

Aintree University Hospital NHS Foundation Trust

Inspection report

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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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

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?

Requires improvement 

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.

Summary of findings

Background to the trust

Aintree University Hospital NHS Foundation Trust is a large teaching hospital in Liverpool.

There are 706 inpatient beds, serving a population of around 350,000 in North Liverpool, South Sefton and Kirkby. The hospital provides care and treatment for people living in some of the most deprived areas in England.

The hospital is one of the largest employers locally with more than 4,800 whole time equivalent staff. The trust gained foundation trust status in 2006 and was one of the first hospitals in Merseyside to do so.

The Emergency Department moved into newly built, bespoke accommodation in the summer of 2015. The hospital is also a major trauma centre

Medical care services at the hospital have 383 beds. There were 51,596 medical admissions between April 2016 and March 2017. Emergency admissions accounted for 22,522 (43.7%), 1,882 (3.6%) were elective and the remaining 27,192 (52.7%) were day case.

The trust had 30,879 surgical admissions between February 2016 and January 2017. Emergency admissions accounted for 10,522 (34%), 14,679 (48%) were day case admissions, and the remaining 5678 (18%) were elective.

End of life care is provided on the wards across the hospital. The specialist palliative care team supports patients and staff, reviewing patients and giving advice for example with symptoms such as pain control, sickness and poor appetite.

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Requires improvement  

What this trust does

The hospital provides a full range of acute services which include: acute medicine, accident and emergency, acute frailty unit, and surgical services. In addition to these services, the trust provides specialist services for Merseyside, Cheshire, South Lancashire, and North Wales. These specialist services include: major trauma, complex obesity, head and neck surgery, upper gastrointestinal cancer, hepatobiliary, endocrine services, respiratory medicine, rheumatology, ophthalmology, and alcohol services.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Summary of findings

Between 3 and 6 October 2017 and 25 and 26 October 2017 we inspected some of the services provided by this trust at its main hospital as part of our ongoing inspection programme.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed is this organisation well-led?

What we found

Our rating of the trust went down. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement and caring as good. We rated four of the trust's services at this inspection. In rating the trust we took into account the current ratings of the services not inspected this time.
- We rated well-led at the trust level as requires improvement
- Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.

Overall trust

Our rating of the trust went down. We rated it as requires improvement because:

- We found safeguarding procedures had not been fully implemented to protect patients in vulnerable circumstances. There were improvements required to provide assurances to senior leaders whilst the review of processes and procedures was being undertaken as identified by the trust.
- Improvements were needed to ensure the trust was compliant with all relevant national institute for health and care excellence quality standards.
- Senior leaders needed to ensure that assurances from services were more effective which included actions to implement learning completed in a timely way and the monitoring of patient moves at night.
- There was no strategy in place for end of life services to help drive and monitor performance and all risks identified by staff needed to correspond to those reported to senior leaders. There were improvements required to mitigate all risks in a timely way.
- Whilst there was an open culture staff satisfaction in services was mixed and staff did not always feel engaged or empowered.
- There was a limited approach to obtaining the views of people who use services in end of life services to help improve standards of care and service delivery.
- Board members recognised that they had work to do to improve diversity and equality across the trust and at board level.
- Learning from deaths was not always effective as the number of mortality reviews was below the trust target.

However,

- The trust had an experienced and stable leadership which was committed to provide high quality services. They had a clear vision and values.
- They recognised the training needs of managers at all levels, including themselves, and there was development opportunities for all staff across the organisation.

Summary of findings

- The trust had a clear structure for overseeing performance, quality and risk and they received information on quality and sustainability.
- There was a planned approach to take part in national audits and shared learning. It was committed to improving services by learning from when things go well and when they go wrong.

Are services safe?

Our rating of safe went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- Although the number of nursing staff working in the hospital had improved, the trust still did not have enough staff of the right qualifications, skills, and training. Staff numbers across the trust were lower than planned especially in medical care, and urgent and emergency care. Agency and bank staff were frequently used.
- Risk assessments were not always completed in line with trust policy and national guidance.
- There were times when patients were in the emergency department for long periods of time and on occasions for over 12 hours.
- Staff did not always follow best practice in relation to infection control. We observed a number of occasions when staff did not adhere to 'bare below the elbow' guidance or remove personal protective equipment before leaving patient cubicles.
- The management of medication was not always in line with trust policy. Patient's own controlled drugs were not managed safely and there were out of date medicines found in medical services.
- We were not assured that all staff across services had the appropriate level of safeguarding training to care for children who may come into the hospital.
- Although the service had suitable premises and equipment staff did not always maintain them appropriately. Resuscitation trolleys were not sealed which posed a risk of unauthorised access in some areas.

Are services effective?

Our rating of effective went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- The assessment of people's mental capacity was inconsistently assessed and was not always in line with national guidance and legislation. Staff were not always following trust policy when undertaking consent for procedures.
- Patient pathways and protocols were not always audited to monitor the effectiveness of care and treatment.
- Do not attempt cardio pulmonary resuscitation forms were not always completed fully or correctly to ensure patients received care which reflected their preferences and in line with legislation.
- There were a number of unplanned re-attendances within seven days in the emergency department which was higher than the England average. Readmission rates for medical wards were also higher than the England average.
- Sentinel Stroke National Audit Programme data showed that the division's performance had deteriorated for some aspects of stroke care.
- The trust was not meeting all the standards for seven day services.

Are services caring?

Our rating of caring stayed the same. We took into account the current ratings of services not inspected this time. We rated it as good because:

Summary of findings

- All managers and staff treated patients with compassion, dignity and respect. There were positive interactions between staff and patients.
- All patients and carers said staff did everything they could to support them and more.
- Staff involved patients in decisions about their care and treatment. Staff made sure to consider all aspects of a patient's wellbeing, including the emotional, psychological and social. This included information about support groups.

Are services responsive?

