Wirral University Teaching Hospital NHS Foundation Trust

Arrowe Park Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Arrowe Park Hospital

Requires Improvement 

Arrowe Park Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. The hospital is the main site and provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity and gynaecology services and a range of outpatient and diagnostic imaging services.

We carried out an unannounced inspection of Urgent and Emergency Services and Medical Care at Arrowe Park Hospital on 19 and 20 October 2021. This was because of continuing concerns about the quality and safety of these services. The inspection took place during the COVID-19 global pandemic and at a time when NHS providers nationally were experiencing a high level of demand on their services.

Our rating of this location stayed the same. We rated it as requires improvement because:

- The medical care service did not always have enough staff to care for patients. Not all staff had training in key skills, mandatory training compliance for medical staff did not meet trust targets.
- Staff did not always identify and quickly act upon patients at risk of deterioration in the urgent and emergency department waiting room.
- People could not always access the service when they needed it. Patients did not always receive timely care and treatment. Waiting times were not always in line with national standards.
- In the urgent and emergency service some staff did not always feel respected, supported and valued by senior managers. The service did not always have an open culture where staff could raise concerns without fear.

However,

- Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The services planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Our findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Medical care (including older people's care)

Good ↑

The medical care core service at this trust provided a range of specialities over two sites, Clatterbridge Hospital and Arrowe Park Hospital. These specialities included older peoples medicine, cardiology, gastroenterology, respiratory medicine, endoscopy, haematology and nephrology. There was also a stroke service with a hyperacute stroke unit, care for people with diabetes and rehabilitation services.

At the Arrowe Park site, there was an acute medical unit, a short stay medical unit, an older peoples assessment unit and an urgent medical assessment unit. There were also wards for haematology, elderly, respiratory and general medicine, as well as an infection control ward, coronary care unit and stroke ward which included a hyperacute stroke unit.

During the inspection we spoke with 21 staff and three patients. Staff we spoke with included ward managers, matrons, registered nurses, health care workers, physiotherapists, speech and language therapists, pharmacy technicians, advanced nurse practitioners, junior doctors and consultants. We reviewed 13 records including risk assessments, nursing care records and medical care records. We held two focus groups following the inspection which were attended by 14 staff including registered nurses and care support workers. We visited the acute medical unit, the urgent care assessment centre, the short stay ward and the older people's assessment unit. We also visited wards 21 and 22 which are older people's wards, ward 23 which is the stroke unit and hyper acute stroke unit and ward 37 which is the respiratory ward. We also visited the discharge lounge.

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

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

However:

- The service did not always have enough nursing staff to care for patients and keep them safe.

Medical care (including older people's care)

- Medical staff did not all have the required safeguarding training to equip them with the key skills to understood how to protect patients from abuse.
- Although there was a process in place to assess the risk to patients who were on the waiting list, people could not always access the service when they needed it.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff but not all staff completed it.

The trust target for mandatory training was 90%. Nursing staff training levels were at 90% in the medicine division. However, training levels for medical staff were 66%. Mandatory training included safeguarding training and part of the training was face to face for more senior staff. Due to the pandemic and social distancing the numbers of staff permitted to access the face to face training had been reduced. The service was continuing to support staff to complete mandatory training with additional face to face sessions. The trust had encouraged staff to update mandatory training and we saw on the acute medical unit that in August 2021 mandatory training compliance for nurses was at 84%. On the stroke unit 89% of staff were up to date with mandatory training and on the respiratory ward the rate was 95%. On the short stay older people's unit mandatory training compliance was at 98%.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and for people living with dementia.

Managers and practice educators monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most nursing but not all medical staff had training on how to recognise and report abuse and they knew how to apply it.

In the medical division 90% of nurses and 66% of medical staff had completed their mandatory training for the mental capacity act and Deprivation of Liberty Safeguards (DoLS) . Appropriate staff had to complete level four in the protecting vulnerable people training which required face to face training. Due to social distancing restrictions the number permitted to access training had been reduced.

Nursing staff and medical staff received training specific for their role on how to recognise and report abuse. On the stroke ward, a staff member told us that often patients did not mention abuse until they were ready for discharge. We were told the abuse was usually financial abuse carried out by people outside of hospital and nurses made referrals to the safeguarding team.

Medical care (including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of when they had made a safeguarding referral and the circumstances around the referral.

Each division was provided with a daily list of patients subject to a DoLS with expiry dates. This was fed down to ward level and managers used the safety huddle to inform staff which patients were coming close to the expiry date of the DoLS for their patients. This meant staff could reapply if needed to ensure they were complying with legislation.

The safeguarding team supported staff to compete applications for DoLS. They informed staff members when they needed to be updated.

The safeguarding lead for children and young people provided daily support to a ward when a young person with mental health problems was a patient on the ward.

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. They kept equipment and the premises visibly clean.

Ward and clinic areas were visibly clean. During the inspection we saw house- keeping staff in all the areas that we visited. Wards carried out infection prevention and control (IPC) audits as part of the ward accreditation system, including for hand hygiene and personal protective equipment (PPE). IPC audit results in August 2021 showed 80% compliance for the older people's assessment unit; on the acute medical unit audit results showed 83% compliance. IPC audit results in September 2021 were 100% compliant for the acute medical unit. In September, the medical short stay ward scored 80%, the results showed lack of compliance with commode cleaning. We saw action plans had been identified for improvement in IPC audits.

Staff used PPE appropriately and there were plentiful supplies. We observed that staff washed their hands according to the World Health Organisation guidelines for handwashing. There was signage across the wards providing information about infection control and use of PPE.

Chairs in the clinical areas were separated by clear plastic screens. Chairs were cleaned after patient use. There were masks available for patient use.

Equipment was cleaned after use with "I am clean" stickers indicating that it was ready for use.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Patients had given feedback in the acute medical unit about the cleanliness of the ward.

The trust monitored incidences of healthcare acquired infections.

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.

There were daily checks of equipment, including resuscitation trolleys, which were documented. Fridge temperatures were checked and recorded.

Equipment we checked had service dates and there was no shortage of equipment to help staff to care for patients. Companies that supplied equipment to the division provided training on how to use it.

Patients had access to call bells and there was a system that showed that somebody was attending to a patient. This was helpful when there was more than one call bell at the same time. Call bells checks and patient accessibility were part of the ward accreditation programme.

The urgent medical assessment unit had clinic areas and seating areas and a trolley area for patients. Clinic areas and treatment rooms had oxygen and suction and there were pulse oximeters at each chair and in each clinic room.

Side rooms were available on the wards for patients who required them and there were negative pressure rooms on the respiratory ward. Negative pressure rooms have lower air pressure inside the room. This means that when the door is opened, potentially contaminated air or other dangerous particles from inside the room will not flow outside into non-contaminated areas.

The wards we visited had day rooms for patients that could be used for meetings with relatives.

Staff disposed of clinical waste safely. We observed that sharps bins were not overfilled and were secure. All the bins we saw were dated.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. There were electronic white boards in all wards which indicated the early warning scores for each patient and the time when the next review was due. Staff followed the trust's sepsis pathway for management of patients who had sepsis.

There was a quality improvement project in place for the deteriorating patient. On ward 22 we saw that staff had made suggestions for opportunities for improvement on a white board.

There was a ward assessment and accreditation programme with 14 domains including safe-guarding, pain, patient safety, infection prevention and control, environmental safety, pressure ulcers and falls. The accreditation used a continuous improvement model approach with weekly self- checks, monthly divisional inspections and then ward accreditation that created an action plan for the ward. On the matrons' monthly audit, the older peoples short stay ward scored 94%, the medical short stay ward and the acute medical unit scored 92%.

The service carried out an adult harms prevention audit in appropriate areas every week and as part of the audit staff spoke to a minimum of three patients on each ward. The audit included areas including falls, pressure ulcers, food and nutrition including satisfaction with meals and patient experience.

There were daily safety huddles in all areas and sometimes afternoon huddles. These were used as a communication mechanism for information from management to staff and for any patient safety and well- being issues. There were records of the meetings and attendance.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Medical care (including older people's care)

Staff shared key information to keep patients safe when handing over their care to others.

Patients were cohorted and bay tagging was used for patients with dementia or those at risk of falls.(Bay tagging is where the nursing staff 'tags' someone else on to the bay if they need to leave ensuring there is someone present in the bay at all times.) Physiotherapists and occupational therapists provided support and equipment to support the safe mobility of patients and those at risk of falls. Speech and language therapists, dieticians were also available to assess patients with language and communication, also nutrition and hydration needs, where this was required.

Patients who had suffered from a stroke were reviewed in the emergency department by the stroke co-ordinators and then transferred to the stroke unit. We saw in the records that a patient had been transferred within five minutes of arrival into the emergency department.

