) on the ward and make any improvements needed.

On ward 22, measures had been introduced to reduce falls such as new ultra-low beds, falls alarms, post fall SWARM (a post-incident huddle that allows rapid investigation and learning) assessment and falls calendar and map.

The service had a specialist stroke pathway and nurse team of six stroke specialist nurses and had recently recruited an additional advanced nurse practitioner due to start in September 2021. The team was based on the stroke ward but

outreached into A&E and any areas with stroke outliers. They were contacted through an internal bleep system and had a fast bleep for stroke alerts where onset time was known. The nurses received an alert from A&E when a potential stroke patient arrived and a pre-alert when ambulance crews advised they were on route with a suspected stroke patient. During our inspection we attended A&E and observed two stroke nurse specialists were waiting when the patient arrived and started their assessment alongside the A&E triage team. The team stated that around 75% of suspected stroke patients turned out not to be stroke so that meant they could quickly assess and keep stroke beds for stroke patients.

A&E staff were trained to use the recognition of stroke tool to enable more timely treatment of stroke.

We observed a handover on ward 33 and saw it included all necessary information including dementia and learning disabilities, deprivation of liberties safeguards, comorbidities, do not resuscitate, care plans, discharge plans and family contact. The handover was attended by nurses, health care assistants and students. Handovers were followed by safety huddle (a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk). Each ward had a separate daily multidisciplinary team (MDT) meeting attended by wider MDT members.

Nurse Staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Though managers regularly reviewed and adjusted staffing levels and skill mix, we found evidence this was not always maintained. Managers gave bank, agency and locum staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants did not always match the planned numbers.

We reviewed the fill rates for registered nursing staff for January to May 2021 and found that on average the service had around 80% of the registered nursing staff they needed, with some areas having as few as 55%. In real terms, that meant for every 10 registered nurses needed between two and four were missing from shifts.

These figures included ward managers being counted as nursing staff, taking time away from their management duties.

Staff said skill mix was a challenge. Changes in staffing policies since the trust had been formed had reduced the scope of duties covered by healthcare assistants and by bank and agency staff brought in to supplement staffing.

However, safe staffing was maintained on the hyper acute stroke unit and inpatient non-invasive ventilation wards in line with national guidance.

Though managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift , reviewed fill rates for nursing and non- registered staff suggested managers increased the unregistered staffing on shifts to mitigate for having less than the required amount of registered staff. The service had conducted a recent nurse staffing establishment review and managers told us they had suggested an uplift to staffing in some areas such as care of older adult wards. However, at the time of inspection the outcome of the review was not known and had not been shared with managers.

The trust had recruited a cohort of 51 overseas nurses due to arrive and that over one third would be deployed to the medicines division across both hospitals.

The ward manager could adjust staffing levels daily according to the needs of patients. At ward level managers told us they reviewed the nurse staffing establishment monthly with their matron. We were shown the monthly nursing staff report for March 2021 which showed staffing was reviewed on a daily basis by the matrons.

The service operated a nursing staff pool. These were staff with substantive contracts but not allocated to wards so were allocated on arrival to the area where they were needed.

The service had high vacancy rates. For example, at the time of our inspection there were five registered nurse vacancies on the stroke ward.

The service had high sickness and turnover rates. The service provided information on sickness and turnover rates for the medical division for the whole trust. Therefore, we do not have rates specifically for medical care at University Hospital Aintree. However, the information provided showed the service overall had high turnover rates and high sickness rates. Sickness absence had increased to 7% in May 2021 from 6% in April and which was higher than the overall trust sickness rate of 6% in May 2021. The turnover rate for the service was 27%.

Managers reported high agency and bank usage. They said they used block booking of bank and agency to try and cover longer term gaps. They said they usually got shifts covered, however skill mix was a challenge. However, fill rates would suggest not all shifts were covered in all areas.

Managers made sure all bank and agency staff had a full induction and understood the service. They used induction checklists for bank and agency staff unfamiliar with the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have enough medical staff to keep patients safe. Ward 24 had only locum medical staff, three junior locums and two locum consultants, one of which rotated between this and another ward.

The medical staff did not always match the planned number. On ward 17B the establishment was three medical staff, but they only had two. This led to delays with getting the patients prescriptions when they were ready for discharge, which in turn delayed their discharges.

The main reason for use of bank and locum medical staff was vacancies and gaps in the medical rota. This had risen steadily from 71.1% in January 2021 to 95.3% in June 2021.

There were gaps in medical staffing which was observed both during our inspection and on reviewing data provided by the trust following inspection. This highlighted that managers were not always successful in acquiring locum staff to fulfil the required amount of medical staffing.

We were not assured that the service had low and/or reducing turnover rates for medical staff or that the sickness rates for medical staff were low and/or reducing.

Medical care (including older people's care)

The service provided information on sickness and turnover rates for medical division for the whole trust. Therefore, we do not have rates specifically for medical care at University Hospital Aintree. However, the information provided showed the service overall had high turnover rates and high sickness rates. Sickness absence had increased to 6.9% in May 2021 from 6.3 % in April and which was higher than the overall trust sickness rate of 5.9% in May 2021. The turnover rate for the service was 26.7%.

The service did not have low or reducing rates of bank and locum staff. Data supplied by the trust following our inspection highlighted that between January and June 2021 inclusive a total of 1,462 bank shifts were covered by bank doctors in the medicines division at this site.

The total number of bank shifts needed per month since January 2021 peaked at 640 in March 2021, dropped to 580 in April 2021 but had risen steadily to 635 in June 2021.

Managers could mostly access locums when they needed additional medical staff. Ward 22 had long term locum consultants.

The service did not always have a good skill mix of medical staff on each shift. Ward 25 had no substantive medical staff, they were all locums, including consultants. During our inspection we observed that there were two new junior doctors, one of which was new to UK. Both the nursing staff and managers reported issues with communication and medics knowledge of systems. We were told that this had impacted on getting TTOs (to take out medications) that patients needed to take home with them. This then delayed some discharges. Staff said they were working together to improve this.

However, staff said they did have consultant led weekend ward rounds. Ward 23 had rotational consultant posts from Liverpool University. Staff felt that this was a successful initiative that they hoped they could keep

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always up-to-date and were not always easily available to all staff providing care.

We reviewed 45 sets of patient records during our inspection, but patients' records were not always completed correctly. For example, on ward 32 we observed that one patient had not had any observations at all documented for that day and had not had their pain score documented the previous evening.

Patient notes were not always comprehensive, and not all staff could access them easily.

On wards 14 and 15 we saw six patient records where the frequency of pressure ulcer repositioning was not recorded.

Locum doctors on ward 25 told us that they struggled with the multiple information systems in use and they were unable to access the Gentamycin calculator on the information technology system which was used to calculate the correct dosage of this medication for patients.

Records were not always stored securely. In one of the rooms in the ambulatory care unit the computer screens were positioned in a way that patients were able to see the information on them such as confidential patient information.

There had been a new electronic records system from May 2021. We were told that the service received additional hardware and some staff told us they have enough computers. Staff told us they were given training and had floor walkers 24/7 during implementation to support staff in the use of the new system. However, ward 17B staff said they did not have enough computers and some charts, such as blood sugars, were still paper based

On ward 25 we observed that doctors did not access the electronic patient records system during the ward round, instead using handwritten notes which they later transcribed onto the electronic system.

We observed on the electronic patient records system that ten out of 20 patients were not recorded as being clerked by a doctor, though we saw evidence that they had been.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, not all staff followed these systems and processes correctly.

Staff did not always follow the systems and processes in place when prescribing, administering, recording and storing medicines.

On ward 25 we observed codeine was recorded as a controlled drug and a stock check had identified 32 tablets and the next check identified 30, meaning there were two tablets unaccounted for. We escalated this to the ward manager immediately.

On wards 25 and the discharge lounge we saw medicines, such as insulin, that had been prescribed to specific patients, who had since been discharged, in the ward stock.