Our rating of responsive went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- People were not always able to access services in a timely way in the emergency department with services struggling to meet targets to see, treat, admit or discharge patients.
- Flow throughout the hospital was a challenge for the trust. There were patients on medical wards who experienced a number of bed moves, especially at night which were not always due to their care pathway. There were also a number of medical patients who were not on the correct speciality ward for their care. On occasions they were being cared for in surgical services.
- There were a high number of patients who were in hospital for longer than they needed to be. This was for a variety of reasons. Due to this there were a number of escalation areas opened on a regular basis as there was a high demand for beds.
- The needs of patients with sensory and cognitive impairments were not always met due to the environment on wards. Services were not always delivered in a way that focused on patient's holistic needs.
- Care plans were not always individualised and specific to the patient.
- Services for palliative or end of life care patients were not always being delivered to meet their needs, as there were times when they were being nursed on main ward areas due to the lack of appropriate space.

Are services well-led?

Our rating of well-led went down. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- Emergency services had not always followed the systems that were in place to identify risks, plan to eliminate or reduce them. Risks on the medical division risk register had been on for a long period of time which meant not all risks were being managed in a timely way. Not all risks identified on inspection were on the risk register.
- Some services had not always shown a systematic approach to continually improve the quality of its services and high standards of care. Some of the governance arrangements did not always operate effectively in medical care services.
- Staff satisfaction was mixed and some staff did not feel empowered or engaged. Some staff did not fully understand their role within strategies and ambitions of services.
- Services had not always collected, analysed, managed and used information well to support all its activities and issues being experienced. Some improvements were not always being implemented in a timely way.
- The end of life care service had no strategy in place; staff told us this was currently being devised and they were working through the end of life care work programme 2017 to 2019.

Urgent and emergency services

Summary of findings

Our overall rating of this service went down. We rated it as requires improvement because:

- The service did not always have enough staff with the right skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment and there were not always sufficient numbers of nursing staff available to keep people safe.
- Patients did not always have timely access to services. This was because the average time from arrival to treatment was greater than 60 minutes on all but one occasion between April 2016 and March 2017. In addition, the service had consistently struggled to meet the four hour target to see, treat, admit or discharge patients.
- The service had a high number of patients who had spent more than 12 hours in the department.
- The service had not always followed the systems that were in place to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. This was because organisational risks were not being formally assessed at departmental level.
- A positive culture had not always been promoted across the service that supported and valued staff, creating a sense of common purpose based on shared values.

However,

- The service managed patient safety incidents well on most occasions and staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and equipment and looked after them well. The department had been modernised and met department of health standards for accident and emergency departments.
- We found that staff provided care with compassion and staff involved patients and those close to them in decisions about their care and treatment.
- The service had a strategy for what it wanted to achieve and workable plans to turn it into action.

Medical care (including older people's care)

Our overall rating of this service went down. We rated it as requires improvement because:

- There were not always adequate numbers of nursing and healthcare staff on duty to ensure patient safety and to protect patients from the risk of harm.
- There was a heavy reliance on bank and agency staff, they were being used to supplement numbers on virtually every shift on every ward.
- We found that medicines were not always managed in a safe way safely and which reduced the risk to patients and staff.
- The division did not always ensure that the capacity of a patient to consent to care and treatment had been determined. They did not apply mental capacity act principles in a way that ensured those who lacked capacity to consent to care and treatment were identified and actions taken to ensure their best interests were determined and recorded.
- Wards and department displayed patients' full names on white boards and display monitors and patient's details and the medication they were receiving was visible to others. This meant that the confidentiality of the patient was not always maintained.
- The documentation relating to 'do not attempt cardiopulmonary resuscitation' orders was incorrect in seven out of eight orders we checked. This meant that patient centred care was not always achieved as patients' wishes may not have been considered and the orders may not have been valid.

Summary of findings

- On some wards the environment posed challenges for staff and patients. The environment was also not always suitable for patients with sensory and cognitive impairments.
- The trust had significant issues with the access and flow through the medical wards and departments. This resulted in high numbers of bed moves for patients many of which were undertaken during the night.
- The use of escalation areas meant that issues with staffing and the environment impacted on patients receiving the appropriate care they required. There were high numbers of delayed discharges and high numbers of medically fit patients occupying beds on medical wards.
- The referral to treatment times for medical speciality care was mostly worse than the England averages.
- There were pockets of low morale amongst staff who spoke of feeling pressured to compromise their standards and the care delivered to patients due to reduced staffing numbers and issues with the environment in which care was provided.
- On some wards patients did not receive a timely response to requesting help and attention. On one ward there were no call bells to gain staff attention.
- We found that infection prevention and control procedures were not always followed in relation to patient under isolation precautions as doors to their rooms were frequently left open.

However,

- We found that most clinical areas were generally well maintained, free from clutter and provided a suitable environment for dealing with patients.
- In some wards and areas staff felt optimistic, passionate and proud of their work and how they cared for patients.
- The majority of patients and relatives stated they were happy with their care and that staff worked hard and were kind and caring.
- Patient outcomes in some national audits were similar to and sometimes better than England averages.
- Complaints and concerns were responded to in a timely and appropriate way.
- The division was familiar with duty of candour processes and complied with the requirements of openness and honesty with patients.

Surgery

Our overall rating of this service improved. We rated it as good because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had suitable premises and equipment. Areas were clean and tidy with cleaning schedules in place and refurbishments undertaken to maintain them.
- The service provided mandatory training in key skills to all staff. Mandatory training systems were in place and competencies were regularly reviewed and adapted to suit staff in all areas
- There was a clear process for staff explaining how to protect patients from abuse.
- All policies and procedures were regularly reviewed and up to date.
- The hospital was above the England average for referral to treatment rates. Access and flow remained challenging but staff worked to ensure it was maintained.

Summary of findings

- There was engagement with the public and with staff at all levels.
- Care was tailored for those with individual needs. Patients with learning disabilities or those living with dementia had access to special equipment. Family and carers were able to remain with them until they were anaesthetised to ease anxiety.
- Translation was accessible and information leaflets were available for patients to take home.
- Staff described managers as approachable and supportive. Staff described a positive culture.

However:

- Although the service had suitable premises and equipment staff did not always maintain them appropriately. Resuscitation trolleys were not sealed which posed a risk of unauthorised access in some areas and temperature checks of drugs fridges were not recorded every day.
- Agency and bank staff were used frequently to subsidise staffing levels on wards and in theatres.
- Not all staff in the service or the safeguarding team had the appropriate level of safeguarding training to care for children. Although the service provided mandatory training in key skills to all staff, they were not compliant in all topics such as basic life support.
- The numbers of staff who had received appraisals was low and below the trust target of 85%.
- The service was not following the trust consent policy for every surgical procedure. For some procedures consent was not taken before the day of surgery.