There was a critical care outreach team who worked 24 hours a day, seven days a week. The staff supported ward teams in the care of patients with, or at risk of, critical illness receiving care in locations outside the critical care unit. Staff on the respiratory ward said that this service was invaluable.

The ward manager on the acute medical unit told us that they had recently had two patients with mental health problems. including patients who were under 18 years old. Although the ward manager felt supported by senior managers while the patients were on the unit, they said that training about how to deal with patients with mental health problems would have been useful.

The pharmacists reviewed the medicines for patients at high risk of falls.

The service had 24-hour access to mental health liaison and specialist mental health support. There was information on each ward of how to contact these teams.

Staffing

Nurse and allied health professional staffing

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

Staffing in the service was reviewed locally and daily at trust and service level, and the acuity of the patients on a ward was considered when making staffing decisions. Staff could be moved from one ward to another to maintain patient safety and cover for any gaps in staffing. Staff told us that this was difficult, and they didn't like being moved to another ward. We were told it was often staff who were covering additional shifts who were moved, and that this could discourage staff from working additional shifts. Staff told us that when the wards were staffed to establishment then there were enough staff to meet the demands of the service.

The fill rates on the acute medical unit for registered staff for days were 81% in September 2021, 77% for August 2021 and 87% for July 2021. For nights for qualified staff the rates were 75% in September 2021, 70% in August 2021 and 79% in July 2021. Unregistered staff fill rates for days were 114% in September 2021, 98% in August 2021 and 93% in July 2021. For nights the fill rates for unregistered staff were 99% in September 2021 and 97% for July and August 2021.

Medical care (including older people's care)

The fill rates for the medical short stay unit were 62% in September 2021, 67% in August 2021 and 60% in July 2021 for registered staff on days and 101% in September 2021, 99% in August 2021 and 99% in July 2021 for registered staff on nights. For unregistered staff on days the rates were 90% in September 2021, 72% in August 2021 and 72% in July 2021. For unregistered staff at nights the rates were 70% in September 2021, 72% in August 2021 and 74% in July 2021. This meant there were potential risks to patients because there were not always sufficient staff to meet patient care needs.

Sickness rates for nursing staff on the acute medical unit from October 2020 to September 2021 were 8% and15%. However, nursing staff turnover was low.

Medical locum staff were used in the service; however, these staff were long term agency staff.

Managers told us that there were a lot of junior staff and some more senior staff were covering secondment roles. This had an impact on skill mix due to the lack of experience of staff.

There was ongoing recruitment of nurses and care support workers across the medical division. The trust had been successful in the recruitment of international nurses. Most of the wards we visited had these international workers as part of their nursing establishment. Feedback from nurse managers and other staff was positive about these staff who were undergoing training to support their roles.

The nurse staffing on the hyperacute stroke unit did not meet the national guidelines. There were eight patient beds for hyperacute stroke patients, with three qualified staff available for these. Guidance suggested the staffing allocation should be four qualified staff. Staffing on the ward was based on the acuity of the patients on the ward and additional staff could be used. The nurse manager was supernumerary to the staffing establishment for the ward and would support the staff if necessary. In addition, there were stroke co-ordinators and a stroke consultant who supported patients on the ward. The ward manager told us that there had been no patient related incidents because of staffing numbers.

There was a respiratory ward and a respiratory support unit in the hospital, one of which was used for patients with COVID-19 at the time of the inspection. Patients who required non-invasive ventilation (NIV) were treated in these wards. Ward 38 had four negative pressure rooms which were used for the treatment of NIV patients and nurse staffing for these patients met the national guidelines. In addition, any patients with a tracheostomy received one to one care from nursing staff.

There was a team of physiotherapists who covered the medical wards on the second floor of the hospital, this included the stroke unit, older people's wards and the respiratory ward. The team was fully staffed and provided weekend cover.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from the potential of 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 trust was actively recruiting doctors including consultants and middle grade staff at the time of the inspection and had been successful in a number of specialities including cardiology and haematology which were now at establishment. However, there was a reliance on agency and locum staff to mitigate the risks in other services and to fill the gaps for consultants and middle grade staff. However, many of these had been working in the trust for several years. There was an over establishment of medical staff to support waiting list initiatives.

Medical care (including older people's care)

There were daily updates on medical staffing levels to senior managers and there was a plan so that if any of the locum staff handed in their notice or medical staff went off sick the consultant rotas could be covered.

The service recognised that their biggest risk to medical staffing was the lack of middle grade doctors. This was on the division risk register and there was a recruitment strategy in place. The trust was also considering the development of roles including advanced nurse practitioners and nurse consultants to support medical services.

Sickness rates were low for the medical staff although staff turnover rates were higher for medical staff. Many of the sickness issues arose from self-isolation requirements due to COVID-19.

There was seven day consultant cover across the medical division.

Records

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

Most records in the trust were electronic. Staff could access the records and there were computers on trolleys so that patient updates could be completed at the patient's bedside.

We reviewed 10 records in different areas of the medical division. All were complete with up to date risk assessments. Records were reviewed within the service as part of the harms review. process and the relevant documentation reviewed for each risk area. For example ward 27 audit results for pressure ulcer documentation indicated these were 97% fully completed

There was a transfer template that was completed when a patient transferred to a new team. This was a paper record, but the trust was working to make the template available electronically.

On one ward we saw one example where a paper record had been left on a trolley, we brought this to the attention of the ward manager who resolved the situation.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff administering medicines wore red disposable aprons so that they would not be disturbed during the medicine round.

The service used pharmacy technicians to review patients' medicines regularly and provide specific advice to patients and carers about their medicines. Ward managers said that they were a great help.

The division used patient group directions (PGD's) for the administration of medicines. PGD's allow specified health professionals to supply and/or administer medicine without a prescription or an instruction from a medical prescriber. On the acute medical unit, we saw that the PGD's had been signed appropriately.

Medical care (including older people's care)

Staff checked the medicines patients were taking on admission (medicines reconciliation) and this was accurately documented. In September 2021 79% of patients in the emergency and medicine division had their medicines reviewed within 24 hours of their admission. The objective is to exceed 95% of patients receiving medicines optimisation with 24 hours of admission, in line with NICE recommendation.

On the acute medical unit there had been incidents with recording and disposal of controlled drugs (CD). As a result of this training had been put in place and there was information for staff in the CD cupboard. There were audits of controlled drugs every three months and weekly CD audits as part of the perfect ward system, with daily CD checks. One of the results for older peoples assessment unit showed 90% compliance. We were told that CD audit results Monday to Friday were compliant with the trust target of 100%. However, results at weekends did not always meet trust targets.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Incidents were reported and managed on an electronic system. There had been no serious incidents or never events reported in the service.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

The service had no never events on any wards.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff received feedback from investigation of incidents, both internal and external to the service through the daily safety huddles. These were on the agenda for seven days to reach all staff.

Managers told us that they debriefed and supported staff after any serious incident.

Ward managers and matrons discussed incidents at their monthly meetings and outcomes were cascaded to ward staff through the safety huddle system. Serious incidents were an agenda item on the division quality and safety board.

There was a weekly serious incident panel at the trust. This was multi-disciplinary with senior clinical leadership. The panel reviewed all newly reported incidents resulting in serious harm and reviewed any investigations arising from the incident. In addition, there was also a monthly patient safety forum within the medical division.

There was evidence that changes had been made as a result of feedback. There had been an incident relating to a patient death and managers and staff told us what measures had been put in place to try to prevent a similar event occurring again.

Safety Thermometer

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

Medical care (including older people's care)

The service continually monitored safety performance using the ward assessment and accreditation system and the self-assessment process to form an action plan to improve in a number of domains including patient safety, falls, and pressure ulcers and venous thrombo- embolism.

Ward managers were responsible for the action plans as part of the improvement plan for each ward.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The service was 100% compliant with guidance from the National Institute for Health and Care Excellence in areas such as for heart failure, cancer guidance and kidney disease.

The electronic white boards on the wards indicated which pathway a patient was on for all staff involved in their care.

Staff could access clinical guidelines on their mobile phones, and we observed a check by medical staff on antibiotic dosage for a patient.

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.

Malnutrition universal screening tool (MUST) compliance was part of the trust quality dashboard. On the older people's assessment unit there was daily monitoring of MUST completion by the ward manager and sister. Scores for completion of MUST within 24 hrs showed 100% for 24 hour checks and seven day checks on the older peoples assessment unit.

The ward accreditation system included hydration, completion of MUST scores and the weighing of patients.

There had been an improvement workstream for nutrition and hydration which included the completion of MUST and completion of dietician care planning. This was part of the trust action plan following the last inspection.

There were nutritional status boards on all the wards which included information about patients such as nil by mouth or soft food.

There was a nurse consultant on the stroke unit who supported non–oral feeding and naso-gastric tube placement. Speech and language therapists conducted safe swallow assessments and provided training and support for other staff on the unit.