On ward 25 we found two patients where the wrong strength of thickener had been recorded and/or administered. Thickener is added to drinks of patients to reduce the risk of aspiration and choking. On ward 33 we noted a thickener left on a patient's bedside table which constituted a potential choking hazard. We escalated this to staff at the time of our inspection.

Staff did not always manage medicines or prescribing documents in line with the provider's policy. On ward 22 our pharmacy inspector was able to access medications on the resuscitation trolley without breaking the security tag which should prevent such access until needed in an emergency. We also found a patient had been administered intravenous antibiotics that had not been countersigned by two registered health professionals.

During our inspection we found staff in the discharge lounge were using a thickener that had expired.

Staff did not always follow current national practice to check patients had the correct medicines. During our inspection we observed that a patient had been administered midazolam by a member of staff but had not had this checked by a second member of staff. This is a controlled drug and should always be checked by two qualified members of staff.

We reviewed patients' prescriptions and found examples of patients being transferred to other wards or areas not receiving critical medications such as anticoagulants (blood thinners), antibiotics, pain killers and inhalers.

On one occasion a patient had not received time critical antibiotics until three hours and 25 minutes after they had been prescribed. The same patient was prescribed Trazodone (used to treat anxiety and depression and can aid sleep) at 10pm but was not administered it as there was none available at night. We observed that a patient did not have thickeners added to their fluids despite this information being forwarded to staff from their general practitioner and the patients relative highlighting this need.

However, some staff we spoke to were aware of gentamicin incidents and told us they always did a two nurse bloods check. The trust policy was if wards held stock midazolam high strength then they also stocked a counter active medication. The wards had high strength in stock not prescribed to specific patients. Staff told us this was in case it was needed for patients but no patients required it currently.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We were told, and observed during our inspection, there was a named pharmacist for each ward and they attended daily Monday to Friday but not at weekends.

Incidents

The service did not manage patient safety incidents consistently. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff did not always raise concerns and report incidents and near misses in line with trust policy. Staff said that due to the short staffing in the department they did not always have time to complete an incident form.

Staff received feedback from investigation of incidents. The incident reporting system included a box where staff could indicate that they wanted feedback. Some staff told us that they always had good quality feedback from incidents and were invited to take part in the investigation.

However, staff on the Frailty Unit reported an incident had been submitted that the patient call bells in the lower part of the unit could not be heard by staff in other areas and that staff were not aware of any feedback nor actions to rectify this issue.

The service had no never events on any wards. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff understood the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with were aware of the term and the principle behind the regulation and could give examples of when the duty of candour would be applied.

Staff that we spoke with during our inspection were aware of the change in practice of how wards stored Midazolam medication following incidents due to medication errors. Staff discussed incidents at the weekly ward safety and governance meeting weekly and the minutes were made available to all staff.

Safety Thermometer

Medical care (including older people's care)

The service used monitoring results well to improve safety. Staff collected safety information but most did not share it with patients and visitors.

Safety thermometer data was not displayed on all wards for staff and patients to see. Following the inspection the trust informed us that all data collection for the NHS Safety Thermometer had stopped in March 2020, following guidance from the NHS Improvement Patient Safety Measurement Unit.

The board on ward 24 had out of date information displayed and pressure ulcer rates and incidences of falls were displayed on ward 33. None of the other wards that we visited during our inspection displayed any information. However, ward managers were sent a monthly report with their respective dashboard and quality matrons carried out weekly walk rounds.

However, on ward 25 it was highlighted on their quality board that risk assessment compliance had risen from 80% compliance in November 2020 to 87% in February 2021 and had peaked at 88% in January 2021. Their latest falls data was seven in January 2021.

There was no live dashboard for staff or managers to have the most up to date performance information to inform areas of improvement

Is the service effective?

Requires Improvement 

We rated effective as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The endoscopy service was accredited by the Joint Advisory Group on gastrointestinal endoscopy.

However, at handover meetings, staff did not routinely refer to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. However, they did not accurately monitor patients' fluid intake on all wards, especially the renal ward.

Staff did not always fully and accurately complete patients' fluid and nutrition charts. On wards 14 and 15 we saw five patient records with incomplete fluid balance totals documented. Four of these were on a renal ward where accurate fluid balance helps prevent acute kidney injury.

However, staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Patients were given a choice of food and drink to meet their preferences.

During our inspection we spoke with 16 patients. They all told us that they were given enough food and they were satisfied with the quality of food.

Staff used red trays to give some patients their meals. This helped staff identify which patients needed extra assistance when eating such as those with dementia or those with swallowing difficulties.

There were nutritional boards on wards so staff could see at glance if a patient was on a special diet or needed a red tray and these were updated daily.

Specialist support from staff such as dietitians was available for patients who needed it.

On ward 33, where patients had capacity, they were supported to make their own drinks with thickeners (added to drinks of patients to reduce the risk of aspiration and choking) in preparation for going home. Patients were advised to keep these in their lockers.

In the endoscopy waiting area there were tea and coffee facilities available for patients.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

There was a risk that patients sent from A&E to the discharge lounge to wait for test results or further consultation would not receive pain relief or other medicines as they were marked as discharged on the patient record system.

However, staff said they always checked with the A&E department that their last dose of medicine had been given prior to being accepted into the discharge lounge.

Staff prescribed, administered and recorded pain relief accurately. We observed pain relief being given for back pain to a patient who was unable to communicate verbally. Patients received pain relief soon after requesting it.

Patient outcomes

We were not assured that staff monitored the effectiveness of care and treatment. As such we are unable to report whether they used the findings to make improvements and achieved good outcomes for patients.

We were only able to report on audits that had been carried out since the trust had formed. Furthermore, many audits were put on hold due to the COVID-19 pandemic. As such, the service was only able to supply us with limited information.

Medical care (including older people's care)

Outcomes for patients were not always positive, consistent or met expectations, such as national standards.

The service submitted their audit data for the Sentinel Stroke National Audit Programme (SSNAP) (measures the quality and organisation of stroke care in the NHS). Between January and March 2021 inclusive, the overall patient centred SSNAP level was B out of a scale A to E, of which A is the best. This was an improvement from the previous quarter where the trust scored a C.

For team centred indicators the trust maintained a score of C. On both the patient and team centred indicators, the stroke unit was rated as E which was the worst score available. This suggested there was an issue with the flow around time getting onto the stroke unit. Patients were taking, on average, nearly five hours longer than the national average to get onto the unit. This then had the impact on the percentage of patients spending at least 90% of their stay on the unit.

However, the scores for access to therapy were improving after they had declined during the pandemic. Speech and language therapists were only available on Saturdays at weekends but all senior nurses on the stroke ward were trained to do swallow assessments. The service was introducing a new swallow screening tool and staff were going through training on its use.

Competent staff

The service did not make sure staff were competent for their roles. We were not assured that managers appraised staff's work performance and held supervision meetings with them to provide support and development each year.

We were not assured that managers supported staff to develop through yearly, constructive appraisals of their work. The service had introduced a new appraisal system in April 2021 and had set compliance to 0%. This meant the service could not confirm all staff had received an appraisal in the last 12 months. Data supplied by the trust covered all staff in the medicines department across all sites. The rate for all staff appraisals in the medicines department was 29%

On review of meeting minutes, we saw no evidence that managers made sure staff attended team meetings or that staff had access to full notes when they could not attend.

Managers identified any training needs their staff had but did not always give them the time and opportunity to develop their skills and knowledge.

Staff did not always have the opportunity to discuss training needs with their line manager or were supported to develop their skills and knowledge.

Staff had been moved from areas of speciality to new wards as a result of the pandemic.

However, managers made sure staff received any specialist training for their role. Stroke nurses were trained to offer thrombectomy (the removal of a thrombus (blood clot) under image guidance) and thrombolysis (treatment to dissolve dangerous clots in blood vessels) and had all the necessary equipment. Specialist stroke nurses were available 24 hours per day.

Multidisciplinary working

Medical care (including older people's care)

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We observed a board round that was attended all members of the multidisciplinary team including a consultant and junior doctor, ward manager, therapy staff and the on-call team. They reviewed all patients and their care plans, updating them where necessary.

However, we also observed a board round where the consultant arrived late and as such it was not the full multi-disciplinary team for the whole duration.

