Final Report – Arrowe Park Hospital Urgent and Emergency Care

Provider name: Wirral University Teaching Hospitals NHS Foundation Trust

Location Name: Arrowe Park Hospital

Assessment ID: AP1926

Date of assessment: 14 and 21 March 2024

Overall rating: Requires improvement

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

Summary

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

Overall service 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.

Overall people's experience

We spoke to 24 people in various parts of the service including patients and relatives and carers in the waiting room, corridors and the paediatric emergency department. Most patients confirmed they had received a timely nurse triage which included pain relief. All patients and carers told us that staff had explained what treatment plan was in place and why they were having tests. We observed staff using accessible language and tools to communicate with people. Most patients were complimentary of staff despite the difficult environment and pressures. Patients commented on corridor care saying: "it shouldn't be happening." Patients told us they had been seen by a triage nurse before being allocated to the corridor and had a member of staff overseeing their care. Patients reported that there were not enough staff visible in certain areas of the emergency department. Patients told us they had no complaints about the time it took to have their initial tests such as ECGs and blood tests completed after initial triage. Patients said they found the checking in process easy to navigate. Wheelchairs were available and offered to those who required them. Those patients receiving care in the corridors had not been told how long they would be in the corridor, though they knew whether they were waiting to be discharged or waiting for a bed.

Safe

Rating: Requires improvement

The service is not always safe.

Key question commentary

We assessed a total of 5 quality statements in safe. We have combined the scores for these areas with scores based on the rating from the last inspection, which was requires improvement. Our rating for this key question remains requires improvement.

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.

Quality statement commentaries

Learning culture

QS Score: 2

Quality statement narrative
Requires Improvement. This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders
Score: 2

Clinical leaders told us there was a process in the department to monitor incidents and complaints. A senior staff member told us that there were "breakfast clubs" which were teaching and learning sessions based on needs identified from incidents. Leaders told us that recent themes from incidents included overcrowding, and incidents involving violence and aggression towards staff by patients with mental ill health. Specific examples were given by clinical leaders on learning from these incident reviews. Front-line staff told us that they knew how to report incidents. However, they had concerns about what actions were taken in response to incidents. They felt that "management give mixed messages" and no feedback happened after they reported incidents. Staff told us that there had previously been a unit bulletin circulated which highlighted positive feedback and learning but that this had not been circulated "in a while." Trust leaders informed us there were regular daily safety huddles. Staff gave an example of Duty of Candour being conducted appropriately following a medication error.

Processes
Score: 3

The service had a process for reporting and monitoring incidents. These were escalated trust wide through daily safety huddle meetings attended by all hospital divisions. We were informed that each division shared updates and incidents. On the day of assessment, we observed one of these taking place.

The service division had divisional quality and management board meetings, where ongoing risks were escalated, discussed, and improvement plans were created. The service understood the main risks and was taking action to reduce and mitigate these. The service shared examples of root cause analyses which had been undertaken for recent serious incidents in the emergency department. These had been completed appropriately. In the Children's emergency department "hot debriefs" in line with the trust Debrief Guidance. They were facilitated by consultants (these are a short process occurring immediately after an incident facilitating first response to the personal and professional needs of the team, allowing for open discussions around care, the opportunity ask questions, and for any equipment errors to be immediately identified and actioned).

Safe systems, pathways and transitions

QS Score: 2

Quality statement narrative:
Requires Improvement. This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders
Score: 2

Staff told us that they received both a verbal and digital handover from ambulance crews. We were told that when there were no nursing staff to receive handover, ambulance crews were expected to remain with the patient. Although the ambulance crew would continue to clinically monitor the patient, hospital staff provided patients with personal care support. Staff told us there were redirection options available for patients who presented in the department and did not require emergency care. Staff told us that they did not always have the capacity to complete National Early Warning Score (NEWS) consistently. Trust leaders explained that NEWS compliance was monitored with good outcomes for NEWS 0 – 4 and patients under NEWS 5 observations and above were continually monitored. If a patient deteriorated, they would escalate promptly to critical care. On receipt of our written urgent concerns, we received evidence from the trust that deteriorating patients on the corridor would be transferred immediately to a resuscitation bay when required. Staff told us that stable patients could be transferred from the emergency department to the wards with a written Situational, Background, Assessment, Recommendation (SBAR) handover or accompanied by a clinical support worker. Staff told us that the number of patients with mental health needs routinely exceeded the available designated cubicles for mental health assessments: these were carried out by staff from the partner mental health trust. Often, these patients had increased length of stays in the service. Senior staff told us the department was "not functioning as an emergency department" due to overcrowding and increased length of stay for patients, which reflected our observations on site.