On the stroke unit we saw that all the ward staff supported patients with eating and drinking at mealtimes if they needed it.

In the records we reviewed the malnutrition universal screening tool and saw that it had been completed for appropriate patients. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Dietetic support was available for patients who required it.

Pain relief

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

Staff prescribed, administered and recorded pain relief accurately.

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

Pain assessment and monitoring was part of the ward accreditation system. As part of this, minimum of three patients had their pain needs reviewed to confirm their pain level, whether this had been assessed and pain relief offered.

Records we reviewed indicated that pain had been monitored and pain relief was provided.

Patient outcomes

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

The service participated in relevant national clinical audits. These included the Sentinel Stroke Audit programme in which the trust was at level A (highest level), the national audit of dementia where the trust was better than the national average and the National Early Inflammatory Arthritis Audit. Following this audit an action plan had been put in place and a business case had been put forward for an additional consultant. The division was doing an audit on acute coronary syndrome and an assessment and diagnosis of acute delirium during the acute medical take. There had been three plan, do, study, act cycles (PDSA) and actions had been put in place following the audit.

There were two quality improvement projects one for the deteriorating patient and another on enhanced communication skills.

The division was using a digital online tool to support their audits and outcomes. Ward managers told us that this could be quite time consuming to complete but the results supported patient safety and quality of care. Results were fed back to staff through white boards and through the safety huddles.

On the stroke unit we reviewed three care plans for patients. These were very detailed and there was evidence of multi -disciplinary involvement and communication with relatives and next of kin. One of the patients was for end of life care and the appropriate documentation was in place.

Medical care (including older people's care)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used the results to improve patients 'outcomes.

Managers used information from audits to improve care and treatment through action plans and the re-auditing of services. Improvement was checked and monitored. Managers shared and made sure staff understood information from the audits through safety huddles and other communication methods.

Competent staff

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

There were two clinical educators who supported the learning and development needs of staff in the division. They supported staff in their mandatory training and accessing additional training to meet the needs of the service.

There was a trust mental health training plan and training including a course to support children and young people presenting to hospital in mental health crisis. Mental health training opportunities also included mental health first aid, drug and alcohol awareness and suicide awareness. There was also training for learning disability and falls prevention training.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates on the acute medical unit were 92%, on ward 38 they were at 95% and on the short stay older peoples ward they were at 98%. The overall appraisal rate for the division was 83% against an 88% target.

There was training and on-going support for the international nurses at the trust. They were from a number of different countries and cultures with varying nursing backgrounds. The nurse managers were providing training on the wards and said that this could be time consuming, but they were beginning to see the rewards of this input.

Staff told us that there was training available. They gave examples of some of the training that they had accessed. On the respiratory ward there were annual updates for staff on non-invasive ventilation and tracheostomy care competencies. There was specialist training for cardiology, atrial fibrillation and respiratory services

The care support workers completed their care certificate within three months of their start date. The newly qualified nurses completed the preceptorship course. There was training for apprentices both qualified and unqualified.

However, the advanced nurse practitioners said that they did not receive training to support their role. While the consultants supported the need for this training, the nurses were not given protected time. One of the nurses had started to organise training in their own time but this was often cancelled if there were staff shortages. The doctors received appropriate training and had protected time for the training.

Multidisciplinary working

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

There was effective multi-disciplinary between nurses and therapists working across the division. Nursing and allied health professional staff told us that they had strong working relationships with the medical staff.

Medical care (including older people's care)

There were handover meetings between medical staff and multi-disciplinary handover meetings. Staff told us that these were useful as they could raise issues with medical staff if necessary.

There was an advanced multi-disciplinary team meeting in haematology with a local secondary care provider and a tertiary care provider.

Nurses on the respiratory ward told us that they had worked closely with the medical staff during the pandemic and this had strengthened the team.

Physiotherapists worked closely with occupational therapists on discharge planning from the patient's admission onwards. They attended ward rounds to assess patients and could advise staff on equipment needs and mobility. They provided treatment to support patients regaining strengthen and function after illness. There was interdisciplinary working with a focus on frailty. Staff liaised with community services to support discharge. The service had MDT meetings for complex patients, and a designated discharge team, who liaised closely with local social workers.

Staff could access the psychiatric liaison team when they needed to. There were signs in each area with information about how to refer patients to the team.

Seven-day services

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

Consultants led daily ward rounds on all wards, including at weekends. Patients were reviewed by consultants depending on the care pathway.

Therapy services were available at weekend and the discharge lounge was open seven days a week.

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

There was pharmacy cover until 4pm at weekends and then an on-call service was used.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

We saw that there was health promotion information available in wards to promote better health. Staff could also refer to services such as the drug and alcohol team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Medical care (including older people's care)

Training for consent, mental capacity and Deprivation of Liberty Safeguards (DoLS) was part of vulnerable adults training. Levels of training available were from one to four with four being the highest level and requiring face to face interaction. Training completion was over 90% for nursing staff and 66% for medical staff.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Staff implemented DoLS in line with approved documentation. The trust had a template that staff completed when applying for a DoLS for patients.

When staff had completed the protecting vulnerable adult training, ward managers supported them in how to complete documentation for DoLS. Staff were responsible for completing the documentation for their own patients. The safeguarding team also provided support.

Staff completed capacity assessments for patients in their care. The staff received training on fluctuating capacity and delirium.

Senior managers were informed about the numbers of DoLS applications and any were coming to an end. There were daily prompts at the safety huddles to review any DoLS if they needed to be extended and staff also received prompts from the safeguarding team.

There was a board on ward 23 which showed staff the benefits of completion of mental capacity and DOLs and the risks and consequences of a failure to complete the information.

We saw that consent was documented in the records that we saw, and that staff made sure that patients consented to treatment.

Speech and language therapists would support staff who were completing capacity assessments on the stroke unit if the patient had communication difficulties.

We reviewed three do not attempt resuscitation (DNACPR) forms which confirmed there had been discussion with the patient and family members about patient needs.

Is the service caring?

Good 

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

Compassionate care

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

The ward accreditation system included questions for patients about their experiences on the wards and questions about privacy and dignity, food and nutrition and support from staff.

Medical care (including older people's care)

During the inspection we observed that staff were kind to patients and listened to their concerns.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way even when they were very busy.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

On the stroke unit records we saw showed detailed care plans for palliative care for patients with communication documented with patient's next of kin.

There were link nurses for end of life care, and they had received training from the palliative care team.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

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

Understanding and involvement of patients and those close to them

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Senior managers were aware of the friends and family responses and we saw that they reviewed numbers and worked with ward managers to improve response rates if numbers were lower than expected.

The trust had developed an enhanced communications plan for communications during restricted visiting. During and following the COVID-19 pandemic patients were not allowed visitors except under certain circumstances. Staff told us that this was very hard on the patients but also staff. Staff contacted patient's relatives the day after their admission. They also followed patients up with a phone call the day after their discharge to check on them. Ward managers told us that this had been helpful for staff, patients and their relatives and that they had received useful feedback on services from patients following discharge.

There was a quality improvement plan to improve communication between patient's relatives and loved ones and the trust.

On the acute medical unit, the ward manager was using a white board to respond to service user feedback and had developed an action plan which was to be shared with the corporate team. This included using voice clips from patients that were shared with staff.

Medical care (including older people's care)

The nurse manager on the acute medical unit had worked to improve the friends and family response rate and at the time of the inspection it was 98% for the previous month. There had been 145 responses with positive feedback about caring staff, ward cleanliness and waiting times.

There were multi-disciplinary team meetings for patients on the older people's wards which included active involvement from families and loved ones.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good.

Service planning and delivery to meet the needs of the local people

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

Managers planned and organised services, so they met the changing needs of the local population.

There were seven day clinics on the acute medical assessment unit, for the treatment of conditions such as pulmonary embolism, transient ischaemic attacks. The unit could take GP referrals. This was to try to reduce the number of people going to the emergency department.

There was an older peoples short stay unit with in-patient beds and an ambulatory area with chairs for patients. The ward took patients from the emergency department and from outpatient clinics. There was a focus on frailty and older people could be streamed from the ward into other services. There were always three consultants on the ward between 9am and 8pm, two for the ward and one for the clinical areas. There was an also a trainee GP. We were told that the patients could be very complex. The ward was supported by specialist nurses, the heart failure team and therapists. The medical staff told us that they had reduced admissions and gave an example where a patient had multiple admissions to the hospital before being accepted by the ward team. There had been no admissions for the patient since.

There was a dedicated email advice line for GP's to provide advice and guidance and to reduce inappropriate admissions.

On the stroke unit there was a telemedicine facility so that consultants could direct the procedure from any location. This could improve treatment times for administration of thrombolysis.

