Liverpool University Hospitals NHS Foundation Trust

University Hospital Aintree

Inspection report

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

Date of inspection visit: 22, 23, 31 March 2022
Date of publication: 22/07/2022

Ratings

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

Our findings

Overall summary of services at University Hospital Aintree

Inspected but not rated

We carried out this unannounced focused inspection under our pressures resilience five (PR5) focused inspection guidance.

We took into account nationally available performance data and concerns we had received about the safety and quality of the services. We inspected against the safe, responsive and well-led key questions. We inspected key lines of enquiry relevant to the pressures resilience five programme. We also inspected the trusts response to conditions imposed on their registration following our last inspection.

We inspected the urgent and emergency services and medical care core services during this inspection.

We did not inspect surgery because the services had not had time to make the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

Urgent and emergency services and medical care services at University Hospital Aintree are provided by Liverpool University Hospitals NHS Foundation Trust. The trust was created on 01 October 2019 following a process of acquisition, in which Aintree University Hospital NHS Foundation Trust acquired Royal Liverpool and Broadgreen Hospital NHS Trust.

We visited University Hospital Aintree as part of our unannounced inspection from 22 March to 31 March which included the emergency department, acute medical assessment unit and the discharge lounge . Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

A summary of CQC findings on urgent and emergency care services in Cheshire and Merseyside (Liverpool, Knowsley and South Sefton).

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Liverpool, Knowsley and South Sefton within the Cheshire and Merseyside ICS below: Cheshire and Merseyside (Liverpool, Knowsley and South Sefton)Provision of urgent and emergency care in Cheshire and Merseyside was supported by services, stakeholders, commissioners and the local authority. We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff had continued to work hard under sustained pressure across health and social care services.

Services had put systems in place to support staff with their wellbeing, recognising the pressure they continued to work under, in particular for front line ambulance crews and 111 call handlers. Staff and patients across primary care reported a preference for face to face appointments. Some people reported difficulties when trying to see their GP and preferred not to have telephone appointments. They told us that due to difficulties in making appointments, particularly face to face, they preferred to access urgent care services or go to their nearest Emergency Department. However, appointment availability in Cheshire and Merseyside was in line with national averages.

Our findings

We identified capacity in extended hours GP services which wasn't being utilised and could be used to reduce the pressure on other services. People and staff also told us of a significant shortage of dental provision, especially for urgent treatment, which resulted in people attending Emergency Departments. Urgent care services, including walk-in centres were very busy and services struggled to assess people in a timely way. Some people using these services told us they accessed these services as they couldn't get a same day, face to face GP appointment. We found some services went into escalation. Whilst system partners met with providers to understand service pressures, we did not always see appropriate action taken to alleviate pressure on services already over capacity.

The NHS 111 service, which covered all of the North West area including Cheshire and Merseyside, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high, and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services. However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service.

Following initial assessment and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours (OOH) provider. We found some telephone consultation processes were duplicated and could be streamlined. At peak times, people were waiting 24-48 hours for a call back from the clinical assessment and out of hours services. We identified an opportunity to increase the skill mix in clinicians for both the NHS 111 and the clinical assessment service. For example, pharmacists could support people who need advice on medicines. Following our inspections, out of hours and NHS 111 providers have actively engaged and worked collaboratively to find ways of improving people's experience by providing enhanced triage and signposting. People who called 999 for an ambulance experienced significant delays.

Whilst ambulance crews experienced some long handover delays at the Emergency Departments we inspected, data indicated these departments were performing better than the England average for handovers, although significantly below the national targets. However, crews found it challenging managing different handover arrangements at different hospitals and reported long delays. Service leaders were working with system partners to identify ways of improving performance and to ensure people could access appropriate care in a timely way. For example, the service worked with mental health services to signpost people directly to receive the right care, as quickly as possible.

The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure. We saw significant levels of demand on emergency departments which, exacerbated by staffing issues, resulted in long delays for patients. People attending these departments reported being signposted by other services, a lack of confidence in GP telephone appointments and a shortage of dental appointments. We inspected some mental health services in Emergency Departments which worked well with system partners to meet people's needs. We found there was poor patient flow across acute services into community and social care services. Discharge planning should be improved to ensure people are discharged in a timely way. Staff working in care homes (services inspected were located in Liverpool and South Sefton)reported poor communication about discharge arrangements which impacted on their ability to meet people's needs.

