Warrington and Halton NHS Foundation Trust

Warrington Hospital

Quality Report

Warrington Hospital
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Urgent and emergency services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Warrington and Halton NHS Foundation Trust serves a population of 330,000. The majority of emergency care and complex surgical care is based at Warrington Hospital.

We carried out an unannounced focused inspection of the emergency department at Warrington Hospital on 18 February 2019. The purpose of the inspection was to review the safety of the emergency department as part of a focused winter inspection programme. At the time of our inspection the department was under adverse operational pressure.

We did not inspect any other core service or wards at this hospital or any other locations provided by Warrington and Halton NHS Trust. We did visit the GP assessment unit and the ambulatory emergency care unit. During this inspection we inspected using our focussed inspection methodology. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

The trust has one emergency department which provides a 24-hour, seven day a week service. It is a designated trauma unit but patients with major trauma are usually taken directly to the neighbouring major trauma centre.

Our key findings were as follows,

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as this was required. This had resulted in a crowded emergency department with patients receiving care and treatment in corridors. One patient spent 18 hours in the department. Another was nursed in the corridor for six hours.
- Initial clinical assessment (triage) of patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. Patients (including those arriving by ambulance) sometimes waited for two hours to be triaged. There was a risk that serious medical conditions could remain undetected with a consequent delay in treatment.
- Early warning scores were not always calculated as often as they needed to be to detect patients who were at risk of deterioration.
- There were not enough nurses and doctors with the right skills and experience to treat all the patients who attended the emergency department.
- Ambulance crews sometimes had to wait in the emergency department because they could not handover their patients to hospital staff. This meant that they were not able to leave the hospital to respond to new 999 calls.
- On-call specialist doctors were often slow to respond when emergency patients were referred to them.
- There was a lack of awareness of performance standards such as ambulance handover times, response times from on-call teams, time taken to perform urgent brain scans, or average time between the decision to admit and admission taking place

However;

- Once identified, critically ill patients were seen quickly by a senior emergency department doctor and were treated according to national guidance.
- There was a supportive and friendly culture within the department which was centred on the needs of patients.
- Junior doctors felt well supported and were positive about the training they received in the department.
- Staff of all disciplines and seniority spoke positively about working in the emergency department.
- The emergency department had an energetic, cohesive and well-motivated leadership team.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We carried out an unannounced focused inspection of the emergency department at Warrington Hospital on 18 February 2019. The purpose of the inspection was to review the safety of the emergency department as part of a focused winter inspection programme. At the time of our inspection the department was under adverse operational pressure. We did not inspect any other core service or wards at this hospital or any other locations provided by Warrington and Halton NHS Trust. We did visit the GP assessment unit and the ambulatory emergency care unit. During this inspection we inspected using our focussed inspection methodology. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Warrington Hospital

Detailed findings

Services we looked at
Urgent and emergency services;

Detailed findings

Contents

Background to Warrington Hospital

The emergency department (ED) at Warrington Hospital provides a 24-hour, seven day a week service. It is a designated trauma unit but patients with multiple trauma are usually taken directly to a neighbouring major trauma centre. It sees approximately 80,000 patients a year.

The emergency department consists of an ambulance assessment area with six cubicles, major treatment area with seven cubicles, a minor treatment area with eight cubicles and a resuscitation room with five trolley bays. There are separate rooms for mental health assessment, eye examinations and application of plaster casts. In addition to the emergency department there is a small primary care centre for the treatment of patients with minor illnesses, a clinical decision unit and an ambulatory emergency care unit.

The ED consists of a 6 trolleyed triage assessment area, accessible via two sets of doors on the corridor, and is used for ambulance triage, and patients triaged from the navigator, or for streaming.

There is a separate Paediatric ED co-located within the footprint of the main ED, which has a waiting area, a separate triage cubicle, a high dependant cubicle, a further cubicle for isolation, Child & Adolescent Mental Health Services (CAMHS) or patients requiring a cubicle for any other purpose, as well as a further four trolley spaces.

We last inspected the emergency department in March 2017 and rated it as Good.

Our inspection team

The team included a CQC inspector with a background in emergency nursing, a consultant in emergency medicine and a CQC clinical fellow.

The inspection was overseen by Judith Connor, Head of Hospital Inspection.