Patients had their care pathway reviewed by relevant consultants.

We observed that therapists attended daily MDT board rounds, where they could.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants did not always lead daily ward rounds on all wards. On ward 32 there were no consultant led ward rounds on Mondays and Wednesdays, these ward rounds were led by junior doctors.

Consultant led ward rounds were carried out every day on the weekend of patients who were either sick, new or patients who were potentially ready for discharge.

We held a focus group with representatives from the therapy teams who told us that were included in the multidisciplinary team ward rounds and safety huddles. However, these did not always take place due to nurse staffing shortages.

Staff could not always call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Pharmacy had limited opening hours at weekends.

Health promotion

We were not assured that staff always gave patients practical support and advice to lead healthier lives.

The service only had relevant information promoting healthy lifestyles and support on some wards/units.

However, on ward 22 we observed patient information leaflets for keeping active, smoking cessation and tuberculosis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Medical care (including older people's care)

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff gaining informed consent before treatment or a procedure was carried out, such as taking blood samples.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. During our inspection we reviewed 45 sets of patient records. Patient consent had been obtained and documented correctly where appropriate.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We observed that Deprivation of Liberty Safeguards were completed electronically and that checks on these were made by the trusts safeguarding team prior to the application being forwarded to the local authority. Staff were emailed back to inform them that their application had been successful and when to submit an extension where appropriate.

However, staff did not always receive or were kept up to date with training in the Mental Capacity Act. Data supplied by the trust for the whole medicines division across both sites was only 62% compliance.

Is the service caring?

Good

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Therapy staff used bedside curtains when carrying out bedside therapy with patients to facilitate privacy and dignity.

Patients said staff treated them well and with kindness.

Medical care (including older people's care)

During our inspection we spoke with 19 patients and one relative whom stated that staff were kind and caring, came when called for, preserved their privacy and dignity and used curtains when giving personal care. All told us they had seen a doctor and knew the plan for their care.

We observed kind caring interactions between a patient and a HCA (Health Care Assistant).

In the discharge lounge we observed that a homeless person was kitted out in clothes that the department had a stock of, to ensure that the patient would be warm and dry upon their discharge.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We carried out a group observation using the Short Observational Framework for Inspection (SOFI) method on 1 July 2021. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period, making recordings at set intervals. In each time period, we recorded the general mood of the service users, the type of activity or non-activity they were engaged with and the style and number of staff interactions with service users. In each time frame there may be more than one type of engagement and multiple interactions with staff. Interactions with staff are categorised as positive, neutral or poor.

The group observation took place in a male six bedded bay at a meal time. The observation started at 12:26 pm and lasted 40 minutes. We observed five patients and five members of staff. Data was collected in five-minute time frames.

The general mood state for patients throughout the observation was neutral for 70% of the period and for 30% of the time it was positive.

In 60% of the time frames the patients were engaged with a task such as eating their meal. In 45% of the time frames there was engagement between patients and staff.

81% of staff interactions were positive, 19% were neutral and none were poor.

Throughout the observation we saw staff engage with patients in a warm, friendly yet respectful way. Staff obviously knew patients well and had rapport with them. Staff acted promptly to support a patient experiencing pain and provided support to patients to eat their meals. Staff provided mouth care in a sensitive manner and assisted patients to prepare for their meal by changing sitting position or encouraging them to use hand wipes.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff in the endoscopy department said that when bad news was being given to a patient, their relatives would be allowed to be with them.

Medical care (including older people's care)

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

In the endoscopy department patients considered vulnerable were permitted to have their respective carer accompany them throughout their treatment in that clinical area during the Covid-19 restrictions.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Visiting was restricted due to Covid-19, but exceptions were made for patients with dementia or nearing the end of their life.

We observed that stroke nurses attended the Accident and Emergency department and talked to a family member when their relative had been brought into the department to explain what they were doing and to gain the patients history.

Staff supported patients to make advanced decisions about their care.

During our inspection we reviewed 25 sets of patients records where a DNACPR (do not attempt cardiopulmonary resuscitation) had been put in place. We noted that where appropriate, these had been discussed between a doctor, patient and or their next of kin, and this plan of care mutually agreed.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement 

We rated responsive as requires improvement.

Service planning and delivery to meet the needs of the local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served. We saw limited evidence of work with others in the wider system and local organisations to plan care.

Staff were not always able to access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia.

Quality matrons said that whilst the mental health service appeared to have improved, they were still struggling to get such patients reviewed due to services having been cut.

Facilities and premises were not always appropriate for the services being delivered.

We observed during our inspection that the service and environment was not always dementia friendly.

However, the service had systems to help care for patients in need of additional support or specialist intervention.

During our inspection we observed a multidisciplinary team meeting to discuss a patient's needs to be able to discharge them home such as arranging a deep clean of their home and the installation of a key safe.

Staff on the medical assessment unit told us they could refer to alcohol specialist nurse where needed.

Meeting people's individual needs

The service was not always inclusive and took account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

Staff did not always make sure that patients living with mental health problems such as dementia, received the necessary care to meet all their needs. The trust employed a nurse consultant for dementia and delirium for the University Hospital Aintree site but following the acquisition this role covered the whole trust. Since this expansion of the role the team employed more staff to cover both sites. However, restrictions during the COVID-19 pandemic, exacerbated by the trust merger, meant that work such as audits like PLACE (Patient-Led Assessments of the Care Environment) and NAD (National Audit of Dementia) had to be postponed. The service had comprehensive plans to carry out this work and to make the environment more dementia friendly as and when restrictions allowed.

The wards we visited during our inspection were not fully designed to meet the needs of patients living with dementia.

Data supplied by the trust following the inspection highlighted that trust wide level one dementia training compliance, which was to be completed by all staff, was 91.85%. Level two, which was for all clinical staff, had a compliance rate of 83.81%.

We were told during out inspection that the matron of the day held the on-call phone and was available for relatives and carers to call to address any issues or concerns. This was more pertinent due to restricted visiting during the COVID-19 pandemic. However, following our inspection we were made aware of two instances where patients families or representatives told us they had been unable to contact them so they could providecould provide updates and reassurances about their friend or relative.

Some staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

On ward 32 we interviewed a patient who was hard of hearing. Staff gave our inspector a speaker system which had ear plugs and a microphone which we were able to use to communicate with them.

During our inspection we did not observe any information leaflets available in languages spoken by the patients and local community.

Medical care (including older people's care)

Access and flow

People could not always access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers did not always ensure that patients could access services when needed to receive treatment within agreed timeframes and national targets.

Trust figures highlighted that whilst two-week cancer waits across the trust were at 98%, referral to treatment time for cancer treatment was between 53% and 66% against the Trust target of 85%.

Managers and staff were not able to make sure patients did not stay longer than they needed to. Trust data highlighted that in April 2021 only 18.57% of patients had been discharged before 12 midday compared to the national average and good practice of 33%.

Stranded patients (those who had been inpatients for more than seven days) had increased from 601 patients in April 2021 to 675 in May 2021. Super stranded patients (those who had been inpatients for more than 21 days) had increased from 228 in April 2021 to 243 in May 2021. The service planned to develop a standard operating procedure to address this.

The service conducted a discharge review in April 2021; however, they did not provide a copy of this review.

There was not a patient flow coordinator on every ward, however, staff reviewed numbers of super stranded and stranded patients daily.

Data supplied by the trust following our inspection highlighted that there had been a statistically significant reduction (improvement) in the percentage of beds occupied by super stranded patients at this site since the middle of June 2021.

The service did not only move patients when there was a clear medical reason or in their best interest. We observed during our inspection instances whereby medical patients were moved to wards due to capacity of bed availability, as opposed to medical need.

There had been no patients staying in the ambulatory care unit overnight since the first wave of the COVID-19 pandemic. However, patients did sometimes wait until the early hours of the morning before being admitted and moved to a ward.

Managers worked to keep the number of cancelled appointments and treatments to a minimum. The triumvirate told us of the work they had carried out to reduce the NIV (Non-Invasive Ventilation) backlog of patients waiting for review and/or treatment that had occurred due to the COVID19 pandemic.