Feedback from partners
Score: 2

A senior paramedic informed us of concerns that, due to ambulance staff waiting and monitoring patients at Arrowe Park, crews were not available to respond to other emergency calls in the community. Ambulance partners told us that they were in discussion with the trust for ambulance crews to have direct access to the trust's same day emergency care services.

In addition, engagement work was in progress with the trust and Wirral locality partners to improve flow within both the hospital and out into the community.

Processes
Score: 2

The service had a streaming (pathway) policy which was detailed, appropriate and in date at the time of our review. We reviewed standard operating procedures for clinical areas and saw that exclusion criteria had been implemented for certain patients who were too frail, ill, or vulnerable to be placed in corridors or specific wards. During the onsite visit, we did not always observe the clinical areas functioning according to these criteria due to the volume of patients in the department. We observed additional corridors were used for patients on trolleys including the main corridor through the hospital and the ambulance arrival zone became a "bedded" area. We reviewed 22 pathway protocols for the emergency department and found them to be ratified, and within their review period. However, we saw examples when patients were moved from the emergency department to medical wards without an appropriate handover.

Safe and effective staffing

QS Score: 2

Quality statement narrative:
Requires Improvement. This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's experience
Score: 2

Patients told us they had been seen by a triage nurse before being allocated to the corridor and had a named nurse or care support worker overseeing their care. Patients reported that there were not enough staff visible in certain areas of the emergency department.

Feedback from staff and leaders
Score: 2

Staff told us that "morale had been low over the past few months due to corridor care". They reported colleagues being off sick with stress and agency staff being used to

staff corridors with instances when agency staff working did not have emergency department competencies or appropriate computer access. Clinical leaders told us that these concerns had been escalated to the senior leadership team and a full business case had been made to increase the department's establishment. During a meeting with trust leaders, we were told that there was immediate agreement by the Executive Team in January 2024 to increase staffing numbers to staff the corridor and to maintain patient safety. This was achieved via bank and agency shifts. It was also indicated that a business case was planned to permanently increase the staffing establishment to this level. The staffing ratio for "corridor care" was 1 nurse to every 4 patients. Staff said that this was difficult when a nurse provided care and treatment for a patient away from the corridor which left 1 nurse to cover and observe 8 patients. Staff told us they did not feel confident caring for patients with mental health needs due to staffing pressures and an increase in incidents of aggression towards staff. Divisional leaders told us there had previously been an arrangement with a partner mental health trust for 6 months to help up-skill staff with mental health competencies, which they hoped they could re-introduce soon. Leaders told us that practice educators and matrons were supporting corridor care during times of low staffing. Staff told us that there was "never much time to do mandatory training" and there were connectivity issues if they attempted to access training modules from home. However, leaders told us staff were not expected to complete training modules at home.

Observation
Score: 2

During the assessment, we saw patients on a corridor with no hospital staff. Ambulance crews monitored small groups of patients and with assistance of clinical support workers (CSW) completed 2 hourly clinical observations for each patient while awaiting registered nurse (RN) staffing. We observed senior nursing staff undertaking observations of patients who were waiting to be assigned an RN.

We observed periods when patients in the waiting room were unattended by trust staff. Staff explained that the triage nurse, although based in the waiting room, had to perform additional duties elsewhere. On both days, we observed ambulance crews, rather than trust staff, staffing a corridor with patients. We are not assured that the crews had the right skills to provide personal care when needed and the subsequent impact on their availability within the community.