How we carried out this inspection

We carried out an unannounced focused inspection of the emergency department at Warrington Hospital on 18 February 2019. The purpose of the inspection was to review the safety of the emergency department as part of a focused winter inspection programme. At the time of our inspection the department was under adverse operational pressure. We spoke with three patients, one relative and eighteen members of staff. We reviewed 23 patients' records.

Detailed findings

We did not inspect any other core service or wards at this hospital or any other locations provided by Warrington and Halton Trust. We did visit the GP assessment unit and the ambulatory emergency care unit. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Urgent and emergency services

Safe	
Responsive	
Well-led	
Overall	

Information about the service

The emergency department (ED) sees approximately 80,000 patients a year. It consists of an ambulance assessment area with six cubicles, a major treatment area with seven cubicles, a minor treatment area with eight cubicles and a resuscitation room with five trolley bays. There are separate rooms for mental health assessment, eye examinations and application of plaster casts.

Children have a separate treatment area with four cubicles, two side rooms and a separate waiting room. In addition to the emergency department there is a small primary care centre for the treatment of patients with minor illnesses, a clinical decision unit and an ambulatory emergency care unit.

Summary of findings

Our key findings were as follows,

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as this was required. This had resulted in a crowded emergency department with patients receiving care and treatment in corridors. One patient spent 18 hours in the department. Another was nursed in the corridor for six hours.
- Initial clinical assessment (triage) of patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. Patients (including those arriving by ambulance) sometimes waited for two hours to be triaged. There was a risk that serious medical conditions could remain undetected with a consequent delay in treatment.
- Early warning scores were not always calculated as often as they needed to be to detect patients who were at risk of deterioration.
- There were not enough nurses and doctors with the right skills and experience to treat all the patients who attended the emergency department.
- Ambulance crews sometimes had to wait in the emergency department because they could not handover their patients to hospital staff. This meant that they were not able to leave the hospital to respond to new 999 calls.
- On-call specialist doctors were often slow to respond when emergency patients were referred to them.
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Urgent and emergency services

- Once identified, critically ill patients were seen quickly by a senior emergency department doctor and were treated according to national guidance.
- There was a supportive and friendly culture within the department which was centred on the needs of patients.
- Junior doctors felt well supported and were positive about the training they received in the department.
- Staff of all disciplines and seniority spoke positively about working in the emergency department.
- The emergency department had an energetic, cohesive and well-motivated leadership team.

Are urgent and emergency services safe?

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

Environment and equipment

- The department had been gradually developed and modernised over several years. The purpose of different treatment areas had changed over time and the minor treatment area (eight cubicles) was now larger than the major treatment area (seven cubicles). The major treatment area did not have enough space for the number of patients attending the department and so patients spent many hours waiting in the ambulance assessment area. During our inspection one patient spent 18 hours in the ambulance assessment area before being admitted to a ward.
- There was not enough space in the ambulance assessment area for the five patients that were being treated there. There was very little space for doctors and nurses to move around which meant there was a risk that they would not be able to respond quickly when patients needed help unexpectedly. The area was designed for the rapid assessment of newly arrived ambulance patients. However, due to a crowded department, patient had to spend many hours in the assessment cubicles which were not suitable for long term care. For example, assessments areas do not have enough room for all the equipment needed for long term care. The medicine storage area was not designed for the regular medicine rounds needed by patients spending a day or longer in the department which meant there was a risk that all medication needed was not available in a timely way. Staff explained that they had a full range of medicines needed for emergency treatment but could not possibly store all the medicines kept on different wards throughout the hospital.
- The layout of the assessment area meant staff had to stop working at the staff base in order to allow ambulance crews to bring patients past and into a cubicle.
- Due to poor patient flow though the department staff had to look after patients in one of the corridors that ran through the department. We observed that the nurse looking after these patients was based at a workstation around the corner from the corridor and did not always

have line of sight of the patients. There was a risk of their condition deteriorating without anyone being aware of it. Research has shown that a crowded emergency department reduces patient safety.