Managers and staff worked to make sure that they started discharge planning as early as possible.

The service had recently introduced a patient review tool, this was completed daily on each ward for all patients and outlined any outstanding tests required, medicines and delayed discharges.

At ward level, discharges were monitored through board rounds. Discharge planners covered more than one ward and supported patient flow coordinators who were ward based.

Medical care (including older people's care)

The discharge lounge was used to facilitate discharges for patients.

Managers monitored the number of delayed discharges and knew which wards had the highest number. However, they did not always take action to prevent them.

The service had implemented a discharge checklist as part of the learning following a complaint and we observed this in practice in the discharge lounge. However, there was no space to document actions at risk of a fall. We observed a patient at risk of a fall being left unattended with nothing in place to prevent them from falling. We escalated this to the nurse in charge at the time of our inspection.

The service no longer had a nurse led ward for medically fit for discharge patients waiting placement. This closed the day of our inspection and a new unit had opened on site which was staffed by a different NHS provider. Staff could not clearly explain the criteria for referral to this service or how to make a referral.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

At the time of our inspection two stroke patients were outliers on other medical wards These were flagged on the trusts information technology system and monitored by the stroke team to ensure that they saw a consultant within 24 or 48 hours

There was no evidence to show pressures experienced by A&E were impacting the wards and beds were available. Bed occupancy across the hospital on the first day of our inspection was 84%.

The service did not have any escalation wards open at the time of our inspection.

Therapy staff ran the Aintree at Home service which provided follow up care at home to bridge the gap between discharge and a care package being in place.

Discharge coordinators attended the MDT (multi-disciplinary teams) board rounds on wards and supported patient flow coordinators and delegated jobs to them to support discharge. They used the standardised North West health needs assessment which was devised with neighbouring trusts, local authorities and CCGs (clinical commissioning groups). There was a single point of contact. The team manager acted across the locality as flight controller (similar to a flight deck where one person has oversight of all available bed capacity across a region, including hospitals and nursing home) through the hospital cell system. Discharge coordinators worked seven days a week, so this enabled discharges at a weekend There was a system call daily with all three local authorities and a daily call with ICB (integrated commissioning boards).

The discharge team and leadership were newly formed and had been in place for four months at the time of our inspection. Team leaders were employed by both the trust and a community trust.

There were two discharge processes for patients nearing the end of their life. The fast track process was for patients whose life was anticipated within days and the rapid discharge process for patients whose death was not thought to be imminent. Staff told us that whilst fast track process was a success, the rapid discharge process often failed due to the length of time taken to get a care package in place.

The discharge team and the flow team did not work together. Following the inspection the trust confirmed that the discharge team, the flow team and the admissions avoidance team were all operated by the trust.

Medical care (including older people's care)

The discharge and flow teams had separate meetings and governance processes. The RFD (ready for discharge) list sat with the flow team and did not match the discharge teams understanding of ready for discharge.

Staff told us pathways were not always aligned with national discharge pathways. They conducted a review and found that 177 patients had been discharged without a care package.

There were daily safety huddles with the integrated care hub.

There was a weekly quality group for discharge to assess which included all partners.

Learning from complaints and concerns

It was not easy for people to give feedback nor raise concerns about care received. As such we were not assured that the service treated all concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service did not always clearly display information about how to raise a concern in patient areas.

We observed posters in some ward areas of how to contact PALS (Patient Advice and Liaison Service) if they wanted to make a complaint about their care or treatment.

Staff understood the policy on complaints and knew how to handle them.

However, some patients and relatives told us they did not receive timely responses to concerns and complaints.

Managers did not always share feedback from complaints with staff and learning was not always used to improve the service.

Is the service well-led?

Requires Improvement 

We rated well-led as requires improvement.

Leadership

Leaders appeared to have the skills and abilities to run the service. They appeared to understand the priorities and issues the service faced. They were not always visible and approachable in the service for all patients and staff.

There had been changes at local management and leadership level and this had led to a lack of stable management and leadership.

Medical care (including older people's care)

We were told by the senior leadership team that executive board members carried out regular walkarounds in the clinical areas. However, during our inspection some staff told us that executive staff had only carried out walkarounds of challenged areas.

Staff told us speciality matrons were visible and accessible. However, they also felt that the quality matrons were not as visible.

The senior leadership team divided their working time approximately 50/50 between this site and the other hospital site.

The divisional director of operations had a deputy based on each site.

We were told that the chief executive had worked with diabetes team and they were able to present their work to the executive team directly.

Nurses told us they had strong nursing leadership from the divisional director of nursing.

Vision and Strategy

The service did not have a fully developed or implemented vision and strategy at the time of our inspection.

However, the senior leaders of the department were able to articulate to us how their plans were evolving and how they had been hindered somewhat by the COVID-19 pandemic. They told us their focus was on staff retention and wellbeing, safety culture and integration linked to the new hospital site.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service aimed to promote equality and diversity in daily work but did not consistently provide opportunities for career development.

Staff said they were exhausted, and we saw staff working in very challenging circumstances.

At local level teamwork and culture appeared very good despite low morale.

Some doctors told us that training opportunities were limited, leave and study leave were difficult to take, they often worked late, and some said that they had not managed to take a lunch break since joining the service.

However, junior doctors on ward 25 were well supported by the consultants, they had two days induction before they started working in the department, then one week shadowing an experienced doctor and one week supervised before working on their own.

Staff said there was good peer support across their service.

Staff were able to access a wellbeing hub in hospital.

There was counselling available that staff were encouraged to access for their wellbeing should they wish to.

Staff on ward 25 said the culture had improved since our last inspection and this was helped by the presence of matron on the ward daily. They had completed a staff survey following the last inspection and managers told us they planned to repeat this to see if the changes made had improved culture and morale on the ward. The ward had a thank you tree in the staff area where messages from patients and staff could be left to thank staff.

We saw information on notice boards about the freedom to speak up guardians, which is a service whereby any staff member can raise concerns in confidence.

Staff were supported to develop professionally for example by being given time and support to complete a degree.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but did not have regular opportunities to meet, discuss and learn from the performance of the service.

The quality matrons carried out regular audits using the Liverpool Quality Assurance (LQA) tool. Following these audits the wards instigated action plans to address areas for improvement and were re-audited dependent on LQA status. For example, following our inspection in October 2020 ward 25 had an LQA and was given a red rating, the lowest rating. They instigated an action plan and were re-audited in February 2021 and rated silver, which is the second highest rating.

Following our inspection, the service provided information that showed monthly quality audits were not consistently completed or performance maintained, for example, the cardiology ward had achieved 94% compliance in these audits in March 2021 but had since declined to 73% in June 2021. The monthly mealtime audit highlighted that the cardiology ward had consistently green ratings (above 90%) since February 2021. The short stay ward only appeared to be audited quarterly. The medical assessment unit had been rated red in December 2020, amber in March 2021 and not audited since.

Following our inspection, we requested action plans completed following a low score in the matron's audits but did not receive any.

Ward 25 had appointed a band 6 as documentation lead to audit patient records and make improvements.

Weekly safety and governance meetings on each ward (SAG) included performance, learning from incidents and complaints.

Ward managers completed daily check on perfect ward application. Monthly matron audits were also completed on this.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. However, they did not always identify and escalate relevant risks and issues nor identified actions to reduce their impact.

During our inspection we identified areas of poor practice on the acute medical unit. When raised with the senior leadership team we found they did not have oversight of patients in this area or the discharge lounge. As such we were not assured that medical patients on these wards were always safe.

Staff at ward level were aware of the risks in their own area of service.

Following the inspection, we interviewed the leadership triumvirate for the service and asked about the top three risks on their risk register. We saw there were new processes being put in place such as the fundamentals of care meetings in medical care; these were to provide more assurance about the management of performance and risks within the division.