End of life services

Our overall rating of this service went down. We rated it as requires improvement because:

- Do not attempt cardio pulmonary resuscitation forms were not always completed fully which indicated that patients may not receive appropriate person centred care and treatment based on their needs and preferences and if there is person who is lawfully acting on the patients behalf, they may not have been involved in the process, have the relevant information and support to ensure they fully understand the choices available to them.
- The end of life care service had no strategy in place although staff told us they were currently working through a three year working programme whilst one was devised.
- Not all risks identified by staff were recorded on the local or divisional risk register and we were not assured that managers were responding to or had full oversight of quality issues and challenges for the service.
- Some nursing staff didn't feel valued or engaged with by the senior leadership team.
- The service did not regularly actively engage with and seek opinions or views of patients and their families to identify areas of service improvement.
- End of life tools that reflected National Institute for Health and Clinical Excellence guidelines were available to ward staff however these were not all embedded on wards across the trust, which meant there was a risk that patients were not receiving evidence based care and although this was recognised by the specialist palliative care team, this was not recorded on the risk register.
- The palliative care team worked with the integrated care team and delivered training to all levels of staff across the hospital. Although over 1000 members of staff had accessed some form of training since April 2016 places were limited on some courses, as these were shared with other providers.

However,

Summary of findings

- The trust had a dedicated consultant led specialist palliative care team who provided support to patients at the end of their and to staff caring for them seven days a week. Care and support was given in a respectful and compassionate way. Staff within the specialist palliative care team worked hard to support staff on the wards to ensure patients received the care and treatment they required. The specialist palliative care team was knowledgeable and competent to respond and provide care to patients.
- The specialist palliative care team worked as an integrated team with hospital and community providers to promote continuity and consistency in patient care. The team also participated in local and national groups to share information and learn from peers.
- Staff knew what incidents to report and how to report them and managers were involved in investigating incidents and shared any lessons learned.
- Staff across the service understood how to protect patients from abuse and how to assess patients' capacity to make decisions about their care. Staff had training on safeguarding, the Mental Capacity Act, and Deprivation of Liberty safeguards.
- Palliative and end of life care services was provided by dedicated, caring and compassionate staff across the hospital. We observed that care was planned and delivered in a way that took account of people's wishes.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in pharmacy at the trust.

For more information, see the Outstanding practice section in this report.

Areas for improvement

We found areas for improvement including seven breaches of legal requirements that the trust must put right. We also found 52 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of services.

Action we have taken

Due to the nature of some concerns we had we issued enforcement action to the trust. This meant the trust had to be compliant with the relevant regulation.

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in urgent and emergency services, surgery, end of life care and medical care (including older people's care) and trust wide.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

Summary of findings

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

There was outstanding practice in the pharmacy department at the trust. There was a clinical portal that had been developed by staff within the department with support of information technology colleagues. The facility streamlined the pharmacists work and allowed staff to prioritise high risk patients to ensure that critical patients were seen quickly. The clinical portal provided a range of information to the pharmacy team to enable them to effectively monitor and manage patient's medicines.

Technology within the department was in constant development, the addition of automated dispensing with the use of a robot and auto production of labels was being used to decrease the dispensing error rate.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of 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 four services: urgent and emergency services, medical care, surgery and end of life services. It also relates to trust wide.

Trust wide

- The trust must ensure that procedures and processes in place to safeguarding people in vulnerable circumstances are fully implemented. This includes implementation of the Mental Capacity Act, Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation forms.

In urgent and emergency Services

- The trust must ensure that there are sufficient numbers of staff to look after patients in the department at all times.
- The trust must ensure that there are sufficient numbers of staff with the correct training to safely care for patients at all times, particularly in regard to advanced life support for adults and children.
- The trust must ensure that clinical risk assessments are completed for all patients who need them in line with trust policy and best practice guidance.
- The trust must ensure that organisational risks are completed in line with trust policy and that all identified risks are added to the risk register so that they can be controlled as much as practicably possible.

In medical care services (including older people's care)

- The trust must ensure compliance with the Mental Capacity Act and Deprivation of Liberty safeguards and trust policy to ensure that care and treatment of service users is only provided with the consent of the relevant person or where they lack capacity to consent appropriate actions are taken and documented.

Summary of findings

- The trust must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed on duty to maintain the comfort and safety of patients.
- The trust must ensure the proper and safe management of medicines.
- The trust must ensure that 'do not attempt cardiopulmonary resuscitation' orders are accurate and complete and that standards are checked to ensure they are fit for purpose.
- The trust must ensure the privacy of the service user maintained by ensuring private information is not visible to others.
- The trust must ensure that escalation areas are suitably equipped and staffed to enable patients to be care for effectively and safely and that patients placed on these areas have been risk assessed as suitable. Together with ensuring access and flow is managed effectively.

In end of life services

- The trust must ensure that Do Not Attempt Cardio Pulmonary Resuscitation decisions are consistently documented and discussions are held and documented to reflect the preferences of the patient and their family.

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

- The trust should ensure that actions are identified to address that Board members recognised that they had work to do to improve diversity and equality across the trust and at board level.
- The trust should ensure that mortality reviews are completed in line with the trust target and learning is disseminated effectively.
- The trust should ensure that improvements are made to be compliant with all relevant National Institute for Health and Care Excellence quality standards.
- The trust should ensure that assurances from services are effective which include actions to implement learning completed in a timely way and risk identified and mitigated effectively.
- The trust should ensure there are effective processes and procedures in place to improve the flow of patients through the hospital.
- The trust should ensure that there is effective engagement with the public in all services to help improve services.
- The trust should ensure that all staff feel actively engaged and empowered.

In urgent and emergency services

- The trust should ensure that all staff have an awareness of female genital mutilation and their legal responsibility to report any incidences that are identified.
- The trust should ensure that all equipment is serviced within the agreed timescale, to reduce the risk of it being faulty.
- The trust should ensure that all staff follow best practice guidance with infection and prevention control.
- The trust should ensure that trust policy is followed for storing fluids containing potassium.
- The trust should ensure that patient records are stored securely so that patient confidentiality is maintained at all times.