- The nurse-in-charge was based at a central work station at the end of the ambulance corridor and adjacent to the major treatment area and the resuscitation room. This enabled them to have oversight of the sickest patients in the department as well as newly arrived ambulance patients.
- There were large computer screens displaying the progress of all patients in the department. These could easily be viewed by the nurse-in-charge of the department and staff in the major treatment area. However, nurses told us that they had difficulty accessing computer terminals in order to record patient information. A senior nurse told us that, after a set of vital signs had been measured, it could take up to 10 minutes before a computer terminal was available to record them. This sometimes led to inaccuracies in recording the time that treatment or observations were commenced on the electronic patient record. However, this did not affect patient safety during this episode of care as observations were recorded on paper records.
- The department had a dedicated ambulance entrance which was located near to the ambulance assessment area although at the opposite end of the department to the resuscitation room.
- There was a designated room for seeing patients who required a mental health assessment. This had recently been modernised so that it met the Psychiatric Liaison Accreditation Network quality standard requirements.
- An adjacent imaging department provided X-rays and scans for walking patients and those on trolleys.
- We checked a range of specialist equipment, including adult and children's resuscitation equipment. It was clean, tamper-evident, clearly organised and well maintained. It had been checked daily to ensure that it was ready for use.

Assessing and responding to patient risk

- Initial assessment (triage) of ambulance patients did not take place according to guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing.

This assessment was required to determine the seriousness of the patient's condition and to make immediate plans for their on-going care. It should take place within 15 minutes of arrival. We reviewed the records of 15 patients who had arrived by ambulance during the night and morning before our inspection. Only one had been triaged within 15 minutes. Three patients had waited more than two hours to be triaged. As a result, there was a risk that serious medical conditions could remain undetected with a consequent delay in treatment.

- Figures produced by the trust showed that, in December 2018, the median (average) time to initial assessment was 32 minutes compared to the England average of 9 minutes
- We discussed these delays with the emergency department matron who explained that the patients would have been briefly assessed by the nurse-in-charge on arrival. However, there was no record of these assessments and so we could not be certain that they had always taken place.
- The department had introduced patient streaming for self-presenting (walk-in) patients at the beginning of 2018. An experienced nurse was based at reception and briefly assessed all self-presenting patients as soon as they arrived. We were told this had improved the speed and quality of the initial assessment. The nurse decided how quickly the patient needed to be treated and in which part of the department. Some patients could be directed to other hospital assessment areas. If further observations were necessary these were carried out by a triage nurse and the patient was then re-assessed. Following this a triage priority was allocated to each patient so that doctors knew which patients had greater risk and needed to be seen quickly.
- During our inspection there was rarely a streaming nurse at the reception desk. One of the nurses told us that, if the ambulatory emergency care unit or the GP assessment unit were not accepting patients, patients would not be streamed. This was because there were limited choices for their ongoing treatment.
- In the absence of a streaming nurse all self-presenting patients were registered by a receptionist and then waited to see a triage nurse. When we arrived, we observed three patients waiting to be triaged. Two of them waited longer than 15 minutes.

- Waiting times for triage could be viewed on computer screens in the department. We observed these at intervals during our inspection and found that patients waited between 10 minutes and an hour to be triaged.
- We reviewed the records of five self-presenting patients who had arrived in the previous 24 hours. Only one had been assessed within 15 minutes. The others had been delayed between 40 minutes and two hours. These delays meant there was a risk of a patient's condition deteriorating without staff being aware.
- The National Early Warning Score (NEWS2) was used for adults. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced.
- Delays in the triage of patients meant that the calculation of the NEWS was not always done quickly enough and opportunities for identifying deteriorating patients were missed.
- Patients being cared for in the corridor and the major treatment area did not always have early warning scores calculated. During the afternoon of our inspection we were told that the sickest patient currently being treated in the major treatment area was someone with breathing difficulties. The NEWS chart showed that the last early warning score had been calculated at 8:30 am. A nurse told us that this was because blood pressure and heart rate were being continually recorded by an electronic monitor. However, calculation of NEWS also requires measurement of breathing rate, oxygen levels and body temperature. Without this the NEWS would be inaccurate and a deteriorating patient may not be identified. We brought this to the attention of a senior nurse who made the relevant observations and calculated the early warning score.
- At 7.30 pm we reviewed the records of a patient who had been nursed in a corridor for at least six hours. The patient had multiple medical problems and was waiting to be admitted to a ward. The last NEWS had been recorded at 12.40 pm. We brought this to the attention of a senior nurse who took immediate action to recalculate the early warning score.
- The nurse-in-charge did not monitor the NEWS charts and was unaware of when they needed to be recalculated. Since our inspection the trust have told us that they have introduced an additional recording process but at the time of writing the report we were unable to assess the implementation of this.
- Patients treated in the resuscitation room and the ambulance assessment area had regular observations recorded and NEWS calculated. When NEWS indicated that a patient was deteriorating senior medical staff were alerted and rapid treatment was commenced.
- We were told that a risk assessment was carried out before patients were placed in the corridor. They should have been examined by a doctor with test results and observations showing that their condition was stable. However, by 4pm staff had found it necessary to move a patient to the corridor who had not been seen by a doctor. The patient's condition did not appear to have stabilised. During the evening we observed a patient in the corridor with chest injuries and with a risk of complications. The patient had been moved out of the resuscitation room to make way for a critically ill patient. Staff told us that there was no space available on a ward able to provide the enhanced level of care that the patient needed.
- Doctors told us that they were sometimes prevented from examining and diagnosing patients because they were in a corridor. One doctor told us that they were worried about the safety of patients when this happened.
- Patients with an early warning score of five or more were screened for sepsis (a potentially life-threatening infection). We observed the treatment of three patients with sepsis. All had been screened and treated quickly and in accordance with national guidance.