On both days, we saw evidence of shifts running on reduced doctors. We are not assured that the medical cover was adequate. We were advised that patients were only placed in a corridor after they had been triaged using the national Manchester triage tool by a trained ED nurse. The trust clarified that ambulance crews were not expected to nurse patients in corridors but to stay with them until a formal handover. We did not always observe the clinical areas functioning according to their exclusion criteria set by the trust due to the volume of patients in the department. In response to feedback, the trust reviewed and assessed the emergency department's equipment. They deemed it adequate for safe care according to national standards and improved corridor signage.

Processes
Score: 2

On 14 March, the middle grade medical rota operated with less than 60% of the required doctors for the shift. On reviewing the medical rota, we identified several gaps in both middle grade and junior doctor rotas for day and nightshifts. The department was staffed with 14.8 consultants. The trust had used the Emergency Care Improvement Support Team (ECIST) staffing tool to review this and found it satisfactory. The service used a demand and capacity model developed by the national ECIST to review medical staffing. On average 20% of shifts from December 2023 to February 2024 were filled by locum doctors, whose skills were reviewed prior to allocation. The service had 3 advance nurse practitioner vacancies. The service had an arrangement for occupational therapy and physiotherapy cover. The service used the Safe Staffing Oversight Tool to analyse nursing staffing needs. A recent nursing staffing review showed that there was a 97% fill rate for shifts with 2% of shifts by agency staff. Sickness rate for the service was higher in nursing and CSW staff than other clinical groups at 6.4% and 7.8%, respectively. Overall compliance for mandatory training at 86.5%, was slightly below the trust target of 90%. We saw that all nurses had completed Advanced Life Support training within the required time frame. The service had an educational programme based on the Royal College of Nurses "competency framework for Emergency Nursing".

Safe environments

QS Score: 2

Quality statement narrative:
Requires Improvement. This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders
Score: 2

Clinical leaders told us that daily environmental audits were conducted which included a check of equipment and environmental cleanliness. Following feedback from staff emergency trolleys had been placed within a 3-minute response distance from patients which was in accordance with Resuscitation Council UK guidelines, and appropriate signage installed. Staff told us that patient beds would not fit on corridors and therefore some patients remained on trolleys for an extended period. Following our assessment, the trust told us that they had previously purchased pressure mattress toppers for corridor trolleys as part of their focus on preventing pressure wounds. Staff did not know there was a reporting log for faulty equipment. Trust leaders subsequently informed us that housekeeping staff were responsible for reporting faulty equipment.

Observation
Score: 2

The service was working around building work and preparing to move to part of the new emergency department site. During both site visits, we saw patients cared for in the emergency department and main corridor. We observed a COVID positive patient being isolated in a cubicle in majors (a part of the department designated for people with very urgent injuries or illness). There was inappropriate personal protective equipment (PPE) signage to alert those entering the isolation area. We observed that there were ligature risks in 2 of the 3 rooms for adult patients with mental health needs. We also saw a toilet which was blocked and floors soaked with urine. Leaders told us that this had been reported to the facilities department. We saw that each trolley with a patient on it in corridors had an oxygen cylinder beneath it. In the children's emergency department, we observed a room which was designated as a mental health room which had ligature risks present.

We observed a mobile ligature risk in one of the designated adult mental health cubicles which was immediately removed. We also observed ligature risks in the children's ED where children with mental health needs were assessed. The trust informed us that they had requested the facilities team make the relevant improvements to reduce these risks. They also advised of current mitigation that children with significant mental health concerns were not left unattended.

Processes
Score: 2

The service had a clinical system which prompted staff to swab patients at point of care with potential respiratory symptoms in triage. The service had processes in place to complete and audit environmental risk assessments covering the general environment, bays, side rooms and sluice area. These audits identified that the trust could not always complete servicing of trolleys due to them being in constant use, the department was overcrowded and equipment not adequately clean. There were risk assessments and checklists relating to ligature risks and self-harming possibilities and an up-to-date fire safety assessment in place at the time of our assessment.