Summary of findings

- The trust should consider ways in which to make sure that all records are completed correctly. This includes a correct modified early warning scale score (observation score) and a documented pain score.
- The trust should ensure that evidence based care pathways are up to date and that compliance with these are monitored.
- The trust team must ensure that all staff have an annual appraisal so that achievements and areas for development are discussed.
- The trust should ensure that patient dignity is maintained at all times, particularly at times when being transferred from an ambulance trolley to a hospital bed.
- The trust should consider the use of tamper seals on resuscitation equipment to ensure all equipment is present in the event of an emergency.
- The trust team should consider ways to make sure that all incidents are reported in line with trust policy.

In medical care services (including older people's care)

- The trust should ensure compliance with infection prevention and control isolation precautions regarding keeping doors closed unless it has been risk assessed and documented.
- The trust should ensure processes are effective for stock check of medicines so that they are completed without omissions.
- The trust should consider progress towards seven days services.
- The trust should consider enabling agency staff to undertake the administration of medication effectively.
- The trust should ensure issues of controlled drugs stock are recorded as an incident.
- The trust should ensure that all nursing and clinical documentation is completed legibly and in full according to recognised professional standards.
- The trust should ensure actions are completed to enable learning from serious incidents is embedded.
- The trust should ensure that all local and national patient outcome audit findings are monitored and reviewed to make sure compliance is measured.
- The trust should ensure that all areas comply with best practice in relation to care of persons living with dementia and sensory or cognitive impairments.
- The trust should ensure there is a positive culture and morale across services
- The trust should ensure that governance processes are effectively monitoring and reviewed to ensure risks are mitigated in a timely way.
- The trust should promote regular ward team meetings across all medical wards and departments
- The trust should ensure that do not attempt cardiopulmonary resuscitation decisions document patient preferences or best interest decisions.
- The trust should ensure that staff have the appropriate level of safeguarding children training in line with national guidance.

In surgery

- The trust should ensure that staff receive annual appraisals.

Summary of findings

- The trust should ensure hand gel dispensers are refilled when empty.
- The trust should ensure that cleaning records are completed.
- The trust should review processes for ensuring that daily checks of resuscitation trolley equipment are always completed.
- The trust should ensure daily checks of fridge temperatures (for storage of medicines and drugs at low temperatures) are always completed.
- The trust should review the accessibility of resuscitation trolleys to minimise the risk of unauthorised access.
- The trust should review the process of referring pre-operative clinic patients for further review by specialties prior to surgery.
- The trust should ensure staff are aware of the process for sourcing information leaflets in other languages if required.
- The trust should ensure that trust procedure relating to capacity planning is adhered to and in particular that surgical assessment areas are only used for surgical patients.
- The trust should ensure that trust procedure relating to consent is adhered to for all patients and particularly in relation to the following; “patients should not be listed for a procedure until they have given consent and that consent is documented”.
- The trust should review the number of observations undertaken for the World Health Organisation safer surgery checklist.
- The trust should review processes for reviewing the standard of record keeping.
- The trust should increase the Friends and Family test response rate for patients.
- The trust should review the efficacy of discharge support initiatives: Aintree to home and Aintree at home. Where issues are identified, actions should be taken to address them.
- The trust should ensure staff have the appropriate level (level three) of safeguarding training for children or increase the availability of on call staff with the appropriate level (level three) of training for children.

In end of life services

- The trust should promote, educate and support staff of all grades trust wide to use the end of life care plan for those patients at the end of their life.
- The trust should ensure that all risks and concerns relating to end of life care are recorded and monitored by the senior managers within the division of medicine.
- The trust should ensure that the end of life service has a strategy in place to determine the plans for the service.
- The trust should ensure action plans are in place following local audits, to assist in the delivery and monitoring of service improvements.
- The trust should ensure that all staff have allocated and sufficient time to perform their roles and responsibilities and have access to clinical supervision.
- The trust should consider increasing the numbers of places available to hospital staff on end of life care training and end of life care champion training.
- The trust should ensure that, where reasonably possible, side rooms are available for those patients at the end of their and that facilities for families are consistent and accessible across the wards.

Summary of findings

- The trust should increase engagement with patients and their families to identify and monitor service delivery and identify improvements.
- The trust should ensure robust arrangements are in place in monitoring all services with service level agreements in place.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- We found safeguarding procedures had not been fully implemented to protect patients in vulnerable circumstances. The trust had recognised that there was work to be done to improve safeguarding processes and procedures. However, there were improvements required to provide assurances to senior leaders whilst this work was being undertaken.
- Improvements were needed to ensure the trust was compliant with all relevant National Institute for Health and Care Excellence quality standards.
- Senior leaders needed to ensure that assurances from services were more effective which included actions to implement learning completed in a timely way.
- There were challenges for the trust in relation to a high demand for beds in the hospital. This meant there were a high number of patients who moved wards during their stay which was not part of their pathway and number of escalation areas opened due to additional capacity required. We found there was limited monitoring of these moves at trust level to improve standards.
- There was no strategy in place for end of life services to help drive and monitor performance.
- Not all risks in services identified by staff always corresponded to those reported to senior leaders. Risks that had been recorded were not always being mitigated in a timely way in all services.
- Staff satisfaction was mixed and staff did not always feel actively engaged or empowered across all services.
- Mortality reviews of deaths were not being completed in line with the trust target and the dissemination of learning from the reviews was an area that required improvement.
- There was a limited approach to obtaining the views of people who use end of life services to help improve standards of care and service delivery.
- Board members recognised that they had work to do to improve diversity and equality across the trust and at board level.

However,

- The trust had an experienced and stable leadership team with the skills and commitment to provide high-quality services. They worked well as a team. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation.