Nursing staffing

- A review of nurse staffing levels had been undertaken in 2018 using evidence-based recommendations from the National Institute for Health and Care Excellence (NICE). These used the following minimum nurse to patient ratios to establish the number of registered nurses needed at any one time:

One registered nurse to one cubicle in triage and/or patient streaming

One registered nurse to four patients in minor and major treatment areas

One registered nurse to two patients in the resuscitation area

One senior registered nurse (Band 7) to lead and co-ordinate the nursing team

- In addition, two registered nurses were required to care for 8 to 10 patients in the clinical decision unit.
- At Warrington hospital this would result in a requirement of 12 nurses on duty in the adult department during the morning. An additional nurse would be needed during the afternoon and evening when there would be more patients in the department. This included a nurse to look after patients in one of the corridors.
- During our inspection there were between 11 and 12 nurses on duty. The matron explained that, despite frequent recruitment initiatives, the department still had vacancies for registered nurses and it was not always possible to achieve minimum staffing levels.
- During the afternoon of our inspection eight ambulances arrived within 20 minutes. It was not possible for the two nurses in the ambulance assessment area to assess them as well as looking after their five existing patients. We were told that the nurse in charge of the department had visually assessed the ambulance patients but was not able to measure vital signs or undertake a full assessment due to other responsibilities. Eventually a nurse was transferred from another patient area but proper assessment of the patients was considerably delayed.
- We asked to see duty rotas and records of staff allocation for the previous four weeks but it was only possible to see those for the previous two weeks. These showed that minimum staffing levels had only been achieved for 33% of the shifts. Remaining shifts were usually short of one nurse although one was short of two nurses. There was always an experienced band 7 nurse in charge of the department.
- The children's treatment area was separately staffed but there was a minimum of two registered children nurses on duty at all times. This met guidance contained in the Intercollegiate standards for children in emergency settings.
- Additional nursing posts included a team of emergency nurse practitioners who treated patients with minor injuries and two nurse consultants. The nurse consultants developed nursing practice, and ensured that it was evidence-based and regularly taught nurses to ensure they had the specialist skills needed for emergency care.

Medical staffing

- The medical team were led by eight permanent consultants and two locum (temporary) consultants. The locum consultants were not included in the specialist register of the General Medical Council and so were not as well qualified as the other consultants. There was a consultant in the department from 7 am to 11pm every day and on most days there were two consultants present. The consultants were supported by two associate specialists. This exceeded national recommendations that were in place until the end of 2018. The Royal College of Emergency Medicine published new recommendations at the end of 2018 which were being considered by the emergency department leadership team.
- We looked at the rota for the month before our inspection and saw that, when there were no consultants in the department, there was a senior middle grade (ST4 or above) on duty. There was a consultant on-call from home at night.
- Senior doctors we spoke with during the inspection told us that there were only four permanent middle grade doctors working in the department. Senior staff could not demonstrate how they would ensure there was one duty every night without using temporary staff. Following the inspection the trust informed us that they ensured that six middle grade doctors were available to work in the department and five covered shifts at night.
- At night the middle grade doctor was supported by four junior doctors. However, few of them had the experience to treat sick children. Doctors that we spoke with told us this sometimes meant delays for sick children if the middle grade doctor was already treating critically ill adult patients in the resuscitation room.
- Junior doctors spoke positively about working in the emergency department. They told us that the consultants were supportive and accessible. There had been a well-organised induction programme. In-house teaching took place twice a week and was comprehensive and well organised.