The provision of primary care to social care, including GP and dental services, should be improved to support people to stay in their own homes. Training was being rolled out to support care home staff in managing deteriorating patients to avoid the need to access emergency services. We found some examples of effective community nursing services, but these were not consistently embedded across social care. Staffing across social care services remains a significant challenge and we found a high use of agency staff. For example, in one nursing home, concerns about staff

Our findings

competencies and training impacted on the service's ability to accept and provide care for people who had increased needs. We found some care homes felt pressure to admit people from hospital. Ongoing engagement between healthcare leaders and Local Authorities would be beneficial to improve transfers of care between hospitals and social care services.

In addition, increased collaborative working is needed between service leaders. We found senior leaders from different services sometimes only communicated during times of escalation.

Urgent and emergency services

Inspected but not rated

We visited University Hospital Aintree as part of our unannounced inspection from 22 March to 31 March which included the emergency department. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

The urgent and emergency care services at University Hospital Aintree form part of the medicine division. Emergency care is provided 24 hours a day, seven days per week and primarily serves the population of Liverpool and the wider Merseyside area. The service is not a designated children's hospital but any child patients attending the department are signposted or stabilised and transferred to a neighbouring NHS children's trust.

At the last inspection in June 2021, the emergency department at University Hospital Aintree was rated Inadequate. We placed conditions on the trust's registration to improve practice.

As part of this inspection, we observed care and treatment of patients in triage and treatment areas including those receiving care on a main corridor within the department. We looked at 24 care records. We spoke to five patients. We also spoke with 12 staff members across the department including staff nurses, senior nurses, a pharmacist, consultants, health care assistants, matrons, service managers, and members of the executive team.

- 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 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.
- There had been no significant improvement in safety and performance since the last inspection. Staff did not always feel respected, supported and valued by the wider hospital and senior managers. Leaders did not always operate effective governance processes, throughout the service 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.

However:

- Staff worked flexibly under extreme pressures to provide compassionate care. 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.
- 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.

Urgent and emergency services

Is the service safe?

Inspected but not rated

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.

The mandatory training programme was comprehensive and if completed met the needs of patients and staff. During our last inspection we identified Nursing and medical staff did not keep up-to-date with their mandatory training. At the time of this inspection, mandatory training compliance for staff in urgent and emergency care across the trust had improved to 83% for nursing staff and 78% for medical staff. However, some elements of the programme were not compliant with trust targets. For example, as of 29 March 2022 55% of staff in the department had completed resuscitation training at level two or three, and 62% had completed paediatric basic life support.

Staff compliance within the department for role-specific training ranged between 20% for Advanced paediatric life support and 94% for Dementia level 1. The failure to maintain compliance with trust targets for the completion of mandatory and role-specific training exposed patients to the risk of receiving unsafe care and treatment.

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 two for adults and children was above 87%. However, compliance for level three safeguarding for adults was 57% and level three safeguarding for children was 40%. This represented a decline in compliance since the last inspection.

Staff described how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act and provided examples of how they had acted when required to do so.

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. Information to improve patient safety was recorded and shared as part of the safeguarding review process. Safeguarding information was displayed on notice boards throughout the emergency department.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Equipment and the premises were visibly clean.

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. At our last inspection we were told plans had been approved to expand the waiting room and increase seating capacity. The planned expansion had not been completed.

Urgent and emergency services

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. However, the department did not operate effective systems to isolate patients with suspected COVID-19 in the waiting area. Patients were tested for COVID-19 if they displayed symptoms or suspected they had contracted the virus, but staff told us they remained in the waiting area for up to one hour while they waited for their results.

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Domestic staff could be called to complete additional cleaning as required.

At our last inspection we saw staff did not label equipment to show when it had been cleaned. At this inspection we found, staff cleaned equipment after patient contact, however they did not routinely use labels to show when this was completed.

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. Patients also received care and treatment in this area while waiting to be moved to one of the treatment or observation rooms. We saw up to 21 patients on trolleys in the ambulance corridor. Staff told us this number was sometimes higher. When the number of patients meant staff could no longer maintain a line of sight along the corridor, ambulance staff were required to wait with their patients until a suitable space had been identified. On the 30 March 2022 we saw six ambulance crew members providing care and treatment to three patients on the corridor.

The service had enough equipment to help them to safely care for patients. We looked at ten pieces of equipment and records for a further 167 and found these were predominantly in date for servicing and maintenance. There were 15 pieces of equipment identified as out of date for servicing and maintenance. The risk this posed was assessed and monitored until the necessary checks had been completed.