The stroke co-ordinators would see patients on arrival in the emergency department and transfer them to the stroke unit without delay.

Staff told us that it was sometimes very difficult to move a patient with mental health problems to an appropriate location for their care and treatment needs because of a shortage of availability of specialist care settings.

Patients being discharged were given food supplies to take home if they were unable to visit the shops, voluntary agencies would take a patient shopping on their way home following discharge if appropriate.

Medical care (including older people's care)

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 made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a trust lead for dementia and the trust had a dementia strategy. Dementia awareness training was part of mandatory training for all staff.

The older people's wards were designed to meet the needs of people living with dementia with appropriate signage and a memory room. There was an activity co-ordinator who provided reminiscence activity therapy for patients.

Patients with dementia could be admitted directly to the older people's wards from the emergency department to try to reduce ward moves for patients. There was a dementia area in the discharge lounge.

The division used signage to indicate if patients were at end of life and tried to provide a side room for them. There were link nurses for end of life care.

Staff could access the psychiatric liaison team for support, and we saw information on the wards about how to do this.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff gave us an example of a patient with a learning disability who was an inpatient at the time of the inspection and the support they had received.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

The ward accreditation system included asking patients about their meals, the quality of their food and if they had support during meals if they needed it.

The service had information leaflets available in languages spoken by the patients and local community. Staff could access translators and support for sign language,

Patients were asked about their choice of food and the quality of food as part of the ward accreditation process and through other feedback mechanisms. On one ward patients had reported that food was not always hot when they received it and so improvements had been made to address this.

Access and flow

People could mostly access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mainly in line with national standards.

The trust was adhering to national guidance on waiting lists for treatment and diagnostics and risk stratification processes were in place to ensure that patients could access care and treatment when they needed it.

There was a trust patient access policy and patients were given a priority status by the speciality so that patients most at risk were prioritised for treatment. Any patient waiting longer than 40 weeks was re-classified for treatment within 12 weeks. If their condition deteriorated and they were re classified and reprioritised.

Medical care (including older people's care)

Any patients waiting longer than 52 weeks from referral had a full clinical harm review undertaken by a consultant.

The referral to treatment time for consultant led treatment showed that 79% of patients were seen within 18 weeks against a target of 90%. The average for the Cheshire and Merseyside Integrated Care System (ICS) was 69%. This was a significant improvement since the same time last year when 64% of patients were seen in 18 weeks. The number of patients waiting more than 52 weeks for treatment was 560 which was 2% of the waiting list, the ICS average was 5%.

The worst performing speciality in medicine was gastroenterology with 69% of patients seen in less than 18 weeks and 0.5% of patients had waited more than 52 weeks. In cardiology 87% of patients were seen in 18 weeks with no patients waiting longer than 40 weeks.

Endoscopy services were achieving the local target for activity levels and had a prioritisation system in place based on patient risk. There was a live tracking patient list and a process was in place for a clinical review if an appointment was not given. The trust was outsourcing some endoscopy services to independent heath providers

There was an over establishment of medical staff to address waiting times.

Emergency readmission rates generally met expectation for acute cerebrovascular disease, septicaemia, chronic obstructive airways disease, acute myocardial infarction, pneumonia, urinary tract infection, fractured neck of femur and renal failure. Readmission rates for acute bronchitis were improved and were worse for fluid and electrolyte disorders.

There was transformation work in progress across the trust and one of the workstreams included patient discharge.

The trust managed their access and flow across the hospital sites. This was an improvement following the last inspection. Senior managers told us that they now proactively managed capacity in the hospital to identify areas for escalation and staffing requirements. There was a capacity management tool and a staffing matron who worked 8am to 8pm seven days a week.

Staff told us that patients were sometimes wrongly admitted to short stay areas and that acutely unwell patients were placed in these areas. Staff reported that patients were placed in areas to avoid breaches in waiting times to meet national targets. There was oversight at trust level and at division level of patient discharge status and any issues delaying or preventing discharge. This was significantly improved since the previous inspection. There was an initiative to discharge over 33% of people before noon on the day of their discharge from hospital. Since June 2021 around 18% of all patients were discharged before noon. There were issues locally about the provision of community care packages. There were meetings three times a week with system wide leaders to try to improve discharge for medically optimised patients.

There were bed meetings in the trust four times a day for all specialities. We attended a bed meeting and found it to be well run and effective. This was in comparison to the previous inspection when we found bed meetings to be ineffective and poorly managed.

In September 2021 there were 393 patients who had been in hospital more than seven days and 132 who had been in hospital for more than 21 days. There was a transfer to assess service to discharge appropriate patients into short term placement beds due to the lack of domiciliary care in the community. Matrons were assigned to those patients who were difficult to discharge because of complex issues to support their discharge to an appropriate setting where their care needs could be met.

There was a discharge team that included social workers including community social workers and local authority social workers. We spoke to one of the team who had responsibility for three wards including one of the elderly care wards. There were twice daily multidisciplinary meetings with ward staff, so they were aware of patients who were medically fit for discharge and facilitated interventions such as diagnostics to speed up discharge.

We visited the discharge lounge as part of the inspection and saw that the service had significantly improved since the last inspection. The function of the discharge lounge is to support patient flow and bed availability. The service was a seven day service from 8am to 8pm It was well run with an area for patients with cognitive impairment. There was pharmacy support so that patients were not delayed waiting for their medicines before they were discharged.

The trust had contracts with a number of patient transport providers including ambulance services, taxi companies and voluntary organisations to transport patients to their discharge venue. Food parcels could be given to patients or they could be taken shopping before they went home. Support was provided by charities to patients following discharge if appropriate.

If any patient who had been on the acute medical unit for more than 72 hours and the short stay ward for 48 hours, it was reported as an incident. This meant learning could be put in place.

There was an early supported discharge team on the stroke unit that worked with community services to support the timely discharge of stroke patients.

There was pharmacy support in the discharge lounge to reduce delays in discharge due to medicine issues.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

In the period 1 April 2021 and 27 October 2021, the medical division received 12 complaints, the main themes of the complaints were communication and complaints about treatment. Of the complaints 13% were upheld and 52% were partially upheld. We saw that outcomes of complaints included shared learning, review and changes of policy and changes or review of patient information.

There was training available to ward managers about dealing with complaints.

Ward managers and matrons were aware of complaints in their areas of work and investigated these complaints. They identified themes from complaints and patient feedback.

The outcomes from complaints was shared at the daily safety huddle meetings so that staff could learn and improve patient safety and experience.

Is the service well-led?

Good ↑

Medical care (including older people's care)

Our rating of well-led improved. We rated it as good.

Leadership

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

Acute medicine was split into emergency medicine and acute medical services. Each division had a triumvirate leadership team with a divisional associate medical director, a divisional director of operations and a divisional nursing director.

The trust was developing their own leaders to provide career progression and succession planning. There were several training courses including associate director of nursing and matrons programme, a top leaders programme, and an effective manager programme.

Ward managers said that they were supported by the directors and assistant directors for the division. They said that this had greatly improved in recent months.

On the wards and units that we visited during the inspection we saw that there was strong clinical leadership from the ward managers and the matrons. Staff told us that they were supported and valued by these managers and they were proud of the work that they did.

Clinical managers worked hard to support their staff and said that this had been difficult during the pandemic and they were expecting significant winter pressures.

Ward managers told us that they were more confident about this inspection as they had the right leaders and that the right processes were in place to support and monitor patient safety and patient experience. This had improved since the last inspection.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had developed a strategy for 2021 to 2026 and each division had a strategy to support the trust strategy. This had been developed with partners, staff and the public.

The strategy included working with primary care services, local authority services and other secondary care providers.

The senior leadership team for the service told us that part of the division had recently split from the emergency department and a paper would be going to the trust executive team in March 2022 for review and a decision about whether this would continue. There was a division of emergency medicine which included the acute medical unit, the short stay unit the urgent medical assessment unit and the older people’s assessment unit.

The senior leaders said that they considered that the split was a positive decision as it allowed them to focus on the priorities for their own division. Ward managers we spoke with agreed with the split in the division.

Medical care (including older people's care)

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff told us that the culture in the division was positive. They highlighted staffing as the main issue that impacted on their work and understood the challenges for their work areas and for the division. Team working was recognised as a strength and staff said that the pandemic had strengthened teamwork and how they valued each other.

Staff on the respiratory ward told us that working on the ward during the pandemic was sometimes very difficult emotionally. They explained about how they supported each other and how their relationships with the medical staff developed during this time leading to better multi-disciplinary working. Break out rooms and Freedom To Speak Up champions were available to support staff in the service. The staff support team visited the respiratory services unit throughout the pandemic. All wards had access to a health and wellbeing resources either online or via a specific health and wellbeing folder.

Ward managers told us that they thanked their staff for the work they did with cards and small gifts.