Falls were found to be an issue across both Aintree and the other hospital sites and as such their work to address these risks were also across both sites. A cross site multidisciplinary team had been formed to address this risk. Their initial work had highlighted that there was a significantly higher incidence of falls in the Department of Medicine for Older People and stroke departments so they devised a formal twelve point action plan to support clinical staff in ward areas to mitigate these risks. These actions included the use of red Zimmer frames so that patients deemed at risk of falls were easily identifiable to staff. There were tagged bays with staff member sat in these bays (nurse or health care assistant) at all times and we saw numerous examples of this in practice during our inspection. They were in the process of procuring new signage, tabards and yellow wrist bands for patients at risk to improve this process. Matrons produced monthly reports which were reviewed and monitored to facilitate shared learning. At these meetings data such as timings of falls were identified. The learning was shared with the relevant ward managers in order that they would disseminate with their staff. The learning was also fed into risk assurance groups. At the time of our interview with the leadership team there were two SI (serious investigations) in process regarding falls.

Information Management

The service collected reliable data and analysed it. Not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

We reviewed the ward meeting minutes for the frailty assessment unit for May 2021 and noted that although the agenda headings appeared comprehensive some sections such as attendees and lessons learnt appear not to have been completed.

However, on ward 22 we saw notice boards highlighting compliance in March 2021 for LAMP (testing for COVID- 19) and NEWS2 (national early warning score), both at 95%.

Engagement

Leaders and staff actively and openly engaged with staff and we saw some evidence of engagement with patients during our inspection. They collaborated with partner organisations to help improve services for patients. However, we did not see any evidence of engagement with equality groups, the public and local organisations to plan and manage services.

Senior leaders recognised staff had not been fully engaged and informed during past changes. Staff said they had been told the changes were a merger but felt more like an acquisition by the other hospital. Neither of which was a true reflection of the acquisition process.

Leaders had established a hospital group which met fortnightly. All departmental leaders from both sites attended and gave their clinical input as to what services should look like. For example, the renal team had carried out engagement with staff about a hub and spoke model new way of working. The cardiology teams devised a plan about what the floor would look like and why and focused on rapid turnaround and in-reach into the accident and emergency department.

There was a divisional email box for their staff to raise concerns directly. This provided a way for staff to access the senior team.

The service worked with an external NHS provider to provide an intermediate NHS care facility. This was based on the University Hospital Aintree site and opened in May 2021and was managed and ran by the other providers staff. At the time of our inspection there were 38 beds but the service planned to have 69 beds. The service provided step down care for medically stable and optimised patients, As well as patients whose care and assessment could be continued at home or in a non-acute setting it planned to open to patients needing step up care from community settings such as reablement or convalescence where alternative out of hospital home care has been exhausted.

Urgent and emergency services

Inadequate 

Is the service safe?

Inadequate 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as inadequate.

Mandatory training

The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets.

Nursing and medical staff did not keep up to date with their mandatory training. At the time of our inspection, mandatory training compliance for staff in urgent and emergency care was 73% for nursing staff and 63% for medical staff. The trust target of 85% compliance had not been achieved.

Nursing staff compliance ranged between 49% for moving and handling and 96% for equality, diversity and human rights.

Staff received life support training for both adults and children. However, training compliance rates for basic life support (BLS) was 52% and paediatric basic life support (PBLS) was 33%.

We requested data from the trust for adult and paediatric advanced life support training. The data provided was not broken down by site and only related to medical staff training compliance. This showed overall compliance of 80% for adult training and 49% compliance for paediatric training.

The mandatory training was comprehensive and met the needs of patients and staff.

Safeguarding

Staff understood how to protect patients from abuse. However, not all staff had completed training on how to recognise and report abuse.

Safeguarding training compliance for level one and two adults and children was above 85%. However, compliance for level three safeguarding adults was 51% and level three safeguarding children was 45%.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Urgent and emergency services

Staff could identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who they could contact if they had concerns. A staff member told us they had identified a safeguarding concern for a patient who arrived via ambulance. The staff member contacted the hospital safeguarding team and completed a digital referral form. The safeguarding team provided feedback to the staff member.

Safeguarding information was displayed on notice boards throughout the emergency department.

Cleanliness, infection control and hygiene

The service controlled infection risk well and kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Since our last inspection, doors had been installed to the cubicles in the majors and resuscitation areas. This meant patients with potential infections could be isolated quickly and the risk of cross infection reduced.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available in all clinical areas. We saw staff changing PPE in between patient contact.

Staff cleaned equipment after patient contact, however there was no labels to show when it was last cleaned.

Social distancing reminders were in place throughout the department, including, posters, signs and floor markings. However, during our inspection, we observed overcrowding in the waiting room which meant people attending the department were unable to adequately socially distance themselves from others. We were told plans had been approved to expand the waiting room and increase seating capacity.

Mandatory training compliance for infection prevention and control (IPC) within the department was 60%.

Environment and equipment

The design, maintenance, use of facilities, premises and equipment did not always keep people safe.

The ambulance admission corridor was located between the main waiting room and the majors and resuscitation areas. The corridor was used to accommodate patients arriving by ambulance and awaiting triage. During periods of high demand there were patients on trolleys in the main hospital corridor. We saw 15 patients on trolleys in the ambulance corridor and in the main hospital corridor. Ambulance crews told us this was a regular occurrence.

The minor injuries unit was in a separate area of the hospital and was in a prefabricated building. There was signage displayed to direct patients from the emergency department. The unit consisted of one waiting room and five treatment rooms. There were no call bells installed for patients in case of an emergency. There were no staff facilities within the unit and no temperature control facilities. Staff told us they had escalated concerns regarding the unit temperature and no action had been taken. We were told there was a completed risk assessment for the minor injuries' unit.

The service had enough equipment to help them to safely care for patients. We looked at 39 pieces of medical equipment and found these were predominantly in date for servicing and maintenance. Staff told us there was an escalation process for identifying out of date equipment. However, during our inspection we found 11 items out of date. For example, we saw a blood pressure monitor which was due for servicing in November 2020. We escalated the items, we found out of date, to staff on the department at the time of the inspection.

Staff did not always carry out safety checks of specialist equipment. For example, from April 2021 to June 2021, we saw 11 gaps in the daily resuscitation trolley checks in the observation unit.

The sluice rooms across the department were unlocked. We saw items which were subject to the Control of Substances Hazardous to Health (COSHH) regulations, for example cleaning solution, which was not in a locked cupboard in each of the sluice rooms.

The mental health room in the department was ligature free, clean and well maintained. There were no blind spots and there was a separate adjacent room with a viewing panel. Staff and patients had access to an emergency alarm system.

Assessing and responding to patient risk

Patients did not always receive appropriate care and treatment in a timely way, exposing them to the risk of harm. There was a risk that staff did not always recognise or respond appropriately to signs of deteriorating health. Staff did not always complete risk assessments for each patient swiftly.

The care records of eight patients we reviewed had delays to treatment including delays in the prescribing and administration of antibiotics for sepsis treatment. These delays ranged between two hours and fifteen hours.

The Royal College of Emergency Medicine (RCEM) guidance on the initial assessment of emergency patients (2017) states face to face contact with the patient should be performed in an environment that has sufficient privacy to allow the exchange of confidential information and that the assessment should be carried out by a clinician within 15 minutes of arrival. At the time of the inspection the time to triage wait was on average 45 minutes. In June 2021, 40% of patients were not seen within 15 minutes.

At a previous inspection we said the service should ensure clear interpretation of the RCEM guidance around consultant response times. At this inspection data provided by the trust showed 83% of patients did not receive a clinical review within 60 minutes. In June 2021 and July 2021, the percentage of patients treated within 60 minutes across the trusts two emergency departments was 8.3% compared to 24.2% regionally and 32% nationally.

Nursing staff triaged patients from the waiting room and the ambulance assessment area. However, during periods of high demand nursing staff completed an interim partial triage, in both areas, which included prompts such as priority, pain score and time of assessment. Walk in patients were booked into the emergency department and asked to wait until they were called into a triage assessment room. This meant there was a risk of patients being in the waiting room without having their physical observations taken. However, we were told the lead nurse completed hourly observations of the waiting room to identify any deteriorating patients. Patients arriving by ambulance remained on the ambulance trolley until space was available in the major's area. When patients were booked into the department the time was updated based on the booking in time and not the actual arrival time. This resulted in an inaccurate reflection of time spent in the emergency department.