Urgent and emergency services

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

Access and flow

- There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as a bed was required. When we arrived, there were five emergency department patients in a corridor waiting to be admitted to a ward. Two of them had been in the corridor for over four hours. A patient with sepsis had been treated in the ambulance assessment area for 15 hours because there were no available beds in the hospital's high dependency unit.
- By 3pm there were 12 patients waiting to be admitted to a ward, some had been waiting for many hours. There were a further 13 patients who had been referred to specialist medical teams and we were told they were likely to need admission.
- We attended a bed management meeting where senior hospital managers made arrangement for the admission of patients to the hospital. Although they could identify empty beds for eight of the patients waiting in the emergency department the beds were not immediately available. It was not clear when the patients would be moved to a ward or where the remaining patients waiting in the emergency department would be treated.
- We were told that the hospital was on Operational Pressures Escalation Level (OPEL) 3. This refers to the number of beds available in the hospital and the number of patients needing to be admitted. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; The local health and social care system capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care. The trust had adapted this national system and had called it the Cheshire & Mersey escalation process. The trust told us that the two systems had equivalent escalation levels.
- The actions to be considered at OPEL 3 status include "Enact process of cancelling day cases and staffing day beds overnight if appropriate" and "Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases". There was no discussion of these actions at the bed management meeting and we could not be certain that the trust had taken all measures necessary to enable emergency admissions.
- We were late told that discussion about reducing the next day's planned admissions, or opening additional overnight beds, would not take place until the 5pm bed management meeting.
- In December 2018, 58% of patients requiring emergency admission waited between four and 12 hours to be admitted. This was worse than the average for hospitals in England which was 14%.
- Many patients spent longer in the department than necessary because of delays in response by on-call medical teams. Two patients had waited for over four hours for on-call teams to respond. This delayed the decision to admit to a ward and meant that the bed management team were only informed of patients requiring admission after the patient had spent several hours in the emergency department. Staff told us that the problem was worse at night because there were very few senior doctors on-call during the night. They often had to respond to very sick patients in the rest of the hospital, making it difficult for them to see patients in the emergency department.
- Many patients requiring admission had been treated by emergency department consultants. However, the trust did not allow the consultants to make the decision to admit, even though they were often more senior than the doctors from the on-call teams. Since the inspection the trust has implemented professional standard giving emergency department consultant admitting rights.
- The hospital had not established any internal professional standards and so different clinical teams were unaware of the response standards that were expected of them.
- The Department of Health's emergency access standard is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the

emergency department. We did not observe discussions between staff in any part of the hospital aimed at achieving this standard. Instead, the main aim seemed to be to admit patients within 12 hours of the decision to admit. This was mostly achieved but there was one patient who had waited 14 hours to be admitted. We observed eight patients who spent between 11 hours and 18 hours in the department in total.