Summary of findings

- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles.
- The trust had an overall strategy which was linked to the vision and values of the trust. This had a clear five-year plan to provide high-quality care with financial stability. The trust also had underpinning strategies such as a quality strategy and finance strategy.
- Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced.
- There were processes in place to create a culture where staff were able to speak up in order to protect patient safety.
- The trust had in place structures, systems and processes to support the delivery of its strategy which included sub-board committees and team meetings.
- The trust had a clear structure for overseeing performance, quality and risk. This gave them greater oversight of issues facing the service. Senior leaders were able to describe how risks and concerns were escalated.
- The board received holistic information on quality and sustainability. They received information and data about the services and divisional leads could challenge the information.
- The trust recognised the risks created by the potential for data security breaches and had put processes in place to mitigate these risks.
- Communication systems were in place to ensure staff, patient and carers had access to up to date information about the work of the trust and the services they used.
- The trust was actively working collaboratively with external partners and worked with staff to gather feedback on issues or concerns.
- The leadership team worked well with the clinical leads and encouraged divisions to share learning across the trust.
- The trust had a planned approach to take part in national audits and shared learning. It was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Ratings tables

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 ↓ Feb 2018	Requires improvement ↓ Feb 2018	Good →← Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement Feb 2018	Requires improvement ↓ Feb 2018

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
Urgent and emergency services	Requires improvement ↓ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018
Medical care (including older people's care)	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2017	Good ↔ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018
Surgery	Good ↑ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018
End of life care	Good ↔ Feb 2018	Requires improvement ↓ Feb 2017	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018
Critical Care	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Outpatient and diagnostics	Good May 2014	N/A	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Overall trust	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2017	Good ↔ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018

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.

University Hospital Aintree

Longmoor Lane
Fazakerley
Liverpool
Merseyside
L9 7AL
Tel: 01515255980
www.aintreehospitals.nhs.uk

Key facts and figures

Aintree Hospital is a large teaching hospital in Liverpool. There are 706 inpatient beds, serving a population of around 350,000 in North Liverpool, South Sefton and Kirkby. The hospital provides care and treatment for people living in some of the most deprived areas in England.

The hospital provides a full range of acute services which include:

- Acute medicine
- Accident and emergency
- Acute frailty unit
- Surgical services.

In addition to these services, the trust provides specialist services for Merseyside, Cheshire, South Lancashire, and North Wales. These specialist services include:

- Major trauma
- Complex obesity
- Head and neck surgery
- Upper gastrointestinal cancer
- Hepatobiliary
- Endocrine services
- Respiratory medicine
- Rheumatology
- Ophthalmology
- Alcohol services

The hospital is one of the largest employers locally with more than 4,800 whole time equivalent staff across the trust.

Summary of findings

During this inspection we visited surgical wards, medical wards, theatres and the emergency department. We spoke with patients and their relatives. We also spoke with 135 members of staff including senior managers, the specialist palliative care team, doctors, nurses, porters, chaplain, medical device staff, therapy staff and pharmacy staff. We also spoke to a number of staff in the accident and emergency department. We also spoke with 42 patients and relatives.

We observed care and treatment and looked at 64 care records of patients. We received comments from focus groups and we reviewed the hospital's performance data.

Summary of services at University Hospital Aintree

Requires improvement ● ↓

Our rating of services went down. We rated it them as requires improvement.

A summary of services at this hospital appears in the overall summary above.

Urgent and emergency services

Requires improvement ● ↓

Key facts and figures

The emergency department is a busy department that serves the above population for minor injuries, medical and surgical emergencies and major trauma. The emergency department moved into new bespoke accommodation in the summer of 2015. The department has 48 treatment areas and employs 180 staff. The department has easy access to other hospital departments such as critical care, radiology and emergency theatres.

The department sees on average 448 patients a day.

We visited all areas of the emergency department including the triage area, the majors and resuscitation areas, see and treat, minor injuries as well the observation ward.

We spoke to staff of different grades, including nurses, doctors as well as members of the management team from both the department and the medicine division. We also spoke to staff from other areas of the hospital that had regular contact with the emergency department.

We reviewed 10 sets of patient records, including prescription charts and reviewed information that was provided by the trust before and after the inspection. We also spoke to 15 patients and relatives about their experience and observed care and treatment being delivered.

Summary of this service

A summary of our findings about this service appears in the Overall summary

Is the service safe?

Requires improvement ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- The service did not always have enough staff with the right skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. This was because the department did not always provide a member of staff who had completed or was up to date with advanced life support training for adults and children.
- There were not always sufficient numbers of nursing staff available to keep people safe. The department had not achieved the planned nursing establishment on several occasions and there had been a number of 'red flag' staffing incidents reported.
- The service did not always keep appropriate records of patients' care and treatment. This was because some patient risk assessments were not being completed in line with trust policy and national guidance.
- Patients did not always have timely access to services. This was because the average time from arrival to treatment was greater than 60 minutes on all but one occasion between April 2016 and March 2017. The longest average waiting time was 93 minutes in July 2016. It was not always clear if patients had received a full triage in line with national guidance within 15 minutes of attending the department.

Urgent and emergency services

- The service did not always follow best practice to control infection risks. We observed a number of occasions when staff did not, adhere to 'bare below the elbow' guidance or remove personal protective equipment before leaving patient cubicles
- The service did not use monitoring results well. The department did not submit data as part of the safety thermometer requirements and did not display information about the number of safety incidents that had occurred for staff or members of the public to see.

However,

- The service managed patient safety incidents well on most occasions. Serious incidents were investigated following NHS England guidance and actions were documented so that improvements could be made.
- The service had suitable premises and equipment and looked after them well. The department had been modernised and met department of health standards for accident and emergency departments.
- The service prescribed, gave, recorded and stored medicines well. This included the storage and recording of controlled drugs.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service provided mandatory training in key skills to all staff and in most cases made sure that everyone completed it.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance. A number of care pathways and protocols had been developed to support staff when providing patient care.
- The service made sure staff were competent for their roles. The trust had introduced a new induction programme which allowed all new staff to complete their mandatory training and have two weeks where they were not included in the staffing numbers.
- Staff of different kinds worked together as a team to benefit patients. We saw some positive examples of collaborative working with staff from other departments and organisations.
- Staff gave patients enough food and drink during the time that they spent in the department.
- Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support those who lacked the capacity to make decisions about their care.

However,

- The service did not always monitor the effectiveness of care and treatment. This was because compliance with patient pathways and protocols was not routinely measured outside of data that was submitted to the Royal College of Emergency Medicine for benchmarking in national audits.
- Appraisal rates for staff working in the department to discuss their achievements and their developments were below the trust target and staff informed us that they were difficult to undertake due to demands in the department.