Infection prevention and control

QS Score: 2

Quality statement narrative:
Requires Improvement. This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes
Score: 3

Matrons completed infection prevention and control (IPC) audits. There was an IPC action plan in place for the emergency department with tasks completed in a timely manner and evidence showing that relevant concerns had been escalated

appropriately. Nurses carried out an IPC assessment for patients who were placed on the corridor based on their infection status. We observed an infectious patient in a side room which did not have appropriate signage to alert those entering the room of the risk and need for PPE. From December 2023 to February 2024, the trust recorded no incidents of Methicillin-resistant Staphylococcus aureus, clostridium difficile, gram negative infections or infections in the blood in the emergency department footprint.

Effective

Rating: Good

This service is effective.

Key question commentary

We assessed a total of 2 quality statements in effective. We have combined the scores for these areas with scores based on the rating from the last inspection, which was good. Our rating for this key question remains Good.

Clinical leaders in the clinical decision unit told us that the unit routinely cared for patients with complex physical and mental health needs in response to demand. Whilst interventions were in place to meet the needs of these, 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 assessments for the patients on the corridor were dynamic and if a patient became too unwell on the corridor, they would be moved to a more appropriate setting. We had concerns that care and treatment in corridors was not always effective due to the environment, fluctuations in staffing and changing individual needs. The service had current clinical protocols based on national guidelines. The service had a process of auditing risk assessments and NEWS scoring compliance.

Quality statement commentaries

Assessing Needs

QS Score: 2

Quality statement narrative:
Requires Improvement. This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's experience
Score: 3

We spoke to people in various parts of the service including patients and relatives in the waiting room, corridors, and carers accompanying their children in the paediatric emergency department. Most patients confirmed they had a timely triage which included pain relief. Patients and carers felt confident in the assessment they had received. A patient with additional communication needs told us that staff had included their family member in the conversations with their consent.

Feedback from staff and leaders
Score: 2

Staff and leaders told us that they carried out triage using the Manchester Triage Tool. Leaders told us that there had been an improvement in triage times. Staff told us that 2 RGNs were assigned for triage. Staff and leaders told us that the triage nurse would complete a full triage unless a patient was going straight into the resuscitation bay. Clinical leaders in the clinical decision unit told us that the unit routinely had patients with complex needs including mental health needs and attention deficit hyperactivity disorder which made it more difficult to assess their needs. Staff told us that a sensory board was made available for these patients where appropriate. Leaders told us that they were reviewing the need to have nurse associates with a professional background in mental health in the department and were working with the mental health trust to implement this.

Observation
Score: 2

We saw staff communicating with patients in an accessible manner. We observed the triage of 8 patients. All patients were assessed for pain and relevant tests such as x-rays were ordered. We identified risks in the triage assessments of 2 patients. One patient displaying possible signs of having had a stroke was sent back to the waiting room after triage, having been assessed as ‘fit to sit’ at this time. There was no effective clinical observation of this patient in case their condition worsened. In the case of a second patient who attended for a leg injury we did not observe the triage staff complete an assessment of the leg itself. We saw that there was no consistent oversight of the waiting room by trust staff as they were pulled away to assist in other areas. We observed triage times were within 15 minutes or less for walk inpatients and after ambulance handover. We did not observe routine follow up for patients remaining in the ED waiting room for several hours.

Processes
Score: 2

There was no standard operating procedure for corridor care at the time of the assessment. Following our immediate written concerns to the trust, it provided a newly approved policy that outlined criteria for patients who could be placed on the corridors and the level of care to be delivered / received on the corridors. There was also an amendment to the NEWS policy to clarify the response required where a patient’s condition was deteriorating in the emergency department (immediate escalation to nearest doctor) which was submitted to the trust management board for approval on 3 April 2024. The trust maintained clear oversight to ensure that triage was timely to identify patients arriving with life threatening conditions. The trust’s triage monitoring

data for the triage process demonstrated that between 1 February 2024 and 23 March 2024 there were only two occasions when triage took longer than 15 minutes, these were 17 and 19 minutes. All patients who arrived by ambulance were triaged immediately upon arrival at Arrowe Park Hospital emergency department.