There were also 12 'see and treat' rooms where advanced nurse practitioners (ANPs), GPs and physiotherapists could see and treat patients. During our inspection we saw a consultant who was also supporting the triage assessments.

We were told that during periods of high demand a secondary triage nurse would assess patients in the booking in queue to ensure patients with higher acuity were prioritised. Staff used an online whiteboard system within the patient electronic note system (PENs) to recognise, prioritise and communicate deteriorating patients.

Ambulance handovers within 15 minutes saw a deterioration in performance from around 45% in March 2021 to 32% in June 2021. Time to triage within 15 minutes from ambulance saw a similar trend with performance deteriorating from around 98% in March 2021 to 76% in June 2021.

Ambulance handovers within 30 minutes deteriorated from around 72% in April 2021 to 60% in June 2021. The average ambulance handover time had increased from around 14 minutes in March 2021 to 24 minutes in June 2021.

Ambulance handovers between 30 to 60 minutes had increased from less than 100 in March 2021 to 220 in June 2021. Ambulance handovers over 60 minutes had also significantly increased from around 10 in March 2021 to 133 in June 2021.

Staff used a national early warning scoring (NEWS2) to identify deteriorating patients but did not always escalate them appropriately. National guidance states patients with a NEWS2 of one should have their observations reassessed between four and six hourly. In one patient record, the patient was reassessed nine hours. In another two cases we saw examples where patients NEWS2 should have been monitored hourly but this was not completed for between two to four hours.

Patient risk assessments were not always completed in line with guidance. In two patient records we saw pressure damage risk assessments completed 10 hours after their arrival. However, all patient trolleys within the department had pressure relieving mattresses.

The service implemented a new electronic patient records system in May 2021. Staff told us this had hindered the triage system resulting in longer patient waits and ineffective patient pathways.

The service had 24-hour access to mental health liaison and specialist mental health support. The departments waiting room had a direct phoneline to the Samaritans to support patients with mental health issues.

Morning and evening handovers were attended by all staff on shift. They were carried out at 7am and 7pm. Topics discussed in the handovers included, volume of patients, patient waiting times and prioritising hourly observations in the waiting room.

There were three major incident leads within the department, and they were all Hospital Major Incident Medical Management and Support (HMIMMS) trained. Major incident accident cards were available.

Nurse staffing

The service had enough nursing staff and support staff. However, they did not have the required levels of training to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Urgent and emergency services

Usually the service had enough nursing and support staff to keep patients safe. However, during our inspection, issues around the flow through the department and attendances meant that additional staff were required.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. We were told that the service used staffing models which were described as bronze, silver and gold outlining staffing allocations across the department.

At the time of inspection there was a gap identified for the number of nurses required for a night shift. Staffing issues were escalated to a band 7 staffing coordinator who was responsible for completing the emergency department communication booklet and implement mitigations such as requesting agency staff.

The department manager could adjust staffing levels daily according to the needs of patients. Safe staffing meetings were held twice per day. Staff were offered incentivised hours in order to fill shifts.

The number of nurses and healthcare assistants matched the planned numbers.

The vacancy rate across the division was 5%.

The staff turnover rate across the division was 14%.

The sickness rate across the division was 7%.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep patients safe. We were told that filling medical staffing rotas was a challenge, and gaps were filled with regular locums and agency staff. However, during the inspection we were told securing locum cover was also challenging.

The service could not always demonstrate medical staff had the right qualifications, skills, training and experience. Mandatory training figures were discussed in a previous section of the report.

However, the service had low turnover rates for medical staff at 8%.

Staff felt there were inequities in terms of medical staffing across both sites. We were told that University Hospital Aintree were allocated eight foundation year 2 doctors per four months and Royal Liverpool University Hospital were allocated 14.

The vacancy rate across the division was 22%. Staff told us there was an over reliance on junior doctors. We were told that the divisional clinical director was preparing a business case for 12 additional doctors.

There were emergency medicine and trauma consultants in the department 16 hours per day from 8am to 2am, which is in line with RCEM guidance. Outside of these hours there were consultants on call. A trauma consultant was resident in the hospital 24 hours per day.

A tactical coordinating group meeting was held daily to review staffing and access and flow issues.

The sickness rate for medical staff was low at 2%.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were unclear and not up to date. The information needed to plan and deliver effective care, treatment and support was not always available at the right time. Staff had to duplicate information due to the confusion of paper and electronic records.

Patient notes were not always comprehensive, and staff had difficulty accessing the multiple electronic records systems. There was no consistency and we found significant gaps in the recording of care offered or given.

Staff told us that the quality of record keeping had deteriorated from around 90% in April 2021 to around 40% at the time of our inspection. Staff told us it was difficult to find a computer and they were constantly having to log in and move between the different systems. They said the recording of nutrition and hydration had been hindered by the introduction of the new electronic system.

There were inconsistencies in recording comfort rounding. Some parts of the emergency department were using paper care records and others were using an electronic record.

We were told record keeping was discussed during safety huddles and shift handover meetings. Records were stored securely, and computer screens were locked when not in use.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. The service did not always follow relevant national guidelines around storing emergency medicines.

At our last inspection we told the service it must ensure staff follow policies and procedures for managing medicines. This had not improved during this inspection.

At this inspection staff did not always follow systems and processes when safely prescribing, administering, recording, and storing medicines. Patients receiving medicines in the department were started on a paper prescription chart and would be transferred over to an electronic system if a patient was admitted into the hospital. We found that not all staff were aware of changes to the way gentamicin was prescribed. This meant there was a risk that the medicines would be missed. Nursing staff said the prescribing of gentamicin had recently changed to be prescribed on the electronic system only, rather than on the paper record. However, we saw gentamycin was still prescribed on the paper charts we reviewed and two managers, we spoke with were unaware of this. We saw examples of some critical medicines, including antibiotics and anticoagulants, that had not been administered in a timely manner.

Medicines were not always stored securely. We found medicines in the resuscitation trolleys not secure and a cardiopulmonary resuscitation box that was not tamper proof. We saw a fridge with a broken lock and found some areas of the emergency department containing medicines that were not temperature controlled. We looked at five medicines in the medicines cupboard and found them to be in date. However, we found two medicines stored in a controlled drugs cupboard which should have been returned to pharmacy.

The department was not supported with a pharmacy clinical service, which meant medicines reconciliation was not completed until after patients were admitted onto a ward. We were told that funding for a clinical pharmacy service (8am to 8pm seven days a week) had recently been approved for a pharmacist to be employed.

Prepacked medicines did not contain the name and address of the trust. This was a concern found at the last inspection and had not been addressed.

Across the trust medicines management training for nursing staff was 35% compliance against the trust target of 85% and medicines management for medical staff was 30%.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with were able to give examples of incidents they had reported on the electronic reporting system.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us how they documented and uploaded photographs of pressure sores as part of the incident reporting process.

There was evidence that changes had been made as a result of feedback. Incidents had occurred where echocardiograms (ECG) had been misinterpreted. Therefore, the service implemented a system which meant patients presenting to the emergency department with chest pain were always reviewed by a middle grade doctor or above.

Learning from incidents was discussed at weekly safety and governance meetings. Minutes from these meetings were available in the staff room.

Safety Thermometer

The service used monitoring results to improve safety.

The service used ‘perfect ward’ audits to monitor performance against key patient safety outcomes. This was a system of lead nurse and matron, daily, weekly and monthly checks to monitor compliance with patient safety measures such as hospital acquired infections, falls and pressure sores. Any areas highlighted as requiring improvement were discussed during safety huddles. We saw the local leaders performing the audits and addressing any non-compliance. We were told audit results were reported to the monthly division quality report.

Urgent and emergency services

Is the service effective?

Requires Improvement

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated effective as requires improvement.

Evidence-based care and treatment

The service had up-to-date policies based on national guidance and evidence-based practice. However, staff did not always provide care and treatment based on trust policies. Staff protected the rights of patients subject to the Mental Health Act 1983.