- Figures produced by the trust showed that 76.4% of patients were admitted or discharged within four hours. This was worse than the national average of 84.4%.
- By 5.45pm there were still five patients waiting in the main corridor and a further seven newly arrived ambulance patients waiting in the ambulance corridor. Six ambulance crews were having to look after their patients because there were not enough nurses available. This meant that they were not able to leave the hospital to respond to new 999 calls.
- In December 2018, 14.4% of ambulances remained at the hospital for more than 60 minutes. This was worse than the average of 6% for other hospitals in England.
- By 6pm the emergency care pathway was significantly compromised and patients in the emergency department were not receiving comprehensive care. For example, they were not being treated or cared for in a suitable environment, early warning scores were not being calculated frequently enough and they were not being treated by the relevant specialist doctors. This indicated that the hospital was close to OPEL 4 status which is the most severe level of escalation.
- The emergency department leadership team had implemented a number of initiatives aimed at reducing the crowding in the department. A GP assessment unit had recently opened so that patients who had been referred to the hospital by their GPs could be seen directly by specialist teams. This meant that they did not have to take up space in the emergency department as they had done previously.
- However, by 7pm the GP assessment unit was full because all the patients needed to be admitted to a ward. Any further GP referrals would need to be treated in the emergency department. Nurses told us that this was a common occurrence. Patients would sometimes spend all night in the assessment unit because there were no beds available on a suitable ward.
- An ambulatory emergency unit was adjacent to the emergency department. It was aimed at providing rapid, day case treatment for emergency patients. Triage nurses could refer appropriate patients to the unit without them waiting to see an emergency department doctor.
- The clinical decision unit was intended to allow emergency department doctors to provide a short period of observation for patients such as those with head injuries or low-risk chest pain. The length of stay should have been 48 hours or less. When we visited five of the eight patients had been on the ward for three days or longer. One had been there for 15 days.
- The frailty team was a consultant-led multidisciplinary team that assessed and managed frail patients to avoid unnecessary hospital admissions. The team was based on a four-bedded assessment unit. There were several patients in the emergency department because of their frailty and one had been assessed by the frailty team.
- Minutes from emergency department performance meetings showed that staff were aware that the clinical decision unit was not the right place for frail patients. However, difficulties had been experienced in finding hospital wards willing to admit these complex patients.
- By 8pm the hospital had released all but one of the ambulance crews who had arrived earlier in the evening. However, four of their patients were still waiting in the ambulance corridor.
- Treatment space had been made available by moving other patients into the main corridor. One patient had sustained serious injuries and had been given very strong pain relief. The corridor did not allow the close observation that was needed. There were now a total of eleven patients waiting on trolleys or beds in corridors.
- By 9pm the bed management team had allocated six patients to empty beds in the hospital and so the number of patients in corridors had reduced to four. However, there were 10 other patients waiting to be admitted and no potential empty beds had been identified. One nurse said that this was a common situation and that she often saw the same patients in the emergency department when she returned to work the next morning.

Are urgent and emergency services well-led?

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

Urgent and emergency services

Vision and strategy for this service

- The leadership team were united in their aim to improve patient flow through the department. By reducing crowding in the department, they would improve patient safety and staff satisfaction.
- They recognised that they needed the co-operation of the rest of the hospital to achieve this. Although the team described supportive actions from some hospital teams, during the inspection we did not clearly see a co-ordinated hospital-wide approach to reduce delays for patients needing emergency admission. After the inspection the trust told us that there were plans in place for the next 12 months to help improve responsiveness

Leadership of service

- The emergency department had an energetic, cohesive and well-motivated leadership team. This consisted of the lead consultant, matron and general manager. The matron and lead consultant were highly visible in the clinical environment, supporting junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose.
- Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns. Nurses told us that the matron and the nurse manager were particularly effective at addressing problems and supporting staff.
- The nurse in charge on each shift had an overview of the progress of all patients in the department. However, the pace of activity was such that it was difficult to for them to leave the main staff base. It was unusual for them to make contact with the children's treatment area or the clinical decision unit. The day-to-day leadership of these areas was unclear.
- The doctor in charge of each shift checked blood test results and ECGs (heart-tracings) for each patient as soon as they were received. In this way, they could quickly identify abnormalities and would commence early treatment.
- We saw effective communication between the nurse and doctor in charge. However, due to the large numbers of patients in the department, joint, two-hourly reviews of patients did not take place as planned.
- The department was part of the urgent and emergency clinical business unit (CBU). This included the acute medical unit and the urgency care centre at the neighbouring Halton hospital. Emergency department staff reported a good working relationship with the rest of the CBU.