Delivering evidence-based care and treatment

QS Score: 3

Quality statement narrative:
Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's experience
Score: 2

Junior medical staff told us that they felt supported in their role by consultants and received regular protected teaching time. The service used a 'message of the week' to promote improvement in clinical practice. Division leaders told us that Royal College of Emergency Medicine (RCEM) audits had been suspended due to the pandemic. These were due to be restarted but this had not yet happened.

Processes
Score: 3

The trust's standard operating procedure for the management of emergency patients when patient numbers exceeded the department's capacity was created following our onsite visit. This included triage, escalation to a senior doctor, clinical observations, escalation of NEWS (National Early Warning Score), and transfer to the resuscitation area. These were implemented to be used alongside existing policies and procedures. The trust confirmed from their incident monitoring that there had been no incidents relating to patient deterioration in the waiting room. Data provided by the trust showed that the average triage times between 1 February 2024 and 22 March 2024 were within the required 15-minute target triage time. The trust provided 22 examples of in date clinical pathway protocols based on national guidelines. These included: administering nebulized drug therapy, anaphylaxis, and fractures in children.

Caring

Rating: Good

This service is caring.

Key question commentary

We assessed a total of 3 quality statements in caring. We have combined the scores for these areas with scores based on the rating from the last inspection, which was good. Our rating for this key question remains good.

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.

Quality statement commentaries

Kindness, compassion and dignity

QS Score: 3

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's experience
Score: 3

Patients we spoke with were positive about the care and treatment they received in the emergency department (ED). We reviewed the friends and family test feedback the trust had received. In January 2024, there were 670 responses with 79% of these being positive. And 80% of the 651 responses in February 2024 for the ED, were positive. Many patients were happy with the care they had received. Ten patients that had left comments where their feedback had highlighted that they had received particularly good person-centred care. One feedback comment was "…. [patient] had severe anxiety and all the nurses and doctors that looked after us were really kind and looked after her really well, another comment was, "every staff member treated me with respect and not like I was an attention seeking time waster. The staff should be praised."

Feedback from staff and leaders
Score: 3

Nurses told us they sometimes held handover discussions within the hearing of patients because this allowed them to continually monitor and observe patients during handover. Staff told us that divisional leaders were visible within the department and would support staff and patients when required. Staff felt they could talk with the new leadership team and that they were approachable for both staff and patients.

Observation
Score: 1

In triage, we observed a staff member taking bloods from a patient in the middle of waiting room with no privacy or dignity. Corridor care made it difficult for clinicians to have confidential conversations with patients and their relatives. We saw patients on the corridor with no privacy screen in place and corridor care extended to the main hospital corridor on both days of our onsite assessment. When personal care was required, we observed patients being moved to a secluded area in the x-ray department.

Responding to people's immediate needs

QS Score: 2

Quality statement narrative:
Requires Improvement. This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's experience
Score: 3

One patient said, "care was superb, … was in and out within 3 - 4 hours, given food and drink, had a brain scan and x-rays, … did all they could and worked quickly and efficiently". "Please can you pass on the patients thanks to those involved in her care". Other patients said, "I had … nearly sliced my thumb off… I expected with it being a Saturday evening I would have a bit of a wait, but I was there less than 2 hours and was happy with the treatment. The triage nurse saw me quite quickly and the doctor I saw later on, … was absolutely fantastic". Patients said pain relief was given promptly, and their first round of tests were completed in a reasonable time.

Feedback from staff and leaders
Score: 2

Staff and leaders recognised that corridor care is not the best place for patients. However, staff told us the CSWs did comfort rounds, and nurses carried out regular, standard checks on individual patients to assess and manage their ongoing needs which included completing patient observations. This included the waiting room.

Observation
Score: 2

The waiting room was not in sight of the reception area due to the building work. During our assessment there was a period when we did not see any staff check the waiting area or carry out any observations. We spoke with the security staff who were frequently in the area, and they advised that if they noted anything of concern, they would call for the help of a clinical member of staff.