Pathways and policies were based on guidelines and standards. However, staff did not always follow policies to plan and deliver high quality care. For example, eight out of 23 reported gentamicin incidents between September 2020 and April 2021 did not have gentamicin levels prescribed in accordance with the policy.

Staff protected the rights of patients subject to the Mental Health Act. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other needs. However, food and fluid documentation were not always accurate and complete.

Staff made sure patients had enough to eat and drink throughout the day. During our inspection, we saw staff providing patients with food and drinks. However, staff told us that during periods of high demand this could be challenging. We were told the senior nurses had escalated the need for a hostess team at the hospital.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. We were told this was due to staff having difficulty accessing the electronic computer systems.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed a patient in the triage assessment room with chest pain who was offered and given pain relief.

Patient outcomes

Urgent and emergency services

Staff could not demonstrate that they monitored the effectiveness of care and treatment. They could not demonstrate that they used the findings to make improvements and achieved good outcomes for patients.

We were told by the senior leadership team for the service, during an interview, that national audit submissions, such as Trauma Audit and Research Network (TARN) and the Royal College of Emergency Medicine (RCEM) audit had been suspended during the COVID-19 pandemic. No internal compliance processes had continued for any of the national audit standards. Therefore, there was limited oversight of the department's performance and opportunity to improve the service provided.

Competent staff

The service generally made sure staff were competent for their roles. However, there were gaps in management and support arrangements for staff, such as appraisal and supervision.

The service could not demonstrate that all staff had the right experience, qualifications, skills and knowledge to meet the needs of patients.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. We were told that 64% of staff had not had a recent appraisal.

Managers gave all new staff a full induction tailored to their role before they started work.

The clinical educator supported the learning and development needs of staff. We spoke with a student nurse who told us they were able to complete relevant tasks within their competencies.

Staff told us they were given time and had the opportunity to develop their skills and knowledge. For example, staff had enrolled onto training courses for trauma and the triage system.

The trust had a process in place to support nursing and medical staff in revalidation procedures.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff supported each other to provide good care. They had reliable links into services that maintained a rounded approach to caring for their patients. Staff told us they had good working relationships with frailty teams, palliative care, physiotherapists and occupational therapists.

Staff worked with other agencies when required to care for patients. For example, the service had regular meetings with other services including mental health, sexual health and drug and alcohol.

Seven-day services

Urgent and emergency services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support throughout the emergency department.

Staff identified those who may need extra support during assessment and signposted them to the right services.

Staff involved in initial assessment asked patients about smoking habits and alcohol consumption during assessment which helped capture national priorities to improve the population's health.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff making sure patients consented to treatment based on all the information available.

Mental health nurses were easily accessible in the trust to promote the delivery of mental health services and support staff to coordinate care.

We were told the trust was working closely with a local NHS trust and developing an emergency department strategy for mental health.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. However, training compliance for safeguarding was low.

Information about the Mental Capacity Act and Deprivation of Liberty Safeguards was displayed on notice boards throughout the department.

Is the service caring?

Good 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated caring as good.

Urgent and emergency services

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We saw staff caring for patients with compassion and feedback from patients confirmed that staff treated them with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We saw staff respecting patient's privacy and dignity, for example pulling curtains around bay areas. However, data from the acute and emergency medicine survey showed 11% of patients felt they were not given enough privacy and dignity.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff apologising to patients for delays to care and treatment during periods of high demand and long waiting times.

There was support available for the bereaved from the chaplaincy service and bereavement service. Information relating to this was displayed on notice boards throughout the department.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We listened to conversations between staff and patients and heard staff answer questions and where necessary explain things in different ways differently to those who did not understand any elements of their treatment plan.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The acute and emergency medicine survey showed 81% of patients felt involved in decisions about their care and treatment. The feedback from the Emergency department survey test was positive.

Urgent and emergency services

Is the service responsive?

Inadequate 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated responsive as inadequate.

Service delivery to meet the needs of local people

The service did not always plan and provide care and treatment in a timely way that met the needs of local people and the communities served. The service did not always work with others in the wider system and local organisations to plan care.

The service did not always plan and provide care in a way that met the needs of local people and the communities served. Patients could not always access care and treatment in a timely manner.

During our inspection there was challenges around the number of attendees and acuity of patients. However, we heard limited examples about how the service was working with other stakeholders for system level solutions.

We saw a mixed sex accommodation breach in the observation unit within the emergency department and raised this with senior nurses to review and take appropriate action.

The urgent and emergency care service was available 24-hours a day throughout the year.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems and learning disabilities. The service had systems to help care for patients in need of additional support or specialist intervention.

The mental health room in the department was ligature free, clean and well maintained. There were no blind spots and there was a separate adjacent room with a viewing panel. Staff and patients had access to an emergency alarm system.

Staff supported patients with dementia and learning disabilities by using 'This is me' documents and patient passports.

The service had facilities for disabled people including automatic doors and toilets.

The service had suitable facilities to meet the needs of patients' families. There was a relative's suite within the department. This had five rooms which could be used to support family members of seriously ill patients in the department. One room was designated as a bereavement room for families. This also had a viewing room which could be used for verification purposes. There was kitchen and toilet facilities within the suite.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Information leaflets on a range of conditions were available in the department.

There was a 24-hour café in the main waiting room.

Access and flow

Ineffective access and flow processes were creating overcrowding in the department and contributing to significant delays in admissions to the wards. Patients did not always receive timely and appropriate care and treatment. Waiting times were not in line with national standards.

Managers monitored waiting times but did not always make sure patients could access emergency services when needed. Patients did not always receive treatment within agreed timeframes and national targets.

Staff told us they were not supported by other teams within the wider hospital. It was perceived by the rest of the hospital that the flow issues were the emergency departments problems. Staff told us that there was a lack effective support provided from the wider hospital.

The clock starts from the time that the patient arrives in the department and stops when the patient leaves the department on admission, transfer from the hospital or discharge. During our inspection the longest attendance in the emergency department was 22 hours and 2 minutes. However, when patients moved to the observation unit, for example whilst awaiting scans or test results, they were subject to a clock stop. NHS England (NHSE) define the requirements for a clock stop as being an environment such that the patient experience is similar to other inpatient wards. For example;

The same privacy and dignity as other in-patient wards in the hospital

Patients must have access to toilet and washing facilities

No staff or public thoroughfare through the area

Facilities for patients to securely store their belongings

Sufficient space between beds to allow visitors to be seated in comfort

Provision of hot meals and appropriate access to refreshments

During our inspection, we raised concerns that the observation unit did not meet the NHSE criteria. For example, patients were not always provided with a bed, the unit was used a thoroughfare and we observed a mixed sex accommodation breach. We raised our concerns with staff in the department and the triumvirate and were not assured that there was a clear understanding of the NHSE requirements.

According to published data, in June 2021 the trust was in the bottom 10 performing trusts nationally for the type 1 ED 4-hour target at 59%.

Urgent and emergency services

Data received from the trust showed that at University Hospital Aintree in June 2021, 80% of patients did not have a decision to admit within 60 minutes. In addition, 81% of patients did not have a decision to admit within 180 minutes.

Delays within the wider hospital setting were impacting on flow through the department. For example, data provided by the trust showed that 82% of discharges were not achieved by 12 noon.

We found the patient flow team did not look for a bed until a decision to admit had been inputted into the electronic system. This meant there were additional delays which resulted in patients being in the emergency department longer than necessary. This put those patients at risk of their care needs not being met.

We saw two patients who spent 18 and 19 hours in the department, these patients were then transferred to the medical assessment unit without having a decision to admit.

We were told patients waiting for discharge from the emergency department who needed transport were transferred to the discharge lounge. These patients were discharged from the hospital on the electronic record system; however, they could then spend time waiting in the discharge lounge. This meant the department was not accurately recording the total time in the department for all patients.