At our last inspection, staff did not always carry out safety checks of specialist equipment. As part of this inspection we completed spot checks on four resuscitation trolleys. Records indicated the majority of checks had been completed as required.

At our last inspection we saw sluice rooms across the department were unlocked. While practice in this area had improved, we saw sluice rooms unlocked on two of the three days of the inspection. We saw items which were subject to the Control of Substances Hazardous to Health (COSHH) regulations, for example cleaning solution, which were not in a locked cupboard in one of the sluice rooms.

The mental health room in the department was ligature free. There were no blind spots and there was a separate adjacent room with a viewing panel. However, some furniture in the room was unsafe because it could be easily lifted and used in an assault. Posters in the room were laminated and could potentially be used to cause injury. Staff and patients had access to an emergency alarm system, but the alarm was routed directly to the security office and could not be heard by staff nearby.

Urgent and emergency services

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.

At the last inspection we found patients experienced delays in treatment. We imposed conditions on the trust's registration to improve practice. As part of this inspection we reviewed the care records of 18 patients and observed practice in the department over three days. Ten of the 18 records we looked at showed significant delays in care and treatment. For example, the time taken from patients arriving at the department to being triaged varied from 15 minutes to 90 minutes. Patients also experienced delays in observations and the administration of medicines.

The Royal College of Emergency Medicine (RCEM) guidance on the initial assessment of emergency patients (2017) states the assessment should be carried out by a clinician within 15 minutes of arrival. The data for March 2022 showed performance of 71% against a trust target of 85%.

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 performance for patients receiving a clinical review within 60 minutes was consistently below the national average between January and March 2022. The data for March 2022 showed performance of 29% against a trust target of 50%.

Nursing staff triaged patients from the waiting room and the ambulance assessment area. At the last inspection we saw 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. During this inspection we saw the same arrangement in place. Observations of patients in the waiting area were limited because the department regularly exceeded its maximum capacity and was consistently understaffed. This placed patients at risk if their condition deteriorated before they were triaged.

At the last inspection 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. During this inspection, we saw a secondary triage nurse deployed on one occasion even though the department exceeded capacity on each of the three days. Some staff told us it was not usual to have a second nurse allocated to triage.

At the last inspection we saw a deterioration in ambulance handover times within the department at Aintree. At this inspection we saw there had been some improvement. However, in March 2022, handovers took in excess of 60 minutes on 119 occasions out of 7,363 attendances against a target of zero. By comparison, the trusts other accident and emergency department reported 60 occasions from 8,926 attendances.

At our last inspection we saw staff used a national early warning scoring (NEWS2) to identify deteriorating patients but did not always escalate them appropriately. The records we saw during this inspection showed NEWS2 had been completed in accordance with recommendation and concerns had been escalated correctly.

At our last inspection we saw patient risk assessments were not always completed in line with guidance. Of the 21 risk assessments we checked during this inspection, 17 had been completed. This placed patients at avoidable risk of harm which was increased by their prolonged waits on trolleys within the department.

Urgent and emergency services

The service implemented a new electronic patient records system in May 2021. At our last inspection staff told us this had hindered the triage system resulting in longer patient waits and ineffective patient pathways. Staff reported the same concerns during this inspection. We saw patient' records were stored in three different electronic systems which required separate log-ins. Staff had resorted to the use of paper records which were later uploaded or scanned to the electronic record. This meant staff did not always have easy access to all the information regarding patient risk.

Nurse staffing

The service did not always have enough nursing and support staff. 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.

The department planned for a maximum of 85 patients at any one time. Planned nurse staffing levels reflected this figure and included additional nurse staffing on two shifts each day as a contingency to cover the busiest periods. The number of patients in the department regularly exceeded the maximum planned number and on one occasion during the inspection staff reported 135 patients in the department. In week commencing 21 March 2022 the department achieved its planned nurse staffing on three out of 21 shifts. The average nurse deployment across the week was 84.3% of the planned figure. On 26 April 2022 this average fell to 72.3%. In addition, we saw there was a delay between shortfalls in staffing being identified and nurses being on shift to provide cover. This meant patients regularly experienced delays in assessment and were exposed to risk of harm.

There were 14 vacancies for nursing staff (13%).

The staff turnover rate across the division was 19%.

The sickness rate across the division was 6%.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers with appropriate qualifications provided practical support to nurses when cover could not be sourced from bank or agency staff. 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.