Urgent and emergency services

- Records indicated that the number of unplanned re-attendances within seven days was consistently higher than the England average.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- We found that staff provided care with compassion. We observed positive interactions between staff and patients and that patient's privacy and dignity was maintained on most occasions.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress. We saw examples of staff taking time to reassure patients despite the department being busy.

Is the service responsive?

Requires improvement  

Our rating of responsive went down. We rated it as requires improvement because:

- People were not always able to access the service when they needed it. The service had consistently been unable to meet the four hour target to see, treat, admit or discharge patients.
- There had been a deterioration in the number of patients leaving the department without being seen for treatment.
- The service also had a high number of patients who had spent more than 12 hours in the department. This happened on a daily basis.

However,

- The trust planned and provided services in a way that met the needs of the local people. The department had been recently modernised to meet the needs of people who used the service.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Requires improvement  

Our rating of well-led went down. We rated it as requires improvement because:

- The service had not always followed the systems that were in place to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. This was because organisational risks were not being formally assessed at departmental level.
- The service had not always shown a systematic approach to continually improve the quality of its services and high standards of care.

Urgent and emergency services

- Managers across the service had not always promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However:

- The service had a strategy for what it wanted to achieve and workable plans to turn it into action. This was because the service had an improvement plan that had been developed in conjunction with different departments within the hospital as well as external organisations.
- The service was committed to improving services by learning from when things go well and when they go wrong.
- The service had managers at different levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service engaged well with local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section

Medical care (including older people's care)

Requires improvement  

Key facts and figures

The medical care service at Aintree University Hospital has 383 inpatient beds.

The hospital had 51,596 medical admissions between 1 April 2016 and 31 March 2017. Emergency admissions accounted for 22,522 (43.7 %), 1,882 (3.6%) were elective, and the remaining 27,192 (52.7%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology
- General Medicine
- Cardiology

Medical services are managed by the 'medicine division' at Aintree hospital. These are divided into smaller clinical business units such as cardiology, nephrology, acute and emergency medicine, respiratory and diabetes. There are various wards and specialist services within the division including stroke services (including 2 hyper acute stroke beds), cardiology, respiratory, endocrinology, nephrology, gastroenterology, general medicine, endoscopy and the care of older persons. They also managed the urgent and emergency care services provided at the accident and emergency department but this is reported in a separate core service report.

The Care Quality Commission carried out a comprehensive inspection between 3 and 6 October 2017. During this inspection we visited wards 8 and 9 (cardiology), ward 11 (gastroenterology), ward 14 (discharge lounge) ward 15 (nephrology), wards 21 (endocrinology) ward 22 and 23 (respiratory), wards 30 and 32 (care of older persons), ward 31 (Aintree 2 home), ward 33 (stroke unit), the endoscopy suite, acute medical unit, emergency ambulatory care unit and the frailty assessment unit.

We spoke to 19 patients and relatives. We also spoke with 65 members of staff including senior managers, specialist nurses, registered nurses, student nurses, health care assistants, consultants, middle grade doctors, junior doctors, medical students, allied health professionals including physiotherapists, occupational therapists, dieticians, pharmacists, domestics, ward clerks, housekeepers and nursing agency staff.

We observed care and treatment and looked at 20 patient care records. We reviewed comments from staff focus groups and we looked at the service performance data.

Summary of this service

Our rating of this service went down. We rated it as requires improvement. A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Requires improvement  

Our rating of safe went down. We rated it as requires improvement because:

Medical care (including older people's care)

- Nurse staffing was a challenge for the service and there were times when there were not enough nurses on duty on the wards. The actual nurse staff levels on wards were often lower than planned. This was because there was not always enough nurses to fill the established staffing levels.
- Staff were often moved to other areas or allocated to care for patients with increased needs. There had been high numbers of 'red flag' incidents of staffing concerns. Agency and bank staff were used frequently to supplement staffing levels on medical wards.
- Agency staff were not always able to undertake a full range of duties. Agency nurses did not have access to the electronic prescribing system and agency care assistants were not permitted to take the observations of patients. This placed extra duties on trust staff who had to make up the shortfall.
- 'Patients own' controlled drugs were not managed safely. There was no effective process to identify which medication belonged to which patient and how many controlled drugs were held in the cabinet. There was no effective system to prevent or identify unauthorised access to these drugs.
- There was no effective system in place to identify the safe disposal of controlled ward stock drugs where less than a complete vial was prescribed and administered.
- There were out of date medicines found on acute cardiac care unit and the frailty assessment unit.
- The storage and availability of thickening powders were not being risk assessed to ensure there was no risk to patient (NPSA Alert 2015).
- Staff who cared for 16 and 17 year olds were not always trained in level 3 safeguarding children as outlined in national guidance.
- We saw several incidents where best practice was not followed in relation to isolation precautions for patients with infections.

However,

- Wards appeared clean and tidy and generally fit for purpose.
- Equipment was maintained and serviced in way that ensured they were in good order and available for use.
- Risk assessments were completed and reviewed appropriately these included risk for nutrition and hydration, venous thromboembolism and falls.
- There were processes in place to mitigate risks to patients identified to be at risk of deterioration. There was an effective system in place for identification and escalation. Mandatory training and safeguarding training completion rates were in line with trust targets.
- Sepsis pathways had been implemented which were reported to have brought about improvements in sepsis identification and treatment.
- Records with the exception of 'do not attempt cardio pulmonary resuscitation' orders were found to be satisfactory.
- Staff knew what incidents to report and how to report them. When things went wrong patients received an apology and were given information about changes the service made to prevent the same thing happening.
- The medical division had no 'never events' during the reporting period.
- Safety thermometer data was recorded, displayed and used to drive improvements in quality across the division.

Medical care (including older people's care)

Is the service effective?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- The division did not always ensure that the capacity of a patient to consent to care and treatment had been assessed and documented in line with the Mental Capacity Act 2005. This in turn led to a failure to undertake best interest decision around patients' care and treatment and a failure to gain appropriate deprivation of liberty authorisations as appropriate.
- The relative risks of readmission for medical wards at the hospital were mostly higher than England averages and below quality indicator standards. Sentinel Stroke National Audit Programme data showed that the division's performance had deteriorated for some aspects of stroke care.
- The division had some work to do to enable them to provide a full range of seven days services.