Governance, risk management and quality measurement

- There was a well-structured clinical governance system in place with the production of information about the department's clinical quality performance.This was discussed at monthly emergency department specialty meetings and used to demonstrate effectiveness and progress. Items such as quality indicators risks, incidents, lessons learnt, complaints, compliments and clinical audits were discussed.
- The meetings were well attended by senior medical staff and there was usually representation from governance or risk management staff. However, a representative of the nursing staff had only attended one of the last three specialty meetings. Nursing and operational issues were discussed at the meetings. Without a senior nurse present there was a risk that poorly informed decisions would be made.
- We were told that a consultant reviewed all deaths in the department and that monthly mortality and morbidity meetings were held. Any issues arising were discussed during monthly specialty meetings.
- There was little awareness of operational performance. For example, senior staff could not tell us whether delays for initial assessment of patients was getting worse or better. Although monthly emergency department consultant performance meetings had been planned only three had taken place between July 2018 and January 2019.
- Performance standards had only been discussed in one of these meetings (September 2018). Minutes of the meeting showed that there had been discussion about the speed of ambulance handovers and the fact that 88% of patients had been admitted or discharged within four hours. (The standard for England is 95%). There was no senior nurse present at this meeting and there was a risk that possible solutions to identified problems could not be fully discussed.

- There appeared to be no regular monitoring of other performance standards at these meetings, such as response times from on-call teams, time taken to perform urgent brain scans, or average time between the decision to admit and admission taking place. Staff were unable to tell us whether delays for ambulance handovers were improving or deteriorating. Without this information the leadership team would not know whether their efforts to improve patient flow and safety had been effective.
- Following the inspection the trust provided us copies of the emergency department senior management team meetings. At these meetings performance, safety and patient experience were discussed.
- Senior staff were aware of the risks in the emergency department. They told us that the highest risks were failure to meet the four-hour emergency access standard, patients waiting on trolleys in corridors and vacancies for nurses and middle-grade doctors. They did not maintain their own risk register but included a description of the risks in the CBU risk register. This defined the severity and likelihood of risks in the department causing harm to patients or staff and the actions needed to reduce the risk. We were supplied with a copy of the risk register (dated 08.01.2019) via our routine provider information request.
- Although failure to meet the four-hour standard was the highest risk on the register (scoring 16), it was described in terms of trust reputation and "below expected patient experience" rather than poor quality of care and patient safety.
- The shortage of nurses and doctors in the emergency department was not included on the risk register. Although patients waiting on trolleys in corridors was on the risk register it was also described in terms of poor patient experience and an increase in complaints. The safety aspects of treating patients in an unsuitable environment were not considered. The risk was rated as moderate with a risk score of 12.
- When the impact and consequences of a risk are poorly described it means that risk scores may not be accurate and high risks are not escalated to senior trust managers.
- The trust later supplied us with a second, undated, version of the risk register which contained more detail about the risks.

Culture within the service

- There was a supportive and friendly culture within the department which was centred on the needs of patients. Two patients told us that staff were always cheerful and were sympathetic to their needs. We observed the nurse and doctor in charge thanking staff for going over and above what was expected of them. We observed nurses giving each other a hug at the end of a very challenging shift and praising each other for the patient care that they had achieved.
- Healthcare assistants told us that there was a strong culture of learning and staff development in the department and that they were always encouraged to expand their skills.

All staff expressed frustration with the difficulties they encountered in providing the standards of patient care and treatment that were required. Some were worried about the safety of patients when the department was crowded. Despite this they displayed resilience, energy and determination to improve the patient experience in the emergency department.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The Trust must ensure that;

- Crowding in the emergency department is reduced so that patients do not have to wait on trolleys in corridors. Regulation 12(2)(b)
- Patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals. Regulation 12(2)(a)(b)
- There are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department. Regulation 18(1)
- Information about the performance of the service is accurate and properly analysed and reviewed by the leadership team. Regulation 17(2)(a)

Action the hospital SHOULD take to improve

The Trust should ensure that;

- Improve and monitor the speed of response from senior specialist doctors when patients have been referred to them by the emergency department.
- Implement hospital-wide measures to reduce delays in admitting patients from the emergency department.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose 1) Care and treatment must be provided in a safe way for service users. (2) 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; 1) Patients' clinical condition was not always risk assessed or reviewed in line with trust or national guidance. 2) Crowding in the emergency department meant that patients had to wait on trolleys or beds in corridors.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

This section is primarily information for the provider

Requirement notices

1. Information about the performance of the service was not properly analysed or reviewed by the leadership team.
2. Safety risks were not accurately described on the emergency department risk register and there was not an effective process to escalate high risks to trust directors.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. There were not enough senior doctors to meet the needs of patients in the emergency department at night. There were not always enough registered nurses to meet the needs of all patients in the emergency department.