



CQC assessment report for Arrowe Park Hospital

Overview

Overall Rating: Requires Improvement

Summary

The service is not performing as well as it should and we have told the service how it must improve.

Summary

Safe	Requires Improvement	Read this section
Effective	Requires Improvement	Read this section
Caring	Good	Read this section
Responsive	Requires Improvement	Read this section
Well-led	Requires Improvement	Read this section

Commentary

Urgent and Emergency Care Services at Arrowe Park Hospital are provided by Wirral University Teaching Hospital NHS Foundation trust. The trust has a 5,600-strong workforce and serves a population of 400,000 people across Wirral, Ellesmere Port, Neston, North Wales, and the wider Northwest footprint. Wirral's only Emergency Department (ED) is a large busy acute emergency department in the North West of England seeing over 8,500 patients per month. This is a similar size to the national average. At the time of this assessment throughout England, emergency departments were experiencing high patient demand. Cheshire and Merseyside Integrated Commissioning Board had issued a letter to acute hospital trusts explicitly requesting that ambulance crew handover was prioritised. We conducted an unannounced focused assessment of the service onsite on 14 and 21 March 2024. The team comprised of 3 inspectors, and 2 specialist advisors and an operations manager. We assessed 14 quality statements across safe, effective, responsive, and well-led key questions and have combined the scores for these areas with scores from the last inspection. We spoke with staff, leaders and people who used the service and stakeholder organisations. The service mostly provided and maintained safe systems of care, in which safety was managed, monitored, and assured. Most processes and policies to plan and deliver people's care and treatment were in line with legislation and current evidence-based good practice and standards. However, people were not always cared for in the right place. Following our site visit, we identified areas of concern which required immediate improvements. We issued a letter to the trust about these and received adequate assurance that the trust had taken immediate actions and put plans in place for longer term actions.

[↑ Back to top](#)

Safe

Rating: Requires Improvement

Summary

This service is not always safe

Commentary

The trust had systems and processes in place to report and investigate incidents. Quality and management meetings took place where risks were escalated, discussed and improvement plans created. Staff knew how to report incidents and told us that they did not always find out about learning from incidents reported. Care and support pathways were in place was mostly planned and organised with people and stakeholders to maintain safety and continuity of care. However, during our inspection patients were being cared for in areas not designated for clinical care. The trust had not identified and mitigated some environmental risks to patients in parts of the emergency department. We fed this back to the trust and action was taken. The trust was in the process of improving staffing levels and higher numbers of staff sickness and absence was observed. Mandatory training compliance in specific subjects was below trust targets.

Effective

Rating: Requires Improvement

Summary

This service is not always effective

Commentary

Clinical leaders in the clinical decision unit told us that the unit routinely cared for patients with complex physical and mental health needs. Interventions were in place to meet the needs of these patients where appropriate. However, there were many occasions when patients with mental health needs waited numerous days in the department awaiting the correct assessment or a bed from partner trusts. Some members of staff were on a British Sign Language (BSL) course to improve the care experience for patients from the deaf community. Trust leaders told us that risk assessment for the patients on the corridor was dynamic and if a patient became too unwell on the corridor, they would be moved to a more appropriate setting. We were not assured all patients were safe in this environment due to the location of the corridors, the fluctuation in staffing and the individual patient need. The service had current clinical protocols based on national guidelines. The service had a process of auditing risk assessments and NEWS scoring compliance.

Caring

Rating: Good

Summary

This service is caring

Commentary

Most patients were complimentary of staff despite the difficult environment and pressures. Patients commended the staff on providing timely care when they needed emergency care. Senior staff were visible within the department and helped within the department as needed. When patients who were on the corridor required personal care, staff moved them to a secluded area. However, we saw occasions when patients' confidentiality was compromised including nursing handovers taking place within hearing distance of other patients. We saw staff members taking bloods in the waiting room with no privacy or dignity. Corridor care made it difficult for clinicians to have confidential conversations with patients and their relatives. The recent NHS

staff survey (2023) showed improved scores indicating good teamwork and staff engagement for the emergency department. Questions relating to staff feeling safe, healthy and their morale levels scored lower than national trust scores. The trust provided appropriate occupational health support for staff, and there were mental health first aiders within the department

Responsive

Rating: Requires Improvement

Summary

This service is not always responsive

Commentary

The department routinely had more patients with mental health needs than there were mental health cubicles available. The trust was working closely with the mental health trust who were responsible for the provision of beds in mental health wards. Staff in the adult emergency department told us that most patients were not waiting for emergency care but were awaiting medical review or beds on medical wards.

Well-led

Rating: Requires Improvement

Summary

This service is not always well-led

Commentary

We found that the service had leaders in post and clear arrangements for staff to speak up. Several projects were underway to improve hospital flow, pathways, escalation, and discharges with system partners and the local integrated care board. A new partnership policy with staff from the mental health provider was not yet active. Staff said they felt there had been an improvement in the service from our last inspection with leaders being visible and approachable. During our interview with divisional leaders, we noted discrepancies between what were told about corridor care arrangements and what staff informed us was happening. Leaders were unable to confirm that RCEM audits had been re-started since the pandemic, though a range of nursing audits were completed regularly by the trust. During our site visit we saw that not all audits had recommenced since the pandemic, but audits that had been undertaken were scoring positively. The continuous flow policy was still being embedded.