However,

- On the whole, staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Managers monitored the effectiveness of care and treatment through continuous local and national audits.
- The division ensured the nutrition and hydration needs of patients were assessed and where required they received specialist input and advice.
- Pain was effectively assessed and patients reported their pain was managed effectively.
- Heart failure audit results showed the division performed better than England average results.
- Staff received a package of support including competencies and a preceptorship programme, which was flexible according to their previous experience and training.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion, treating them with dignity and respect.
- The majority of patients were happy with the care and treatment they received on the medical care wards and departments at the hospital
- Patients and relatives felt that staff were kind and caring and demonstrated empathy and understanding.
- We saw positive and respectful interactions between patients and staff.
- Patients felt included and involved in decisions about their care and treatment plans.

However,

- Patients were being encouraged to use the commode rather than the bathroom due to issues with the environment on the Aintree 2 home ward.

Medical care (including older people's care)

- Patient's confidential information was not always protected and their personal information and medications could be seen by other patients and visitors in the ward areas.

Is the service responsive?

Requires improvement ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- Out of hours bed moves were high, a large number of these took place on medical wards at night between the hours of 10.00pm and 8.00am. These were not always due to the patient care pathway.
- Due to the high number of patients ready for discharge who could not be discharged for a number of reasons, there were a number of escalation areas opened on a regular basis as there was a high demand for beds. These were often opened at short notice and access and flow throughout the medical division remained a challenge. Medical patients at the hospital had a higher risk of readmission than the average patient across NHS hospital in England.
- The needs of patients with sensory and cognitive impairments was not always met due to the environment on wards and because their needs were not always identified.
- Care plans were not always individualised and specific to the patient.

However,

- Referral to treatment times within the division were similar to the England average that was 92% of patients were seen within 18 weeks.
- Managers planned and provided services in a way that met the needs of local people. They were flexible and made changes to improve services and support patients more effectively.
- The division dealt responded to complaints within appropriate timescales. Complaints were addressed in an appropriate manner, investigated in sufficient detail and we saw evidence of learning and changes based on complaints.

Is the service well-led?

Requires improvement ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Staff satisfaction was mixed and staff did not always feel empowered. There were areas of low morale and disillusionment across the division.
- Although senior leaders in the division were sighted on the issues they faced, there appeared to be delays in the pace of change in achieving improvements. The division lacked sustainable solutions to deal with the issues they were experiencing.
- Whilst there was a strategy in place, this was not aligned to key challenges the service was facing for example how the issues with access and flow might be addressed. Staff did not fully understand their role within the strategy and the ambitions of the division.
- The division risk register had items that had remained on the register for long periods of time and risks were not always being managed in a timely way.

Medical care (including older people's care)

- Not all teams had regular formalised team meetings due to the operational demands of the ward areas and ward managers time was often taken up with filling in for reduced staffing numbers in clinical areas.

However,

- There were engagement strategies in place within the medicine division.
- There was good access to information, to drive quality improvement and for managers to be sighted on emerging and continuing issues within the division. Managers monitored performance and used the results to help improve care.
- Managers supported their staff and encouraged training.
- The division had good results in relation to clinical trial participation.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section

Surgery

Good   

Key facts and figures

Surgery services at Aintree Hospital consist of four main theatre suites; Main A (which has seven theatres), Main B (which has five theatres), the elective care centre (day case which has four theatres and two treatment rooms) and accident and emergency department (which has three theatres). Each suite has a recovery area.

There are five general surgical wards and other specialist wards (for urology, trauma, head and neck and orthopaedic patients) for patients to await or recover following surgery. There is also a private patient suite which at the time of our inspection was caring for NHS surgical patients.

The trust had 30,879 surgical admissions between February 2016 and January. Emergency admissions accounted for 10,522 (34%), 14,679 (48%) were day case admissions, and the remaining 5678 (18%) were elective.

(Source: CQC Insight)

During the inspection we reviewed 15 patient records and spoke with 45 members of staff. We also spoke with three patients. We visited six theatres, five wards, the pre-operative clinic and waiting areas.

Summary of this service

Our rating of this service stayed the same. We rated it as good. A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The service managed patient safety incidents and used well safety monitoring results well. Staff shared learning with colleagues and used information to improve the service.
- The service controlled infection risk well.
- The service provided mandatory training in key skills to staff who reached the trust target of 85% compliance in some topics including health and safety, information governance, equality and diversity, infection control, patient consent and mental capacity.
- Risks were identified through clinical assessments undertaken before during and after surgery.

However,

- Although the service had suitable premises and equipment staff did not always maintain them appropriately. Resuscitation trolleys were not sealed which posed a risk of unauthorised access and temperature checks of drugs fridges were not recorded every day.
- Although the service provided mandatory training in key skills to all staff, they were not compliant in all topics such as basic life support.

Surgery

- The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Instead they used bank and agency staff to support numbers.
- Not all staff had the appropriate level of training on how to recognise and report abuse.

Is the service effective?

Good ● → ←

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance by bodies including the National Institute for Health and Care Excellence and the Royal College of Surgeons.
- Local policies were regularly reviewed and supported staff delivering care.
- Pain was appropriately managed. Patients had adequate nutrition and drink to meet their needs and staff made adjustments for patients' religious, cultural and other preferences.
- The service monitored the effectiveness of care and treatment and used the findings to make improvements. They contributed to national audits, and performed in line with other trusts nationally in many of them.
- The service made sure staff were competent for their roles and staff from different professions worked together as a team to benefit patients.
- Staff told us they had access to the information they required to care for patients and understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

However,

- Appraisal rates were below the trust target of 85%.
- The service was not following its consent procedure for every procedure. For some procedures consent was not taken before the day of surgery.

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.
- The trust used the Friends and Family test. The average percentage of patients who would recommend services to friends or family was 82.6%.

Surgery

Is the service responsive?

Good  → ←

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. Services ranged from frailty to major trauma care.
- The service took account of patients' individual needs. Patients living with dementia, those with complex needs or those whose first language was not English were all cared for in a way that was tailored to suit these needs.
- Managers and staff worked to maintain flow with theatre lists regularly reviewed and discharge planning commencing at the time of admission.
- Patients were prioritised based on clinical need, particularly emergency surgery patients.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However,

- Outlier patients were often cared for in the surgical assessment unit which was not in accordance with trust policy.