Workforce wellbeing and enablement

QS Score: 3

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes
Score: 2

Nursing staffing appraisal rate was 74% and clinical support worker appraisal rates were 90% in February 2024. The average sickness rates for nursing and CSWs at the time of assessment were 7%. This was slightly higher than the NHS sickness rate average which was 5-6%. The most recent NHS Staff survey (2023) showed an improvement for scores indicating good teamwork and staff engagement for the emergency department. Scores for staff reporting feeling safe and healthy and staff morale were below the trust's overall scores and lower than ICS and national averages. The service provided a discreet alcohol service for staff and access to mental health first aiders within the emergency department.

Responsive

Rating: Requires improvement

This service is not always responsive.

Key question commentary

We assessed one quality statement in responsive. We have combined the scores for this areas with scores based on the rating from the last inspection, which was requires improvement. Our rating for this key question remains requires improvement.

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.

Quality statement commentaries

Equity in access

QS Score: 2

Quality statement narrative:
Requires Improvement. This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's experience
Score: 2

Patients found the checking in process easy to navigate. Patients were cared for in the corridor area for several hours before being transferred. Patients on trolleys in corridors had not been told how long they would be in the corridor, but they knew if they were waiting to be discharged or waiting for a bed. Patients needed to go through the emergency department to access to the acute medicine unit (UMAC), a service designed to provide urgent assessment for patients with acute medical problems. This route was different from what one patient was initially told to follow by primary care with a direct referral to UMAC. Patients and relatives described confusion following arrival by ambulance and following advice from their GPs over which department they should attend. A total of 32 formal complaints and 130 informal concerns were reported from Sept 2023 to February 2024. Delay or failure in access to hospital care

accounted for 20% of these, communication failure (with patient/visitor/carer) accounted for 20%, while treatment/procedure-delay/failure and communication failure (with patient/visitor/carer) accounted for 13%.

Feedback from staff and leaders
Score: 2

Staff we spoke with advised that many patients in the department were not waiting for emergency care but a medical review or medical beds on ward. Staff advised that the department routinely had more patients with a primary mental health need than there were mental health beds available. Staff and leaders explained that nursing staff often tried to assess patients with mental health needs in conjunction with a mental health liaison colleague from a local mental health trust. Staff told us that mental health colleagues attended when required and usually within an hour of a request being made.

Processes
Score: 2

Our review of ambulance handover times from February 2023 to February 2024 showed that the 15-minute target was met only once, however 31% were within 30 minutes. Handover times showed significant variation; for instance, on 11 February 2024, the average handover time was 36 minutes for 78 ambulances, while on 14 February 2024, it extended to 3 hours and 27 minutes for 75 ambulances. Data from 1 February to 23 March 2024 indicated that most patients were triaged within 15 minutes of arriving at the Emergency Department (ED). On average, only 62% of attendees met the 4-hour wait target from April 2023 to March 2024, a 2% decrease from the previous year and below the NHS standard of 76%.

The trust acknowledged their full capacity protocol was only partially effective and initiated a continuous flow model on 19 February 2024. This was not fully embedded at the time of our inspection, however the trust continued to make improvements to this model. This model involved transferring patients from the emergency department to wards at predetermined times during the day, as data provided showed that beds are available for patients using the continuous flow model. Following the adoption of the continuous flow model, the average ambulance handover time decreased by 57% to 42 minutes, surpassing the Cheshire and Merseyside average of 47 minutes. From 1 December 2023 to 20 March 2024, a total of 3,666 / 28,786 (13%) patients were treated in the corridors. Of these, 3,242 (88%) stayed in the corridor for less than 12 hours, 359 (10%) for 12 to 24 hours, and 65 (1.8%) for over 24 hours. From September 2023 to February 2024, the Emergency Department (ED) saw an average of 8,666 patients per month, aligning with the regional average. The rate of patients returning within seven days was 8%, slightly lower than the national average of 9%.

“The average wait for an urgent CT scan was 30 minutes throughout the year”. “The MRI order to scan time fluctuated; in January 2024, it was 4 hours and 18 minutes, and in February 2024, it was 1 day and 18 hours”.