Governance

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

There were effective governance processes in place in the service. There were divisional health and safety committees, divisional management boards and divisional quality boards that fed into the trust patient safety quality board.

The recent split in the division from the emergency medicine division meant that many senior managers were new in post or on secondment from another role.

The divisional quality board was attended by directors, matrons, medical staff, associate directors of nursing and governance leads for the division. Minutes of meetings showed that the risk register was updated, complaints and patient safety incidents and patient experience indicators were reviewed.

Ward managers in the division met every month and information from this meeting was communicated to staff.

There was a weekly governance huddle for matrons and managers.

Following the pandemic there were no longer staff meetings on the wards and ward managers used the safety huddles to communicate with their staff. On most wards these were twice daily. Information was also sent out by email and some wards had newsletters. Ward managers said that it would be very difficult to have staff meetings due to issues round social distancing.

Staff told us that the safety huddles were effective and that they didn’t want to go back to staff meetings as they considered them a waste of time.

Medical care (including older people's care)

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a division risk register with actions and due dates. Senior managers were able to verbalise their top risks which were completion of risk assessments by staff, medical staffing and discharge of patients. There was an overdue risk on the services register related to ensuring care plans reflected individual needs. This had been due for completion in January 2021.

There were weekly meetings at division level to discuss and review previous risks and monthly meetings to ensure that the risk register was up to date.

Ward managers were aware of the risks in their areas of work and were able to verbalise these and the plans in place to mitigate these risks. Whilst staffing was an issue for ward managers, they told us about their risks specific to their ward which included pressure ulcers and falls. They had action plans in place to try to mitigate the risks.

There was a learning from deaths policy and a weekly mortality group.

Information Management

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

The service provided data about their activity to the trust board who used it to review division performance. They shared it with appropriate organisations.

Senior staff in the division used dashboards to review performance of their wards This provided oversight of patient safety and patient experience. Support could be given to areas where it was needed. This was disseminated to matrons and ward managers.

There were dashboards available to ward managers that provided the outcomes of the ward accreditation outcomes. These formed the basis of the action plans for improvement for each ward which were monitored at division level.

Engagement

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

Ward managers and senior nurses engaged with patients in the ward accreditation process. They used feedback to improve services.

The division used friends and family data for service improvement.

The trust worked with Healthwatch to monitor and understand service provision and to make changes as necessary.

Medical care (including older people's care)

The division worked with commissioners, the local authority and other community partners to improve patient safety and patient experience.

Learning, continuous improvement and innovation

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

There was a culture of learning in the division and we saw that staff at all levels wanted to improve services for patients and their relatives.

We saw that there were quality improvement projects taking place across the division and that staff were participating in these projects. They were using plan do study act cycles to support the quality improvement.

The ward accreditation process supported continual improvement to services.

The respiratory service had participated in clinical trials during the COVID-19 pandemic.

Outstanding practice

We found the following outstanding practice:

- There was an ambulatory heart failure service for day case patients and community referrals to try to prevent hospital admissions.
- There was a physiologist led implantable loop procedure service. Two device physiologists had been trained to implant loop recorders.
- A virtual COVID-19 ward had been set up to support patients at home with or without oxygen support. Pulmonary rehabilitation was also delivered through the virtual ward and had been throughout the pandemic.
- The trust had implemented faecal immunochemical testing during the pandemic. This supported risk stratification of patients on surveillance lists and could reduce the number of invasive scopes required for patients and so prioritise patient appointments.
- Stroke telemedicine was used to reduce ‘door to needle’ time for thrombolysis.

Areas for improvement

MUSTS

Medical core service

- The trust must ensure that there are enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. (Regulation 18(1))
- The trust must ensure medical staff complete mandatory training. (Regulation 18 (1)(2) (a))

Medical care (including older people's care)

SHOULDS

Medical core service

- The trust should consider formalised training for the advanced nurse practitioners with protected time.
- The trust should ensure that they continue to work with partners to ensure medically optimised patients are discharged to an appropriate location for their care in a timely manner.
- The trust should work to reduce referral to treatment times for gastroenterology.

Urgent and emergency services

Requires Improvement 

The emergency department at Arrowe Park Hospital provides care for patients from across the Wirral and surrounding areas with major injuries, life threatening illnesses and urgent medical emergencies. Each year the department cares for over 90,000 patients. The department has areas for resuscitation and treating major injuries. Patients attending with minor injuries are treated in the adjacent urgent treatment by staff from the department.

There is a dedicated children's emergency department that is open from 8am to 11pm.

As part of this inspection, we observed care and treatment of 19 patients and looked at 14 care records. We spoke to 12 patients and three carers. We also spoke with 35 staff members across the emergency department including staff nurses, senior nurses, a pharmacist, junior doctors, consultants, matrons, clinical service managers, the associate medical director, the director of operations, and the nurse director. We visited all areas of the department including the paediatric emergency department. We held two focus groups following the inspection which were attended by registered nurses and care support workers.

Our rating of this location stayed the same. We rated it as requires improvement because:

- Mandatory training compliance for medical staff did not meet trust targets. The design, maintenance and use of facilities, premises and equipment did not always keep people safe. The mental health assessment rooms did not meet national Psychiatric Liaison Accreditation Network (PLAN) guidance. The layout of the emergency department was difficult to navigate, and we saw patients getting lost and accessing restricted areas during the inspection. We found some substances hazardous to health stored in unlocked rooms which could be accessed by the public. Not all staff wore the correct personal protective equipment at all times. Staff did not always identify and quickly act upon patients at risk of deterioration in the waiting room. Staff did not consistently carry out daily checks of emergency equipment. Though staff recognised some incidents and near misses, they did not always report them appropriately. Although managers investigated incidents, they did not always share lessons learned with the whole team and wider service.
- Patients did not always receive timely care and treatment. Waiting times were not always in line with national standards. Patients often had a long wait within the department for admission.
- Some staff did not always feel respected, supported and valued by senior managers. The service did not always have an open culture where staff could raise concerns without fear. We saw limited examples of innovation or quality improvement programmes.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service controlled infection risk well and kept equipment and the premises visibly clean. The service had enough nursing and 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. Staff kept detailed records of patients' care and treatment. The service used systems and processes to safely prescribe, administer, record and store medicines. The service used monitoring results well to improve safety.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff gave patients enough food and drink to meet their needs and improve their health. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service

made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. Key services were available seven days a week to support timely patient care. Staff gave patients practical support and advice to lead healthier lives. Staff supported patients to make informed decisions about their care and treatment.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Leaders and staff actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to staff. However, not all staff had completed it. Mandatory training compliance for medical staff did not meet trust targets.

At the time of our inspection, mandatory training compliance for staff in the emergency department was 89% for nursing staff and 55% for medical staff.

The practice educator for the emergency department supported staff to access and keep up to date with mandatory training through holding block training days which staff were rostered to attend.

The mandatory training was comprehensive and met the needs of patients and staff. However, some staff told us that staff completed mandatory training in their own time.

Staff attended a one-day training session each quarter which included simulation and core skills training as well as mandatory training. Staff told us the training was designed around current issues and learning from incidents as well as changes to practice.

The block training day had included sessions delivered by external providers and specialist nurses on subjects such as mental health and domestic violence. Clinical support workers were offered the opportunity to spend a day shadowing the mental health team to address the difficulty in accessing training in mental health.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Safeguarding training compliance for level two adults and children was 80%. However, compliance for level three safeguarding adults and children was 67%.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff checked the national Child Protection Information Sharing (CPIS) system for every patient under 18 years old who attended the department to check if there was a safeguarding alert in place.

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

Safeguarding information was displayed on notice boards throughout the emergency department.

Cleanliness, infection control and hygiene

The service controlled infection risk well and kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Staff followed daily, weekly and monthly cleaning jobs checklists. These were collated by housekeeping staff and monitored through weekly matron checks which then formed part of the matron audits within the department. The cleanliness score for September 2021 was clearly displayed in the children's emergency department and showed the department had achieved 98% compliance.

The service had a designated area for patients who had been identified as positive for COVID-19. We saw hand washing facilities and alcohol hand gel at the entrance of each area and throughout the department. Personal protective equipment (PPE) was available at the entrance to each area or bay.

Staff could access support from specialist infection prevention and control (IPC) nurses, who were part of the IPC team. Two IPC nurses were assigned specifically to the department and did regular walk rounds. However, during our inspection we saw some staff not adhering to PPE guidelines. We observed seven occasions where staff did not wear gloves and aprons when providing patient care.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Point of care testing for COVID-19 patients was carried out by a separate team between 12 noon and 8pm. Outside these hours staff within the department carried out the testing.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The design of the environment did not follow national guidance. We reviewed the mental health assessment rooms and saw they did not meet the 2017 Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services. This was because there was no strip alarm in any of the rooms and doors to two of the rooms only opened inwards. Guidance states doors should open outwards or both ways to enable staff to enter and exit the room quickly. Two rooms only had small windows in the doors, and these did not have a privacy panel. The room for use for patients assessed under the Mental Health Act, had a privacy panel in the door but had a large observation window with no privacy panel.