We observed two patients who had been discharged from the trust and had been in the discharge lounge for over an hour. We were told if they deteriorated, they would be taken back to the emergency department and readmitted. We were not assured there was effective management oversight of this system or oversight of the patients as they had been discharged from the trust and did not appear on any figures of flow through the discharge lounge. This meant the trust had no oversight of the number of patients flowing through the discharge lounge from the emergency department.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Patients raised complaints via the Patient Advocacy and Liaison Service (PALS).

Concerns and complaints were shared through monthly newsletters, weekly safety and governance meetings and weekly consultant meetings.

The service included patients in the investigation of their complaint.

Managers investigated 23 complaints and identified themes for the division of acute and emergency medicine, in the first quarter of 2021/2022. The service responded to complaints within the response deadlines as per trust policy. We saw examples were learning from complaints had been implemented. For example, the waiting room audits in times of high demand.

Urgent and emergency services

Is the service well-led?

Inadequate 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated well-led as inadequate.

Leadership

Frontline nursing and medical leaders were visible and approachable within the service. However, senior leaders were not visible and did not always have a clear understanding of the risks, issues and challenges in the service. They did not always act in a timely manner to address them.

Throughout the inspection frontline department leads were visible in the department. We observed them speaking with and supporting staff. This was also evident from the discussions we had with staff. The department leads were committed and passionate about the service and worked to ensure patients were kept safe.

The emergency department was part of the division of acute and emergency medicine. There was a triumvirate leadership team for the division, this being a divisional medical director, deputy divisional director of operations and divisional nursing director. However, staff we spoke with told there was a lack of senior leader visibility and they did not feel listened to.

Senior leaders were familiar with the current challenges impacting on the service's performance. However, there was little evidence to mitigate the risks identified such as patients not receiving appropriate care and treatment in a timely manner, ineffective processes in relation to access and flow through the emergency department to safe discharge or transfer and poor documentation in patient records and on clinical systems.

Senior leaders recognised patients were not always reviewed by a speciality team in a timely way, however we found no evidence of how the leadership team were addressing this issue.

Vision and Strategy

Senior leaders had a vision for what they wanted to achieve within the division but did not have a clear strategy to turn it into action. We were not assured local leaders and staff understood the vision and knew how to apply and monitor its progress.

The trusts two emergency departments were not aligned, and leaders were unable to articulate a clear strategy which would enable them to align the two sites and achieve their vision.

The vision of the trust focused on providing high standards of compassionate care and listening to patients, staff and partners. There were four strategic priorities; great care, great people, great research and innovation and great ambitions. Senior leaders told us that their values aligned with the trust vision.

We were told about 'Getting It Right First Time (GIRFT)' which is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. We were told this was work in progress which was evident from the inspection.

Since our inspection, in July 2021, the trust launched a new trust-wide strategy for 2021 to 2024, 'Our Future Together'. This was aligned to support the One Liverpool Plan which was a city-wide plan. The trusts vision was 'healthier, happier, fairer lives.'

Culture

Staff did not always feel respected, supported and valued by the wider hospital and senior managers. The service did not always have an open culture where patients, their families and staff could raise concerns without fear. However, staff were focused on the needs of patients receiving care.

Staff said they felt concerns they raised were not always heard. Therefore, they would not always record these in the form of an incident. Staff felt that senior leaders within the trust did not have oversight of the flow issues.

Frontline staff of all levels felt they were valued and respected by their colleagues and local managers within the department. We asked staff about the morale of the department and they all said it was generally good, despite the challenges in the department. However, some staff told us about how the overcrowding challenges impacted the level of care they would like to provide. Despite these concerns, they said they worked as a team and supported each other during busy periods with limited resources. We were told local managers were visible within the department to assist when it was busy.

There was a desire from all staff to provide good care and treatment to patients, but they had limited resources when the department was busy. We saw staff working extremely hard, in challenging situations. Staff were working additional shifts to help the service manage the pressures. There was a risk this passion and drive was not sustainable in the longer term and could lead to staff burn out.

Staff praised the wellbeing resources available within the hospital. There was psychologist and occupational health support. Staff could be referred to them after a major incident. In addition, there were activities including massage sessions and fitness programmes. There were opportunities for flexible working.

Governance

Leaders did not always operate effective governance processes, throughout the service, across both sites and with partner organisations. Learning from the performance of the service was not clear.

Senior leaders told us that governance across both sites needed to be updated and aligned. We did not see any evidence that plans were in place to achieve this despite the two sites being part of the same trust for 22 months.

At the triumvirate meeting we were not assured by the senior leaders that they were fully sighted on the activity and performance in the emergency department. They were unable to demonstrate having appropriate audit systems in place.

There was not a clear focus on development and training for staff to support them in their roles. This was supported by low training and appraisal figures. There had been trajectories created but no clear action plan to achieve appropriate compliance figures.

Staff were clear about their roles and accountabilities and had regular opportunities to attend weekly meetings which provided a platform to discuss agenda items such as department issues, staff concerns and patient feedback.

Information was shared through key messages at handovers, newsletters and a mobile telephone application. We were told there were plans to introduce a governance board to display information such as root cause analysis action plans, complaints and compliments.

Management of risk, issues and performance

Leaders did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues. They did not always identify actions to reduce their impact. However, they had plans to cope with major incidents.

The acute and emergency medicine division risk register was available and had been defined to detail overarching risks under themes. The top risks reported at the time of inspection were the ability to maintain high quality services during COVID-19, patients waiting in the waiting areas for long periods of time and managing demand on services. However, we were not provided with robust plans and mitigating actions to address these risks.

There were no systems in place to manage the performance and activity of the emergency department. Senior leaders recognised they were behind in terms of submitting audit data. We found no assurance that the senior leadership team for the division was sighted on how the department was going to deliver the audit data and drive improvements through these audits. This was not on the risk register.

Senior leaders could not demonstrate clear oversight of what was contributing to the access and flow issues. They reacted by reviewing the information technology systems and comparing the trusts monitoring standards against the Clinical Commissioning Group. This demonstrated they were not fully aware of the problem so were unable to mitigate any of the risks.

All staff received Central Alerting System (CAS) alerts via email from Public Health England. Lead nurses and matrons were responsible for reviewing alerts and disseminating to teams.

The service had robust systems in place for major incidents.

Information Management

The service used multiple clinical systems which were impacting on patient safety and effective care. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated.

The service implemented a new electronic record keeping system in May 2021 and staff told us this had hindered the emergency departments performance. We were told the performance against the 4-hour target had deteriorated from around 83% to an estimated 40% following the implementation of the system.

Staff were frustrated of how the new system had been implemented and said they had not been involved in the consultation process. Staff felt the training provided for the system was not a structured approach and did not provide a full insight of the how the system worked.

Staff told us they had escalated concerns with the system and how it had impacted patient access and flow but there had been limited actions to support. We were told the trusts chief executive had been informed that the implementation had been successful, despite staffs concerns. Senior leaders told us there were plans to gather staff feedback regarding the system.

During our inspection we saw support workers providing support to staff members about how to use the system.

Engagement

Leaders and staff did not always actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not always collaborate with partner organisations to help improve services for patients.

During our inspection it was highlighted to us that there was limited engagement by most of the senior leadership team with some staff. Staff told us they felt that the board did not respond to the concerns and risks they raised. Staff did not feel that senior leaders considered their views and ideas.

Staff told us that they felt there was unilateral decision making and changes being imposed without discussion and sometimes at short notice whilst ignoring the communicated concerns of clinicians.

The service participated in the friends and family test and CQC surveys but had not carried out any local surveys, recently in relation to the quality of urgent and emergency care services.

Senior leaders told us the high number of emergency department attendances were linked to issues within the primary care system. During the inspection we were told 68% of attendees did not require hospital treatment and had attended the hospital due to difficulty accessing other healthcare services. However, we saw limited evidence of the trust engaging with external partners to deal with this situation.

We were told there were plans to establish an urgent treatment centre on the hospital site to help reduce the number of emergency department attendances.

Learning, continuous improvement and innovation

We saw limited examples of continual learning and improving services. Leaders stated that they encouraged innovation and participation in research, but we did not see evidence of this.

Lead nurses told us there was a focus on Leading Quality Assurance (LQA) to identify areas of improvement within the emergency department and implement action plans.