The trust informed us following the inspection that this data was not specific to emergency department referrals and included outpatient MRI scan data. They provided details to clarify that any urgent MRI scans for patients in the emergency department were completed in under 10 hours.

Well-led

Rating: Good

This service well-led.

Key question commentary

We assessed a total of 3 quality statements in well-led. We have combined the scores for these areas with scores based on the rating from the last inspection, which was requires improvement. Our rating for this key question is good.

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.

Quality statement commentaries

Freedom to speak up

QS Score: 3

Quality statement narrative:
Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders
Score: 3

The lead freedom to speak up (FTSU) lead guardian commenced in post February 2023. They were supported by two existing guardians in the trust along with a network

of 34 FTSU champions. The trust advised that regular reports were produced and submitted to a variety of trust management committees to ensure appropriate monitoring took place for speaking up data. Potential trends and themes were monitored to ensure that the trust captured and shared any lessons learned. Data was also submitted quarterly to the National Guardian's Office to ensure wider monitoring of speak up process. There had been 2 concerns raised over the past year in the Emergency department. There were 2 champions within the Emergency Department; 1 consultant and 1 matron, who actively promoted the freedom to speak up service.

Governance, management and sustainability

QS Score: 3

Quality statement narrative:
Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders
Score: 2

Staff told us leaders were visible and approachable and commented on an improvement in culture in the service since our last inspection. Leaders informed us the rationale for the continuous flow policy was an intervention to improve flow through the hospital and to reduce overcrowding in the emergency department. This was still being embedded and improved at the time of our assessment. Staff told us that improvements could be made to integrate IT systems to improve efficiency of care delivery.

Processes
Score: 3

The trust provided us with the emergency department leadership structure and responsibilities. There were no gaps in leadership posts and responsibilities were outlined. There were 34 risks on the ED risk register which were reviewed monthly. The leadership qualities framework provided the basis for the trust's development opportunities, not only for staff in management roles, but for all staff to be able to broaden their personal leadership skills or to progress into a management role. The trust carried out several audits including NEWS scores and had oversight of attendance but had not recommenced audits in line with the Royal College of Emergency Medicine (RCEM) guidance following the coronavirus pandemic. There were improvement projects and pathways underway to improve hospital attendance, flow, and discharges. These linked to improving governance processes, service oversight and working with system partners on improving wider access to urgent care. Two existing improved processes had shown good outcomes. These included the virtual respiratory wards with 100% utilisation and expansion of the pathways. Secondly, the home first service had progressed well and had supported 1000 patient

discharges. Projects in progress included discharge processes which gave clear accountability for pathway management and improved operational oversight and escalation and included clarity on commissioning arrangements. The trust had also drafted an implementation plan to boost staff engagement and update technology and IT systems, focusing on the safe discharge of patients no longer needing clinical care.

Partnerships and communities

QS Score: 3

Quality statement narrative:
Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders
Score: 3

Clinical leaders told us that that learning from other trusts to improve mental health competence had been done in the past and was planned for the future. Staff told us they had a process of verbal and digital handover from ambulance crews. Leaders told us they were finding a workable solution with the ambulance provider to increase the speed of freeing up ambulance crews back to the community. The trust had worked closely with their mental health trust partner to develop a side-by-side assessment process. Work was ongoing to make improvements and increase care and treatment for people with urgent mental health needs presenting at Arrowe Park Hospital up ambulance crews back to the community.

Feedback from partners
Score: 2

The service's major ambulance provider told us that the trust's senior team had undertaken engagement with them and had good situational awareness of pressures with honest, open conversations to improve patient care and staff morale, but work to improve ambulance handover procedures and timescales was still required.

Processes
Score: 2

The trust was aware that further work was required to develop links with community walk in centres and the trust CEO had been leading work on developing a Wirral approach to unscheduled care which included wider system partners. The trust had worked closely with their mental health trust partner to develop a side-by-side assessment process. Work was ongoing to make improvements and increase care and treatment for people with urgent mental health needs presenting at Arrowe Park Hospital.