We spoke to staff and senior managers about panic alarms. Senior leaders told us all staff had personal panic alarms. However, staff in the department told us these had been taken off them, they could not show us any alarms and told us they had to shout for help. We heard examples of staff who had been physically injured caring for patients in these rooms.

During our inspection, we observed overcrowding in the waiting room and patients had to stand or sit on the floor due to lack of space.

Staff carried out daily safety checks of specialist equipment. There was specialist paediatric resuscitation equipment within the department which was checked daily by a member of the paediatric team. We saw machines such as blood pressure monitors and defibrillators marked with an in date portable appliance test sticker. However, we saw seven gaps in the daily checklist in August and September on one emergency trolley.

We checked resuscitation trolleys in the majors area. They were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag. However, we found some out of date items such as test vials. This was escalated immediately to staff and the items were removed from the trolleys.

The sluice room and storeroom in the majors area were not locked and contained items subject to the Control of Substances Hazardous to Health (COSHH) regulations.

The service had suitable facilities to meet the needs of patients' families. There were two relatives' rooms which could be used by relatives whilst their loved ones were being treated in the department or if they had been given bad news.

Staff used a public address system to call staff to different areas of the department as needed.

The department had a clinical decisions unit which had its own staffing establishment. This had two four bedded bays and some seating for patients who were awaiting investigation results prior to discharge or admission to the hospital.

Staff disposed of clinical waste safely. Clinical waste bins were clearly marked and locked. Sharps bins were dated with a partial closure mechanism in place.

Assessing and responding to patient risk

Staff did not always identify and quickly act upon patients at risk of deterioration in the waiting room. However, once seen staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments.

Urgent and emergency services

The department was not meeting the Royal College of Emergency Medicine (RCEM) guidance on the initial assessment of emergency patients (2017). This states face to face contact with the patient should be performed in an environment that has sufficient privacy to allow the exchange of confidential information and that the assessment should be carried out by a clinician within 15 minutes of arrival. Data provided by the trust showed between July 2021 and September 2021 the average time to triage was 31 minutes. From 1 October 2021 to the date of our inspection the average time to triage was 24 minutes and 45% of patients were not seen within 15 minutes.

In addition, RCEM standards state patients should be seen by a doctor within 60 minutes of arrival in an emergency department. The service was not meeting this standard. From July 2021 and September 2021, data showed that 70% of patients were not seen by a doctor within 60 minutes. From 1 October 2021 to the date of our inspection 72% of patients were not seen by a doctor within 60 minutes.

At the end of September 2021, the number of ambulance attendances taking between 30 and 60 minutes to hand over was 11%, the number waiting over 60 minutes was 18%.

A streaming nurse from the adjacent urgent treatment centre streamed patients at reception and directed those who required treatment in the emergency department to book in with the department's reception. The urgent treatment centre nurse was not employed by the department and did not have access to the same streaming pathways and 'hot' clinics as triage nurses within the department. This meant that further 'complex streaming' took place during triage, impacting the patient journey as they had to wait for further triage following streaming before being directed to a more appropriate service. It also meant there were potentially patients in the waiting room waiting for triage who could be streamed elsewhere earlier in the patient journey.

Staff completed risk assessments for each patient on arrival. Two triage nurses were always on duty in the department and they used the Manchester Triage Scale (MTS) to assess patients. MTS is a clinical risk assessment and management tool for use in emergency departments. There was also an additional ambulance triage nurse on every shift to triage patients arriving by ambulance using the MTS. However, some staff told us there was often only one triage nurse on duty. During our inspection, we observed a senior nurse being asked to cover triage as the triage nurse was on their own, as the other had left the department.

Managers told us that during periods of high demand a second triage nurse would assess patients on the ambulance admission corridor to ensure patients with higher acuity were prioritised.

Patients requiring treatment for minor injuries were seen by emergency nurse practitioners who worked in the treatment room and in the adjacent urgent treatment centre.

Walk in patients were seen by a nurse, not employed by the trust, who used MTS to stream patients who were appropriate to be seen in the emergency department. Following triage patients who were assessed as 'fit to sit' were asked to wait in the waiting room. The service did not fully assess the risks to patients waiting in the waiting room, nor do all that was practicable to mitigate the risks. Staff did not carry out any further assessment of patients deemed 'fit to sit'. There were no staff present in the waiting room to recognise and escalate any deteriorating patients. We saw no evidence of walk rounds of the area or comfort rounds for patients during our inspection. The service told us they had recruited additional staff to carry out patient rounding throughout the department including in the waiting room. These staff were currently being trained and planned to start in November 2021.

Staff used a national early warning scoring (NEWS2) to identify deteriorating patients, and reviewed this regularly, including after any incident.

Urgent and emergency services

There was a process for transferring children to a specialist children's hospital, where appropriate, in line with the North West Major Trauma Children's Network pathway. A hotline telephone number to a specialist children's resuscitation team at a specialist children's hospital was displayed in the department.

The department had three mental health assessment rooms, one of which was a room specifically commissioned for patients requiring assessment under the Mental Health Act.

Staff attended a weekly managing violence and aggression group with partners from mental health services to identify actions to prevent patients becoming aggressive in the department and ensure plans were in place to address aggression from individual patients.

Handovers between nursing and medical staff took place each morning at shift change. We observed a medical staff handover and saw all patients in the department were discussed, staff allocated to key areas and any safety messages shared. The matron attended the medical staff handover to share any key messages from a nursing perspective. At handover key 'messages of the day' were given to all staff for example, to ensure blood cultures for sepsis were requested for all patients in a timely manner.

Staff knew about and dealt with any specific risk issues. In three patient records we saw evidence of staff following appropriate guidelines, pathways and screening tools, based on national guidelines for the management of sepsis and stroke.

Nurse staffing

The service had enough nursing staff and support 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 staffing levels, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. However, during our inspection, staff felt there were not enough staff with the required skill mix to meet the demands of the service.

The department had a dedicated children's emergency department, this operated between 8am and 11pm. It was staffed by dedicated paediatric nurses and when closed there was a dedicated children's bay in the emergency department and access to on call paediatric nurses 24 hours a day.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Staffing issues were escalated to a band seven staffing coordinator who was responsible for implementing mitigations such as requesting bank or agency staff.

The number of nurses and healthcare assistants matched the planned numbers. The numbers were planned following a full staffing review in 2019.

Senior leaders told us they conducted an acuity and dependency audit within the emergency department using the Royal College of Nursing Baseline Emergency Staffing Tool (BEST). Staffing plans were in place for winter pressures. Managers had identified potential areas of staff shortfall and surplus using this tool and at the time of our inspection further work was planned to review audit data and test out proposed staffing models.

Urgent and emergency services

The vacancy rate across the emergency department was low at 2.5%.

The staff turnover rate across the emergency department was 12%.

The sickness rate across the emergency department was 7%.

The practice educator ensured all bank staff, new staff to the department and workers returning from shielding completed a local induction. New staff completed an additional 12-week induction to ensure learning from the initial induction was embedded.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough consultant and junior grade medical staff to keep patients safe. However, senior leaders told us that medical staffing for middle grade doctors was one of the top risks within the emergency department. The triumvirate had implemented actions to mitigate this issue including the use of locum doctors and advertising clinical fellow positions. The children's emergency department had a paediatric consultant when open and out of hours staff could access paediatric medical support from the children's department.

Managers could access locums when they needed additional medical staff. Information received from the trust showed there had been an increase in the use of locum and agency staff from August 2021 to October 2021.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was paediatric consultant cover available on each shift.

The vacancy rate for medical staff across the emergency department was 12%.

The staff turnover rate for medical staff across the emergency department was 38%.

The sickness rate for medical staff across the emergency department was 5%.

The service always had a consultant on call during evenings and weekends.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed fourteen patient records during this inspection. All records reviewed included NEWS observations, pain scoring, comfort rounding and patient consent. However, in four patient records there were gaps in comfort rounding checks.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

The department had one full time pharmacist on a Monday to Friday. At weekends and out of hours staff were supported by the on-call pharmacy team.

Staff stored and managed medicines and prescribing documents in line with trust policy. All anaphylaxis and emergency drugs kits we checked were sealed, signed and had an expiry date.

The fridge used to store medicines displayed the average, maximum and minimum fridge temperatures and this was monitored daily by staff. There was an automatic alert to pharmacy if a fridge fell outside range.

We checked a random sample of medicines and all were in date.