At our last inspection we found 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. At the time of this inspection the department had eleven vacancies for medical staff (13%) of which six were for specialists. Turnover rates were not provided for the department at Aintree. However, rates across the division were 19%.

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%.

At our last inspection staff told us there were inequities in terms of medical staffing across both sites. The same concerns were shared at this inspection.

Urgent and emergency services

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.

Three separate daily tactical meetings were in place throughout the day to discuss both Safe Staffing and Flow and Access.

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.

At our last inspection we identified significant issues with patient records which placed patients at risk. As part of this inspection we checked records and spoke with staff to monitor improvements. Patient notes were not always comprehensive, and staff had difficulty accessing the multiple electronic records systems. There was a lack of consistency in the way information was recorded and we found significant gaps in the recording of care offered or given.

Staff told us they still had difficulty accessing a computer and they were constantly having to log in and move between the different systems.

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 was taking action against an agreed plan to improve the systems and processes in place to handle, prescribe and administer medicines safely.

Following our previous inspection, the trust was taking action to improve the safe prescribing of gentamicin. Actions including education, trust formulary review to reduce gentamicin use and greater oversight of prescribing and monitoring had led to a reduction in recorded incidents of 63% [period August 2021 to November 20211, compared with April 2021 to July 2021]. A continued focus on safe use of gentamicin was included in the trust's Medicines Safety Improvement Plan.

To help support the prompt identification and treatment of sepsis, the sepsis nursing team was being expanded with four nurses undergoing training, supported by the sepsis lead nurse. A PGD [Patient Group Direction] was also in development to support the prompt treatment of Neutropenic Sepsis. Trust data showed 72% of patients with suspected sepsis received antibiotics within 1 hour, against a target of 90% [Quarter 3 2021-22].

Dedicated pharmacist support was now provided to the emergency department on weekdays. However, due to limited capacity, pharmacist support focussed on patients prescribed critical medicines and those patients who had an extended stay in the emergency department, following the decision to admit. The pharmacy team checked electronic records and spoke with patients to confirm their current medicines (medicines reconciliation) liaising with medical staff should any concerns or omissions be identified.

Urgent and emergency services

As seen at our previous inspection staff in the emergency department used the paper CAS card to prescribe the first doses of medicine, with the electronic prescribing system being used following the decision to admit. All three of the records we looked at where antibiotics has been prescribed showed delayed doses. The pharmacist was collating their interventions to demonstrate the impact of pharmacist activity in the emergency department to form a baseline for further improvement activity. Discussions were underway regarding proposals for new ePMA [electronic prescribing and medicines administration] roll out in the emergency department.

On discharge, medicines had to be manually added to the electronic discharge letter, and trust data showed that 24% were not sent to GP's within the target 24 hours [March 2022]. This means there may be delays in updating patients' records when they moved between services.

Medicines safe storage and controlled drugs [CD] checks were audited monthly. Trust data (October to December 2021) showed some improvement although this was below the 90% target. A task and finish group had been set up to review issues of medicines management.

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. We saw evidence that incidents were investigated and reported in accordance with trust policy.

There was evidence that changes had been made as a result of incidents and feedback. For example, nurse staffing levels in the department had been increased in advance of a full staffing establishment review.

Is the service effective?

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

At our last inspection there were no active internal compliance processes for any of the national audit standards. Therefore, there was limited oversight of the department's performance and opportunity to improve the service provided. At this inspection the trust confirmed they were part of the annual submission of audits from the Healthcare Quality Improvement Partnership (HQUIP). Data was submitted last year and was available on the RCEM website. Data and intelligence were being used to plan improvements in the safety and quality of care. However, at the time of the inspection the trust was unable to demonstrate any positive impact on patients or performance.

Urgent and emergency services

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.

At our last inspection we found 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. The data provided by the trust for March 2022 showed a slight decline in performance to 63%.

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. However, staff also told us pressures within the department meant they sometimes prioritised working additional hours at the expense of learning and development.

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 told us they had good working relationships with frailty teams, palliative care, physiotherapists and occupational therapists. However, staff reported delays associated with the completion of the revised Healthcare Needs Assessment (HNA). This document was completed by therapists prior to a patient being discharged and detailed the level of care they would need in a community setting. Staff told us the revised document took more time to complete which caused delays for some patients. They also highlighted arrangements for working with social care commissioners had not returned to normal following the easing of restrictions imposed in response to the pandemic. For example, staff from one local authority had not returned to the hospital after restrictions were eased. This meant communication was sometimes more difficult which potentially caused additional delays in patient discharges.