Is the service well-led?

Good  → ←

Our rating of well-led stayed the same. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Staff were positive about these managers and most of them felt respected and valued and supported in their roles.
- An effective governance framework provided clear monitoring of quality and service delivery. Policies were up to date and regularly reviewed.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- Risks, issues and performance were managed appropriately using risk registers and monthly risk and departmental meetings

Surgery

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section.

End of life care

Requires improvement  

Key facts and figures

End of life care is provided on the wards across the hospital and was everyone's responsibility. The specialist palliative care team supports patients and staff, reviewing patients and giving advice for example with symptoms such as pain control, sickness and poor appetite.

The specialist palliative care team at the trust was led by a consultant in palliative care and consists of seven whole time equivalent clinical nurse specialists, one end of life care project lead and a 0.6 whole time equivalent education / advanced care planning lead, 1.2 consultants and 1.0 speciality registrar.

The specialist palliative care team provide a 9am to 5pm service seven days a week and medical advice and support was available 24 hours via a telephone line.

The trust reported 1639 deaths between 1 April 2016 and 31 March 2017.

The specialist palliative care team received 557 referrals between July 2016 and June 2017 and 97% of these patients were seen within 24 hours.

During this inspection we visited ward 11 (gastroenterology), ward 16 (surgery), ward 22 (thoracic), ward 30 (elderly medicine), Sefton Suite (surgery), the mortuary, the chapel and multifaith room.

We spoke with three patients and two relatives. We also spoke with 25 members of staff, including senior managers, the specialist palliative care team, doctors, nurses, porters, chaplain and medical device staff.

We observed care and treatment and looked at 14 care records of patients that were either palliative or receiving end of life care. We reviewed 11 do not attempt cardio pulmonary resuscitation forms. We received comments from our focus groups and we reviewed the hospital's performance data.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- Staff knew what incidents to report and could demonstrate how to use the electronic reporting system.
- Staff recorded patient care consistently. The records showed that patients were reviewed regularly by the specialist palliative care team.
- Medicines were provided in line with national guidance. We saw good practice in prescribing anticipatory medicines for patients who were at the end of life.
- Lockable syringe drivers were well maintained and available to nursing and medical staff at all times.
- The department was meeting the trust's target for staff completing mandatory training in all but one module.

End of life care

- There was a tag on the electronic system, which informed staff that the patient was known to specialist palliative care team on admission and the service had recently implemented a triage system to enable staff across the trust to contact the specialist palliative care team for timely telephone advice or referral.

However,

- There was no formal process for escalating relevant incidents from the wards to the specialist palliative care team; however, they proactively reviewed all incidents to monitor themes and trends.
- There was a consultant and nurse vacancy for the service. Consultants currently worked one in every three weekends and this was on the risk register.

Is the service effective?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- Do not attempt cardio pulmonary resuscitation forms were not always completed fully which indicated that patients may not have received person-centred care which reflected their preferences and decisions may not have been in line with national legislation. .
- Not all end of life tools were embedded across the hospital which meant there was a risk that end of life care and treatment was not always based on national guidance. Action plans were in place to improve and audit uptake.
- Managers did not always monitor the effectiveness of care and treatment through continuous local audits.
- The specialist palliative care nurses had not received clinical supervision recently although we were told this was being addressed. End of life care training was not mandatory and although over 1000 members of staff had accessed some form of training since April 2016, places were restricted on some courses, as they were shared with other providers. Not all staff we spoke with had accessed end of life care training.

However,

- Patients nutritional and hydration needs were met and monitored effectively.
- The specialist palliative care team were competent and worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide end of life care.
- New staff received induction included training in end of life care and nursing staff were supported through revalidation.
- The specialist palliative care team were available seven days a week, with on call support and advice via a telephone available out of hours.
- Patients received pain relief in a timely manner however pain scores and the review of pain following administration of pain relief was not always documented.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

End of life care

- Staff cared for patients with compassion, treating them with dignity and respect and we observed this during our inspection.
- Patients, families and carers gave positive feedback about their care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service provided emotional support to patients, information about support groups, and supported spiritual needs through a multi-faith chaplaincy.

Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- Managers planned and provided services in a way that met the needs of local people. They were flexible and made changes to improve services and support patients more effectively.
- The team were visible and all staff we spoke with knew how to access them and said they were responsive. Recent data showed 97 % patients of patients referred to the SPCT were seen within 24 hours of referral.
- The specialist palliative care team had good working relationships with hospital staff and their community colleagues. This ensured that care and treatment was coordinated with other services and providers.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However,

- There was no specific ward for palliative or end of life care patients and side rooms were not always available, which resulted in patients at the end of their life being nursed on main ward areas.
- Arrangements for families who wished to stay overnight with patients was variable across the wards. Adequate sleeping arrangements were not always available.

Is the service well-led?

Requires improvement  

Our rating of well-led went down. We rated it as requires improvement because:

- The end of life care service had no strategy in place although staff told us they were currently working through a three year working programme whilst one was devised.
- End of life care risk register was in place but not all risks staff identified were recorded on the local or divisional risk register, which did not give us assurance that senior managers at divisional level had full oversight of risks or that risks were being monitored effectively.
- The service had a clear management structure at departmental level. However we were not assured that senior managers within the division knew about or were responding to quality issues, priorities and challenges.
- Some nursing staff didn't feel valued or engaged with by the executive team following changes with their immediate line management.

End of life care

- The service did not regularly actively engage with and seek opinions or views of patients and their families to identify areas of service improvement.

However

- The hospital had non-executive board representatives for end of life care, who provided representation and accountability for end of life care at board level.
- Staff and the majority managers within the end of life service were clear about the challenges the service faced. They could explain the risks to the department and the plans to deal with them.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to within their team.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Our inspection team

Nicholas Smith, Head of Hospital Inspection and a lead Inspection Manager led this inspection. An executive reviewer supported our inspection of well-led for the trust overall.

The team included two further inspection managers, nine inspectors, one assistant inspector, ten specialist advisers, and an expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.