We reviewed the controlled drugs check in, ward stock and patient's own stock books. All were fully completed with two signatures and no gaps. All controlled drugs stored in the treatment room were in date.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Incidents

Though staff recognised incidents and near misses they did not always report them appropriately. Managers investigated incidents, but they did not always share lessons learned with the whole team and wider service.

Staff knew what incidents to report and how to report them. Incidents were reported on an electronic system.

However, during our inspection, staff told us of incidents involving patients using the mental health assessment rooms and we could not find evidence that these had always been reported. Some staff told us about potential patient safety incidents they had not reported due to workload. Additionally, some staff told us they were discouraged from submitting incident reports by senior managers.

Security staff we spoke with told us they documented all incidents of restraint and de-escalation in a daily record book and any restraint carried out by security staff was reported using the online incident reporting system.

Staff understood the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. All staff we spoke with were aware of the term and the principle behind the regulation and could give examples of when the duty of candour would be applied and by whom.

There was evidence that changes had been made as a result of feedback. For example, a mental capacity assessment had to be completed on the patient record system before a clinical sedation procedure.

Urgent and emergency services

Managers told us that they debriefed and supported staff after any serious incident.

Learning from incidents was discussed at daily safety huddles and shared through the emergency department monthly newsletter. However, some staff told us that learning from incidents was inconsistent and not always timely.

Safety Thermometer

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

The service used 'perfect ward' audits to monitor performance. This was a system of lead nurse and matron, daily, weekly and monthly checks to monitor compliance with safety measures such as controlled drugs, hand hygiene and housekeeping. Any areas highlighted as requiring improvement were discussed during safety huddles. We saw the local leaders performing the audits and addressing any non-compliance. For example, we saw the matron's perfect ward audits for August to October 2021 showed 91.2% compliance across all areas and audit types. The audit breakdown for August 2021 showed two areas of concern identified on the previous audit had now been resolved.

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Clinical pathways and guidance were available and easily accessible on the trust intranet.

We observed staff using the fractured neck of femur and stroke pathways in line with the National Institute for Health and Care Excellence (NICE) guidelines.

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.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Urgent and emergency services

Pain relief

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

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

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed two patients in the triage assessment room with chest pain who were offered and given pain relief. Four patients in the waiting room told us they had been offered pain relief.

Patient outcomes

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

The service participated in relevant national clinical audits such as the Trauma Audit and Research Network (TARN) and Royal College of Emergency Medicine (RCEM) audits. Such audits were suspended nationally during the COVID-19 pandemic. However, senior managers told us the audit lead for the department had continued to carry out and monitor RCEM audit outcomes though they were not required to report the outcomes to the national system.

The clinical lead and clinical director were the RCEM leads for the emergency department.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The trust was one of the top performing hospitals in the region for compliance with the National Audit of Seizure Management in Hospitals Round 3 (NASH 3).

Managers used information from the audits to improve care and treatment. They identified a need for improving identification and initial management of silver trauma in the emergency department. Silver trauma is a term used to define trauma and injuries occurring in older patients. Audit data showed 72% of patients received a full trauma assessment in the emergency department. However, it was also identified that patients were not always triaged as trauma resulting in receiving less specialised care. Implemented actions included improving the emergency department handbook and introducing teaching as part of the staff induction.

In addition to national audits the department carried out local perfect ward audits which included hand hygiene, controlled drugs, housekeeping (environmental), adherence to personal protective equipment use and audit of any patient harm.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were link nurses for key roles such as sepsis and trauma. If there was an emergency involving a child there was a dedicated paediatric emergency team of paediatric doctors and nurses who were additional to the department staffing levels.

Urgent and emergency services

Managers gave all new staff a full induction tailored to their role before they started work. We saw the emergency department junior doctor handbook which included information regarding the department layout, how to refer patients to different services and tips on how to avoid staff burnout.

Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisal rate across the division was 81%, however this excluded medical staff due to the national suspension of the medical appraisal framework.

The practice educator for the department monitored all nursing staff clinical competencies and arranged skills sessions and competency checks for nurses. They met with staff on return to work following long term sickness absence to ensure mandatory training and competency and skills checks were completed. They worked with managers to review and address any performance issues amongst nursing staff.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The practice educator was conducting a training needs analysis to ensure the training offered met the needs of staff. They described plans to introduce a career pathway for nurses based on the Royal College of Nursing competency framework.

Managers made sure staff received any specialist training for their role. The service employed security staff, who were present in the department throughout our inspection. They told us they received in house training on de-escalation and control and restraint.

Managers were working with local mental health providers to offer clinical supervision in mental health as part of block training days for staff. The trust had offered some trial online learning modules for mental health.

However, we spoke to clinical support workers who carried out observations of patients in the mental health assessment rooms. They told us they had not received any additional mental health training to help them carry out that role.

We requested data from the trust for mental health training compliance but this was not received. The trust had drafted a mental health training plan in October 2021 for all staff across the emergency department.

Multidisciplinary working

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

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

Staff supported each other to provide good care. They had reliable links into services that maintained a rounded approach to caring for their patients. Staff told us they had good working relationships with frailty teams, physiotherapists and occupational therapists.

Staff worked with other agencies when required to care for patients. For example, the service had regular meetings with other services including mental health, sexual health and drug and alcohol services.

Seven-day services

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

Urgent and emergency services

The children's emergency department did not operate 24 hours a day, seven days a week. However, after 11pm when the department closed, a bay within the main emergency department was kept as a children's bay with appropriate emergency equipment in place. Staff could access an on call paediatric consultant outside of opening hours.

Staff could access support from psychiatry liaison services provided by another trust and available on site 24 hours a day, seven days a week.

Staff told us they had access to diagnostic services 24 hours a day, seven days a week. We observed during a bed management meeting that there were no delays for diagnostics.

Staff could access on-call pharmacy support out of hours.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support throughout the emergency department.

In the children's emergency department there was a board which had information displayed particularly for adolescents such as advice lines, counselling, information for young carers and children experiencing child sexual exploitation. Information was also displayed on basic first aid for children.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.

Staff clearly recorded consent in the patients' records. Patient consent was recorded in the fourteen patient records we reviewed.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Clinical support workers had completed 'We Can Talk' training. 'We Can Talk' uses coproduction to improve the experience of children and young people who attend hospital due to their mental health and the staff who support them.

Urgent and emergency services

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We observed kind and caring interactions between staff of all levels and patients. Staff drew curtains during consultations and when providing care to maintain patients' dignity.

Staff followed policy to keep patient care and treatment confidential. When patients had to wait on the corridor or in the waiting room staff brought them into cubicles or treatment rooms for any investigations or personal care.

Patients said staff treated them well and with kindness.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

We heard thank you letters from bereaved relatives read out at staff handovers which said they had been treated kindly and compassionately by all staff in the emergency department.

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We listened to conversations between staff and patients and heard staff answer questions and where necessary explain things in different ways differently to those who did not understand any elements of their treatment plan.

Urgent and emergency services

However, we saw a deaf patient in the emergency department communicating with staff using paper. We were told that clear face masks were available however some staff members were not aware of this.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw patient experience feedback cards available in the emergency department and patient feedback was displayed on notice boards.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population.

The urgent and emergency care service was available 24-hours a day throughout the year.

The service had systems to help care for patients in need of additional support or specialist intervention.

Facilities and premises were not always appropriate for the services being delivered. The layout of the emergency department was difficult to navigate, and we saw patients getting lost and accessing restricted areas during the inspection.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff could access support from specialist learning disability and dementia nurses through an on-call system. However, there was no specialist support available out of hours.

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

Staff could access translation and interpretation services for people who did not speak English as their first language.

Information leaflets on a range of conditions were available in the department.

The service had facilities for disabled people including automatic doors and toilets.

Access and flow

Patients did not always receive timely care and treatment. Waiting times were not always in line with national standards. However, people could access the service when they needed.

Urgent and emergency services

Patients often had a long wait within the department for admission. For example, during our inspection one patient was waiting over 14 hours for admission. Staff told us it was not unusual for mental health patients to spend up to 50 hours in the department waiting admission to a provider of acute mental health services.

Managers monitored the length of time patients stayed in the department, including those patients waiting in the waiting area and being seen in the urgent treatment centre for minor injuries. However, during our inspection the longest attendance in the emergency department was 17 hours and 54 minutes.

The number of attendances to the department had steadily increased from February 2021. In the same period, the department had admitted, transferred and discharged fewer patients. In September 2021, 37% of patients waited longer than four hours for admission, transfer or discharge. This was below the England average and performance had steadily declined since June 2021. Since July 2021, the department had seen an increase in the number of patients waiting more than 12 hours for admission, transfer or discharge. There had also been a steady increase in the number of patients leaving the department before being seen since July 2021.