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 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

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.

Urgent and emergency services

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service did not always 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 effectively with others in the wider system and local organisations to provide care.

At our last inspection we identified issues with the number of attendees and acuity of patients. These factors were causing delays in care and treatment, but were not routinely addressed by the trust at an appropriate level. In response we imposed conditions on the trust's registration which required them to improve practice and reduce risk. During this inspection we saw the same issues. COVID-19 had a noticeable impact on patients' physical and mental health which was causing an increase in attendances. However, staff told us some patients were presenting at the department because they were unable to access primary healthcare services such as GP's and dentists. This meant patients in need of urgent or emergency care were placed at risk. The trust continued to work with other agencies in the local health and social care system to resolve this issue.

At our last inspection 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. As part of this inspection we checked the observation unit and saw it continued to be used for both male and female patients.

Access and flow

Ineffective access and flow processes were creating 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.

At our last inspection we identified concerns relating to access and flow within the department. Following the inspection, this was subject to regular monitoring and discussion. However, there had been no discernible improvement in performance.

Managers monitored waiting times, but patients did not always receive treatment within agreed timeframes and national targets.

At our last inspection we saw a process which stopped the clock when patients were transferred to the observation ward. We found the ward did not meet requirements to justify this practice. On this inspection we were told the practice persisted. This meant data relating to the length of stay in the department was sometimes inaccurate. However, performance in relation to delays and other key measures was consistently below target and in some cases worse than the national average. For example, the average time to treatment in December 2021 was 119 minutes compared to the England' average of 65 minutes. In the same month 12% of patients left the department without being seen. In January 2022, 54.5% of patients were seen within the four-hour target.

Data published by the trust for February 2022 showed that at University Hospital Aintree in February 2022, 71% of patients were not triaged within 15 minutes. With 29% not seen by a clinician within 60 minutes and 1,640 patients in the department for over 12 hours.

Urgent and emergency services

Delays within the wider hospital setting were impacting on flow through the department. For example, data provided by the trust showed that 84% of discharges were not achieved by 12 noon.

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.

Is the service well-led?

Inspected but not rated

Leadership

Frontline nursing and medical leaders were visible and approachable within the service. However, senior leaders were not always 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.

At our last inspection we identified concerns relating to oversight of the department and delays in triage and treatment. In response we imposed conditions on the trust's registration which required them to improve practice and reduce risk. The trust had developed an action plan to generate and monitor improvements. However, these measures had not resulted in the improvement required.

Throughout the inspection senior nursing staff were visible in the department. In some cases they were required to supplement the nursing staff due to shortages. We observed them speaking with and supporting staff. This was also evident from the discussions we had with staff. The department leads were aware of the pressures within the department and the impact this had on patients and staff. They remained committed and passionate about the service and worked to ensure patients were kept safe.

The emergency department was part of the medicine division. 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 our last inspection we saw senior leaders were familiar with the current challenges impacting on the service's performance. However, the risks identified during this inspection 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 record keeping had not been adequately mitigated.

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.

At our last inspection we found the trust's 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. As part of this inspection we checked whether this had improved. Again, we found significant differences in the way the two departments were managed and performed. We discussed this with members of the executive team who acknowledged there was further work to do to ensure best practice was replicated across both departments.

Urgent and emergency services

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.

The trust had a 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 strategy contained no specific reference to urgent and emergency care.

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.

During the inspection there were limited opportunities to talk with front-line staff because the department was consistently busy and working beyond its stated capacity. The staff we spoke with reported similar issues to those found at the last inspection. They said they felt concerns they raised were not always acted on. They also said they sometimes felt concerns about their own health and wellbeing were not fully acknowledged by senior managers.

As with the last inspection, frontline staff of all levels felt they were valued and respected by their colleagues and local managers within the department. However, they spoke of a decline in morale because of the pressures they experienced and the lack of improvement since the last inspection. Staff said they continued to work as a team and support each other during busy periods.

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.

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.

At our last inspection we identified concerns relating to governance within the department. Significant differences in governance and performance were identified between the two main locations. Following the inspection, governance was subject to regular monitoring and discussion. However, there had been no discernible improvement in performance.

Governance across both main sites still needed to be updated and aligned. Plans were in place to achieve this, but there was no agreed timeframe for completion.

As with the last inspection, we were not assured by some senior leaders that they were fully sighted on the activity and performance in the emergency department. However, they were able to demonstrate that appropriate audit systems were in place.

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.

At our last inspection we identified concerns relating to risk management within the department. Following the inspection, the level of risk was subject to regular monitoring and discussion. However, there had been no discernible improvement in performance.

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, the trust's response had not generated the required improvements in performance and patient safety.

Senior leaders had an improved understanding of the causes of the access and flow issues within the department. Plans were in development to improve practice in this regard through more effective working with health and social care partners.

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 continued to hinder the emergency department's performance. Staff were required to access multiple electronic records and some paper records to get a full picture of a patient's care and treatment. Electronic records required separate logins and not all staff had the relevant permissions in place to use the systems.

Staff had developed 'work-arounds' involving the creation of additional paper records to aid efficiency. The paper records were added to the electronic records later. This meant there was a risk of records being incorrectly transcribed or essential timings being inaccurate.

We discussed these issues at length with staff and managers during the inspection. We received assurances that changes would be implemented, and additional equipment purchased to mitigate the risk the current systems posed.

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 effectively with partner organisations to help improve services for patients.

During our last inspection 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. As part of this inspection we asked if the situation had improved. Staff told us the problem persisted. They said their concerns were not adequately responded to and as a result, some staff had experienced significant, persistent pressure.

Urgent and emergency services

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.

As with the last inspection, we were told a significant proportion of attendees did not require hospital treatment and had attended the hospital due to difficulty accessing other healthcare services. Despite extensive joint working with partners in the local health and social care system, there was limited evidence of improvement in this regard.

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.

Areas for improvement

MUSTS

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 12)
- The service must ensure that care is provided in line with national performance standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. (Regulation 12)
- 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)
- The service must ensure specialist facilities for patients with mental health issues are safe and fit for purpose.
- The service must ensure that they are maintaining securely an accurate, complete and contemporaneous records 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)
- 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)
- 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)

Urgent and emergency services

- The service must ensure flow through the department is improved to improve the quality and safety of service users and to mitigate risks to health. (Regulation 17)

SHOULDS

University Hospital Aintree Urgent and Emergency Care

- The service should consider developing a clear vision and strategy that reflects the services provided at Aintree Hospital and that aligns to the Trust vision and strategy.
- The service should consider a review of its arrangements for raising an alarm within the mental health suite to ensure they reflect best-practice.

Medical care (including older people's care)

Inspected but not rated

We visited Aintree University Hospital as part of our unannounced inspection from 22 March to 31 March 2022 which included the Acute Medical Unit [AMU] and the Discharge Lounge. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

- Staff understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. 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.
- The service planned care to meet the needs of local people and took account of patients' individual needs.
- Leaders ran services well and supported staff to develop their skills. Staff were focused on the needs of patients receiving care.

However:

- The service did not always have enough staff to care for patients and keep them safe.
- Staff we spoke reported delays associated with the completion of the revised Healthcare Needs Assessment (HNA).
- People could routinely access the service when they needed, however they did not always receive the right care promptly**.** Patients often had long waits in the discharge lounge.
- Managers did not robustly monitor the number of patients whose discharge was delayed and took action to prevent delays.

Is the service safe?

Inspected but not rated

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.**

There were systems, processes and standard operating procedures to keep people safe and safeguarded from abuse, using local safeguarding procedures whenever necessary. Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance for level two for adults and children was above 87%.

However, compliance for level three safeguarding for adults was 57% and level three safeguarding for children was 40%. 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 make a safeguarding referral and who to inform if they had concerns.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.

Staff kept equipment and the premises visibly clean. Ward areas were clean and had suitable furnishings which were clean and well-maintained. Social distancing reminders were in place throughout both the Acute Medical Unit [AMU] and the Discharge lounge.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available in all clinical areas. Patients who were COVID-19 positive or who had contracted a communicable disease were nursed in single rooms, there was clear signage to indicate the risk of infection and the need to wear appropriate personal protective equipment.

All areas were visibly clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Domestic staff could be called to complete additional cleaning as required.

We reviewed cleaning records, on both the AMU and Discharge lounge and noted that they were up-to-date and demonstrated that all areas were cleaned regularly.

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.

Both AMU and the Discharge lounge, had enough equipment to safely care for patients. We looked at five pieces of equipment and records for a further 53 and found these were in date for servicing and maintenance.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were checked daily. We reviewed these checklists, and each had been completed appropriately.

Staff disposed of clinical waste appropriately, areas where clinical waste was stored was visibly clean and well organised.

Patients told us they could reach call bells and staff responded quickly when called.

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.

Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies, or identifying and managing challenging behaviour. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Records we saw during this inspection showed NEWS2 had been completed in accordance with recommendations and concerns had been escalated correctly.

Medical care (including older people's care)

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed six patient records in AMU and the Discharge Lounge and observed practice in both departments over two days. None of the records we reviewed showed significant delays in relation to risk assessments, patients monitoring or the delivery of care and treatment. For example, managers carried out a programme of repeated audits to check improvement over time.

Staff mostly shared key information to keep patients safe when handing over their care to others. However, staff told us that at peak times when the AMU or the discharge lounge were where full, there had been issues regarding the quality of the information shared. For example, we were told that there had been complaints from patient relatives and care providers that the discharge summaries for specific patients lacked key details.

Where relevant, there were handovers at shift changes to ensure that staff could manage risks to people who used the services. We observed a shift change and the handover included key information to help keep patients safe.

Staffing

The service did not always have 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, agency and locum staff a full induction.

Nurse staffing

The service did not always have enough nursing and support staff to keep patients safe.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, the number of nurses and healthcare assistants did not always match the planned numbers. The trust board report from March 2022 highlighted that the trust wide AMU team, had reported 167 episodes of absence in one month. The service operated a system of staffing gaps per shift, meeting gold, silver bronze or red standards. The gold standard was met if there were no staffing gaps, bronze was met if there were minimum (worst case scenario) nursing staff on shift and red was classed as unsafe staffing levels.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us that they 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The services did not have enough medical staff with the right qualifications, skills, training and experience to be compliant with national guidance. However, due to consultants working overtime and flexibility of other grades of medical staff, patients were kept safe from avoidable harm and there were sufficient staff to provide the right care and treatment.

The service always had a consultant on call during evenings and weekends. The consultant on call at weekends and evening was supported by a registrar and junior doctors.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Medical care (including older people's care)

Medicines

The service did not always use systems and processes to safely prescribe, administer and record medicines.

On discharge, medicines had to be manually added to the electronic discharge letter, and trust data showed that 24% were not sent to GPs within the target 24 hours [March 2022]. This meant there may have been delays in updating patients' records when they moved between services.

Medicines safe storage and controlled drugs [CD] checks were audited monthly. Trust data (October to December 2021) showed some improvement although this was below the 90% target. A task and finish group had been set up to review issues of medicines management.

Is the service effective?

Inspected but not rated

People have comprehensive assessments of their needs, which include consideration of clinical needs (including pain relief), mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes are identified, and care and treatment are regularly reviewed and updated, and appropriate referral pathways are in place to make sure that individual patient needs are addressed.

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. Patients told us that they were given enough to eat and drink, we observed patients receiving lunch and dinner. We noted that alternatives were found for patients who did not like the meal they had chosen.

Staff completed patients' fluid and nutrition charts where needed. We reviewed patient records such as fluid balance charts which confirmed that patients had been given enough to drink. Staff told us that they had access to 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. We reviewed four Malnutrition Universal Screening Tool [MUST] this is a five-step screening tool to identify adults, who are malnourished or are at risk of malnutrition. All the records we reviewed where comprehensive and up to date.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Information about people's care and treatment, and their outcomes, was routinely collected and monitored. The service participated in relevant national clinical audits. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff.

Medical care (including older people's care)

Improvement is checked and monitored. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, the trust took part in the National Sepsis Quality audit to assesses the proportion of patients who underwent sepsis screening.

Managers shared and made sure staff understood information from the audits. Managers told us that information gained from audits would be shared through staff meeting and group emails.

Competent Staff

The clinical educator supported the learning and development needs of staff. We spoke with two student nurses who told us they were able to complete all relevant tasks within their competencies.

Staff we spoke with confirmed that where relevant, staff were supported through the process of revalidation. There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.

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 told us they had good working relationships with frailty teams and palliative care team.

Records we reviewed confirmed that patients had their care pathway reviewed by relevant consultants.

Seven-day services

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

Consultants led daily ward rounds on the Acute Medical unit, including weekends. Patients were reviewed by speciality consultants depending on the care pathway.

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

Is the service caring?

Inspected but not rated

Compassionate care

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

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients told us staff treated them well and with kindness.

Medical care (including older people's care)

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

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.

We observed staff talking with patients, families and carers in a way they could understand.

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. All patients we spoke with gave positive feedback about the service.

Is the service responsive?

Inspected but not rated

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.

The AMU and discharge lounge had systems to help care for patients in need of additional support or specialist intervention. The service relieved pressure on other departments when they could treat patients in a day.

Facilities and premises were appropriate for the services being delivered.

However, all staff we spoke with told us there were challenges for the provision of care in the community across the city, which impacted on the service's ability to discharge patients in a timely way. Staff gave us examples of where a timely discharge had not been possible due to a lack of domically care packages being available or delays in patient transport services.

Patients we spoke with were positive about the care they received but told us that long waits following discharge were draining.

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 supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Medical care (including older people's care)

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Patient relatives told us that patients had the help they needed to ensure they could communicate with those caring for them.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Two patients told us that they had been offered a selection of Halal foods while in the AMU.

The inpatient satisfaction score from across the trust, improved marginally in February 2022 to 92.9% compared to 92.6% in January 2022.

Access and flow

People could routinely access the service when they needed, however they did not always receive the right care promptly.

Waiting times t and arrangements to admit, treat and discharge patients were not always in line with national standards. Managers and staff worked to make sure patients did not stay longer than they needed to. However, At the time of inspection, the data for therapy delays for the organisation were around 27% of all delays this result meant that the Trust was an outsider compared to other comparable trusts regionally.

An audit was carried out by the trust in March 2022 focused on therapy escalations, each patient was reviewed by a clinician using the Patient Electronic Notes System, the finding across the trust showed an error rate of approximately 80%. This meant that we could not be assured that the service was always ensuring that patients consistently discharged in a timely manner.

We noted that the Operations and Performance Monthly Report presented to board in March 2022, confirmed the establishment of a Patient Flow Collaborative to improve flow through the trust. This had a focus on discharge planning to ensure commencement on day one of admission; the provision of education and support to ward staff in relation to appropriate discharge summaries; transfer of care documentation; criteria to reside; and discharge processes on specific pathways.

All staff we spoke with reported delays associated with the completion of the revised Healthcare Needs Assessment (HNA). This document was completed by therapists prior to a patient being discharged and detailed the level of care they would need in a community setting. Staff told us the revised document took more time to complete which caused delays for patients. At the time of inspection, the data for therapy delays for the organisation were around 27% of all delays.

An audit was carried out by the trust in March 2022 which focused on therapy escalations; each patient was reviewed by a clinician using the Patient Electronic Notes System, the findings across the trust showed an error rate of approximately 80%. This meant that we could not be assured that patients consistently discharged in a timely manner.

Managers and staff told us they started planning each patient’s discharge as early as possible. Managers told us they had carried out quality improvement work to try and improve flow through the AMU and discharge area, however this work was ongoing.

Medical care (including older people's care)

We observed two patients who had been discharged from the trust and had been in the discharge lounge for over four hours. We were told if any patient deteriorated, they would be taken back to the emergency department and readmitted. Staff told us that delays in discharge were due to several factors, such as long waits for patient transport services, waits for discharge medications or patients waiting for relatives to pick them up.

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 there was a potential risk that patients were being accurately recorded in terms of the total time they spend in the discharge lounge.

Is the service well-led?

Inspected but not rated

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.

On the AMU the ward manager had an open-door policy so that staff could speak to them and raise any concerns at any time. Staff told us the ward manager was visible on the ward and supported staff when needed.

In the areas we visited, staff commented that senior nurses and ward managers where visible and supportive.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues, however they did not always ensure actions were taken to reduce their impact.

We saw that managers were sighted on the main risks in relation to discharge planning, coordination of timely clinical input and access to primary care support. However, the clinical Effectiveness Overview Report, March 2022, identified that the AMU struggled to meet discharge compliance targets during weekdays as well as weekends. This meant that we could not be assured that managers consistently monitored the number of patients whose discharge was delayed and took appropriate action to prevent delays.

Senior leaders spoke about how the service had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.

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.

Areas for improvement

MUST

Medical care (including older people's care)

Aintree University Hospital

- The trust must ensure that the ongoing work relating discharge summaries is completed. The trust must ensure that staff have the time they need to fully complete all discharge documentation appropriately.
- The trust must ensure that individual patient medical and therapy assessments are completed in a timely manner.

SHOULDS

Aintree University Hospital

- The trust should ensure that all staff are fully compliant with all mandatory training.