The wait for a medical review for patients was lengthy, for example during our inspection we attended a bed management meeting and saw the wait for a medical review was 2 hours and 40 minutes.

The care records we reviewed showed that around 79% of patients did not have a decision to admit within 60 minutes. Data provided by the trust showed that between July 2021 and September 2021, 45% of patients spent longer than four hours in the emergency department.

In September 2021, 29% of patients waited more than four hours from the decision to admit to admission. This was an increase of 8% from August 2021 and performance had continued to decline since June 2021.

Managers told us there were regular 'streaming meetings' with colleagues from the urgent treatment centre, however the focus was on the future capital programme.

Staff told us an ambulance liaison officer from the ambulance trust attended when there were a large number of ambulances arriving, but they were not present at the time of our inspection. The trust had implemented a Situation-Background-Assessment-Recommendation (SBAR) tool for ambulance handover delays and corridor care.

Managers reviewed capacity in the department and escalated any challenges through bed management meetings which took place four times a day.

Senior managers described a range of initiatives to improve flow through the department such as work with primary care partners to deflect patients away from the emergency department who would be best treated elsewhere.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Managers investigated 45 complaints and identified themes for the acute division in the period 01 April 2021 and 27 October 2021. The main themes of the complaints were treatment and procedure and communication. Of these complaints, 13% were upheld and 52% partially upheld. We saw that outcomes of complaints included shared learning, review and changes of policy and changes or review of patient information.

There was training available to managers about dealing with complaints.

The lead nurse and matron were aware of complaints in their areas of work and investigated these complaints. They identified themes from complaints and patient feedback.

The outcomes from complaints were shared at the daily safety huddle meetings so that staff could learn and improve patient safety and experience.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good.

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

The trust was developing their own leaders to provide career progression and succession planning. There were several training courses including associate director of nursing and matrons programme, a top leaders programme, and an effective manager programme.

The emergency department was part of the acute division. There was a triumvirate leadership team for the division, this being a divisional associate medical director, divisional director of operations and divisional nursing director. Throughout the inspection frontline department leads, such as shift and team leaders were visible in the department. We observed them speaking with and supporting staff. However, despite seeing evidence of planned visits by senior leaders some staff we spoke with told us there was a lack of senior leader visibility and they did not feel listened to.

Some staff we spoke with told us there had been a lot of changes and instability in nursing leadership within the emergency department.

The department leads and senior leaders were committed and passionate about the service and worked to ensure patients were kept safe.

Senior leaders were familiar with the current challenges impacting on the service's performance and identified actions to mitigate these risks.

The trust had implemented a programme of monthly executive visits to the emergency department for 2021/2022.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Urgent and emergency services

The trust had developed a strategy for 2021 to 2026 and each division had a strategy to support the trust strategy. This had been developed with partners, staff and the public.

The strategy included working with primary care services, local authority services and other secondary care providers.

The trusts values were 'caring for everyone, respect for all, embracing teamwork and committed to improvement'. We saw the trust values displayed throughout the department.

Culture

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

We found a mixed culture in the emergency department with several nursing staff expressing concerns regarding staffing levels, leadership support and a blame culture. Some nursing staff told us they had raised concerns to senior leaders and through their union and freedom to speak up guardian but felt they had not been listened to and action taken did not always address their concerns.

Some staff also told us they felt there was bullying within the department and within specific staff groups and staff were resistant to some of the changes managers were introducing. The triumvirate had held a meeting specifically for staff groups who reported bullying. However, they told us this had not been well attended.

Leaders acknowledged there had been a number of changes in the department including changes to strengthen nursing leadership and this along with the impact of the COVID-19 pandemic had impacted nursing staff morale.

Local leaders held weekly drop-in meetings for all staff and senior leaders held 'listening in action' events in the department. Senior managers told us they had action plans to address concerns raised in these meetings. Senior managers also attended Freedom to Speak Up meetings and staff we spoke with were aware of how to contact the Freedom to Speak Up Guardian.

Local leaders met weekly with unions but reported no issues had been escalated. Senior leaders planned further meetings with unions to improve engagement from certain staff groups.

Staff expressed concern about the impact of current pressures in the department on staff well-being and welfare. Some staff told us they did not feel safe working in some areas of the department. They reported there had been an increase in patients being violent and aggressive towards staff. Staff told us there was a lack of proactive wellbeing support for staff. However, the department had trained some staff to provide mental health first aid to colleagues.

Governance

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

There were effective governance processes in place in the service. There was a divisional health and safety committee, divisional management board and divisional quality board that fed into the trust patient safety quality board.

Urgent and emergency services

During our meeting with the senior leadership team we were assured that they were fully sighted on the activity and performance in the emergency department.

The leadership team had an 'executive buddy' who was the trust Medical Director. Senior leaders met with the trust executives on a weekly basis. They also met with the clinical advisory groups to discuss pressures within the emergency department.

We were told there were weekly governance meetings for nursing staff and medical staff. However, nursing staff we spoke with told us the last three meetings had been cancelled.

Consultants from the acute and medicine divisions attended a joint patient quality safety forum to review serious incidents and identify learning.

Information such as learning from incidents was shared through the emergency department clinical governance newsletter.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The divisional 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 increase in mental health patients attending the emergency department, the mental health facilities and medical staffing for middle grade doctors.

There were monthly meetings at divisional level to review risks and the actions and improvements to ensure that the risk register was up to date.

We saw a letter dated October 2021 from the trust chief executive writing to all staff members in the emergency department in response to an anonymous letter from staff highlighting concerns in the department. The letter included actions taken by the deputy chief nurse including;

- A review of the emergency department quality and safety data to identify any issues.
- A review of all incident reporting.
- A review of the quality assurance processes in place in the emergency department.

The letter also included a range of measures to improve patient flow across the hospital including;

- Trust wide focus on discharges from the hospital working with partners.
- Weekly MADE (Multi Agency Discharge Event) to ensure full multidisciplinary oversight and action taken on delayed discharges.
- A full review of patient flow processes and escalation measures to relieve pressure at the front door.
- Work with primary care and community partners to deflect patients who attend the emergency department.

These measures were monitored through the patient safety quality board.

Urgent and emergency services

We were told there was a planned review of the triage process to improve communication with patients.

The trust had an escalation policy to deal with increased attendances and admissions.

There was an emergency department improvement action plan with a focus on topics such as triage, diagnostics, streaming and patient flow.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Data was collected to measure performance using the business intelligence (BI) systems. This included ambulance handover times, time from arrival to treatment, length of stay in the emergency department and time for referral to specialty.

The trust had an electronic dashboard in the executive office corridor showing waiting times to be seen in the department, however this was not displayed in the emergency department. Managers within the department had access to a 'live' online dashboard which gave greater detail on waiting times, ambulance handover times and time to triage.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

Staff had access to policies and procedures via the trust secure intranet.

Engagement

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

The department hosted a monthly 'frequent attenders' meeting with local system partners including the voluntary sector. Each identified frequent attender was reviewed at this meeting and care plans put in place to address the patient's needs that involved all partners. Staff gave examples of where this approach had reduced the number of times some patients attended the department unnecessarily.

Senior leaders told us they had engaged with medical staff through focus sessions and created proposed rotas in line with best practice to ensure they had the required workforce for the next five years.

Friends and family test data from December 2020 and January 2021 was displayed on notice boards in the emergency department. There were examples of positive and negative feedback, however there was no examples of implemented actions or changes for improvement.

Learning, continuous improvement and innovation

Though staff were committed to continually learning and improving services, we saw limited examples of innovation and improvement projects.

Urgent and emergency services

Areas for improvement

MUSTS

- The trust must ensure medical staff in the emergency department complete mandatory training. Regulation 18 (1)(2)(a)
- The trust must ensure that it assess the risks to patients waiting in the emergency department waiting room and do all that is practicable to mitigate the risks. Regulation 12 (1)(2)(a)(b)(h)
- The trust must ensure they provide a secure, fit for purpose environment in the mental health assessment rooms and section 136 suite. Regulation 15 (1)(b)(c)(d)

SHOULDS

- The trust should ensure that staff in the emergency department use personal protective equipment (PPE) in line with national guidelines.
- The trust should take appropriate action to improve staff mandatory training.
- The trust should ensure there are effective processes for sharing learning and improvement from incidents in the emergency department.
- The trust should ensure staff in the emergency department complete daily checks of emergency equipment.
- The trust should ensure all substances potentially hazardous to health (COSHH) are stored in secure areas in the emergency department.
- The trust should act to improve signage to ensure patients and the public can find their way around the emergency department.
- The trust should ensure that effective and timely care is provided to improve patient access and flow through the emergency department to safe discharge or transfer to inpatient services.

Our inspection team

The team that inspected the service comprised CQC lead inspectors, team inspectors, specialist advisors and an inspection manager. The inspection team was overseen by Karen Knapton, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing