healthwatch Warrington

healthwatch Halton

Enter and View

Warrington and Halton Hospital A&E department

Announced Visit

29/10/2025

What is Enter and View?

Part of Healthwatch's remit is to carry out Enter and View visits. Healthwatch Authorised Representatives will carry out these visits to health and social care premises to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows Authorised Representatives to observe service delivery and talk to service users, their families, and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists, and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation so that we can learn about and share examples of what they do well from the perspective of people who experience the service first hand. Healthwatch Enter and View visits are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit, they are reported in accordance with Healthwatch Warrington and Halton's Safeguarding Policy, the Service Manager will be informed, and the visit will end. The local authority Safeguarding Team will also be informed.

Details of the Visit

Details of Visit	
Service Address	Warrington and Halton Hospital A&E department
Date and Time	29th October 9:30 – 1.30 PM
Authorised Representatives undertaking the visit	Lisa Fidler Kathy McCullin Lee Payton Norman Holding Dot Holding

Disclaimer

Please note that this report is related to findings and observations made during our visit on 29th October 2025. The report does not claim to represent the views of all service users, only those who contributed during the visit.

Who we share the report with

This report and its findings will be shared with Warrington and Halton Hospital, Care Quality Commission (CQC) and Healthwatch England. The report will also be published on the Healthwatch Warrington and Healthwatch Halton website.

Healthwatch principles

Healthwatch's Enter and View programme is linked to the eight principles of Healthwatch, and questions are asked around each one.

1. A healthy environment: Right to live in an environment that promotes positive health and wellbeing.
2. Essential Services: Right to a set of preventative, treatment and care services provided to a high standard to prevent patients reaching crisis.
3. Access: Right to access services on an equal basis with others without fear of discrimination or harassment when I need them in a way that works for me and my family.
4. A safe, dignified and quality service: Right to high quality, safe, confidential services that treat me with dignity, compassion, and respect.
5. Information and education: Right to clear and accurate information that I can use to make decisions about health and care treatment. I want the right to education about how to take care of myself and about what I am entitled to in the health and social care system.
6. Choice: Right to choose from a range of high-quality services, products and providers within health and social care.

7. **Being listened to:** Right to have my concerns and views listened to and acted upon. I want the right to be supported in taking action if I am not satisfied with the service I have received.

8. **Being involved:** To be treated as an equal partner in determining my own health and wellbeing. I want the right to be involved in decisions that affect my life and those affecting services in my local community.

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1. Introduction and Purpose

This joint Enter & View visit to the Accident & Emergency (A&E) Department at Warrington Hospital was conducted by authorised representatives from Healthwatch Warrington (lead) and Healthwatch Halton. The purpose of the visit was to observe the physical environment and patient flow, speak with patients and relatives about their experiences, and identify areas of good practice and opportunities for improvement. Enter & View powers are conferred under the Health and Social Care Act 2012 and allow authorised representatives to visit publicly funded health and social care services to gather feedback and share findings with providers, commissioners, regulators and the public.

2. Methodology

Representatives undertook a structured programme of observation across key parts of the A&E footprint, including the main Waiting Area, Escalation Area, Corridors 1 and 2, the Ambulance Corridor, Majors, Majors Respiratory and the Discharge Decisions Unit (DDU). The team also spoke with patients and relatives who consented to share their experience using a short, consistent set of

questions. Eight anonymised patient/relative accounts were collected and are presented in Section 5. Team members held informal conversations with staff where appropriate to clarify process and pathway information. All direct quotes are reported verbatim where possible; spelling and grammar have been standardised for clarity without altering meaning.

3. Environment, Access and Facilities (External and Internal)

Location, Access and Parking

The hospital sits within a housing estate in Warrington and is accessed by road. Parking for patients and families was described as insufficient, and the car park layout was considered in need of an update. Bays were reported as too small for many modern vehicles, and the flow of traffic into the main car park led to vehicles approaching from multiple directions, creating confusion and congestion. Parking immediately outside A&E is reserved for ambulances only. There are two A&E entrances: one dedicated to ambulance staff and one for walk-in patients.

Initial Impressions and Building Condition

The A&E environment is housed within an older building that does not appear to have had major refurbishment for many years. A general impression of pressure and crowding was evident throughout the visit, with a high volume of patients and limited space, particularly in areas used for corridor care.

Entry and Foyer

There is level access via sliding doors leading to a small foyer that doubles as wheelchair storage. During the entire visit no wheelchairs were available in this area. Paintwork in the foyer requires redecoration. A glove dispenser on the wall was empty, while the apron dispenser contained stock. Staff movement was noted through a back entrance that also connects to Paediatrics.

Waiting Area, Reception and Triage Layout

The waiting area was extremely busy throughout the visit. On entering, three triage rooms are situated to the left with a couple of seats set out in front. The reception desk stands ahead and can be accessed from two sides; staff periodically switched between sides during the day. The desk is surrounded by a screen; some sections are clear, while others have a reflective coating that can appear almost mirror-like. While still partially transparent, this effect may pose challenges for people with visual impairment, balance issues, or dementia. A clearer approach would be to use fully transparent panels or, conversely, a solid block colour to reduce visual confusion.

To the right of reception, the main waiting area begins. Behind reception are the main doors into the clinical areas of A&E. Vending machines are available but accept cash only; it would be more inclusive to offer both card and cash options. A Health Care Support Worker (HCSW) was stationed in the waiting area with a small desk, observation equipment and a privacy screen to monitor patients requiring ongoing observations while they waited. While this role is positive in principle, the audibility and clarity of callouts were poor. Several patients' names were called in quick succession, and the announcements were difficult to understand from across the space. The HCSW tended to remain seated rather than moving through the waiting area to speak more clearly to individuals. Patients with hearing impairment or learning disabilities would likely struggle in this context without a more proactive and accessible approach. A nurse also supported the waiting area as part of the escalation arrangements.

A single television in the waiting area was showing general programmes; the patient information and patient-calling screen was not functioning during the visit. Two noticeboards towards the back of the waiting area contained essential patient information, but these were partially obscured by the HCSW privacy screen and would benefit from relocation to the right-hand wall by the main entrance, where there is adequate blank space. Given the large number of staff in varied coloured scrubs, a simple poster guide to uniform colours and roles would help patients and families understand who is who.

Toilets, Seating and Cleanliness

Male and female toilets are located within A&E. In the ladies' facility, of the three cubicles, one had its sanitary bin sealed in a yellow bag and unusable; this requires immediate replacement. Hand sanitiser units were available around the department and were stocked and operational. A number of broken chairs had been removed from service and taped off; given the department's sustained busyness and the consequent pressure on seating, timely replacement is advisable.

Clinical Areas and Corridor Care

Within the main A&E we visited the Waiting Area, Escalation, Corridors 1 and 2, Ambulance Corridor, Majors, Majors Respiratory and High Respiratory. The Discharge Decisions Unit (DDU) contains nine beds, currently used for patients aged over 65 and those with frailty; a leak was observed on this unit at the time of the visit. On the day, 41 patients were reportedly waiting for beds elsewhere in the hospital.

Corridor care was observed on two corridors, each with five patients in beds. Each patient's space displayed a laminated A4 sign that included the named nurse and prompts related to fluids and falls, and each corridor had a stationed nurse with a small desk, chair and computer. Nonetheless, the corridors do not provide privacy, dignity or the basic facilities of a clinical bay: there were no call buttons, no oxygen points at the bedside, and no bed-trays to hold drinks or meals. We were advised the department is exploring clip-on trays for corridor patients. A double treatment room is located on one corridor; this corridor-care model is currently being audited weekly, with consideration to increase auditing to twice weekly.

Triage Process and Quiet Space

Triage rooms operate with a senior nurse in "T1" who streams, supports and refers onward as needed. "T2" comprises two nurses who take clinical observations. All patients receive full observations including blood glucose checks. Two additional rooms are used for ambulance arrivals and triage, and there are investigation rooms for bloods and related procedures. Staff advised that the 15-minute triage standard was "almost always met".

The department indicated a “quiet space” situated behind the triage rooms; however, this was effectively a chair in the corner of a room, with no screen in use and only a curtain rail without a curtain. It offered little privacy and limited comfort, and there was no space for a carer or relative to sit alongside the patient. With minimal changes — a suitable privacy screen or curtain, comfortable seating, a small side table and visual cues such as calm colour on the wall — this could be made more appropriate for patients with sensory sensitivities, dementia or acute distress.

4. Summary of Key Findings

Across the day, the department appeared to be operating under sustained pressure, with long waits for medical review and admission driving much of the patient frustration. Many patients reported being triaged promptly but then waiting many hours — and in some cases over a day — for a doctor, diagnostic results or a bed. Communication was a consistent theme: patients and relatives often did not receive clear or timely updates, and some encountered conflicting information about their next steps. The physical environment creates challenges for dignity and comfort, particularly where corridor care is used. Seating capacity, signage, and accessible information could all be improved. The waiting area information screen and calling system were not functioning, which compounded communication issues. Hydration and basic comfort measures were variable; several patients described not being proactively offered water, hot drinks or pain relief, or not realising that these needed to be requested.

Staff were widely praised for working hard and remaining professional and courteous, especially during the day shift. However, some patients described poor experiences overnight, including delays in pain relief, noise and a lack of visible identification on some staff. On the operational side, the department described persistent exit-block pressures as the primary driver of long stays, with bed availability on wards and assessment capacity limiting flow. The team was told the four-hour standard is rarely met but that approximately 60% of under 12-hour waits were met, while several of the patients we interviewed had been in A&E for more than 24 hours. Staffing remains a significant challenge: the department reported around a 30% shortfall (roughly 15 vacancies) and a mixed model of permanent and agency nurses. On the day, the nurse in charge advised

there were regular bed meetings — five times daily — and the ability to escalate to Silver if additional staffing support is needed.

5. Patient and Relative Accounts (1–8)

Patient/Relative Account 1 (Postcode WA7 6) – Corridor 1

The patient's relative reported an arrival by ambulance the previous afternoon. A corridor bed was allocated around 10pm. The patient had only been discharged two weeks earlier after a prolonged admission. A nurse had advised a 12-hour to wait to see a doctor; at the time of interview, they had already waited approximately 16 hours. Staff were described as "brilliant but too busy." The patient has dementia and there was no quiet area available. The relative was unsure what the current IV drip was for and had not been given an update on next steps. Positives were not identified; when asked what could be improved the relative said there was nothing more staff could do given the pressures. Ratings reflected good initial triage, but poor experiences around waits, communication and explanation. Additional observations included very dry mouth and cracked, swollen lips; a request was made for mouth swabs and lip cream, but staff were uncertain whether such items were available; a wet gauze was later sought. Parking was also described as "terrible."

Patient/Relative Account 2 (Postcode WA5 2) – Corridor 1

A relative reported their father had arrived early Tuesday and had been present for over 24 hours. Communication had been minimal. They felt informed but not involved and said no timescales were given for decisions. Pain relief had not been required. Next steps were said to be a bed review with no timeframe. Staff were said to be working very hard. The relative suggested A&E was not designed for corridor beds and called for a larger department to meet demand. Ratings indicated good triage and imaging times, but poor waits to see a doctor, to be admitted, and across most experience domains. Additional notes highlighted repeated door slamming from a nearby storeroom and patients screaming throughout the night, adding to the distressing environment.

Patient/Relative Account 3 (Postcode WA7 0) – Majors

This patient was initially in the hospital for an outpatient scan and was then rushed through as an emergency at approximately 7.45pm the previous evening. They had been told they might remain in A&E for up to three days. They felt listened to but reported conflicting clinical information about whether a drain was required. Pain relief had been provided and was effective. The patient spoke positively about care from nursing staff, noting even having tea with nurses, but asked for clearer, non-contradictory information. They also reported only one toilet for Majors and the corridors, which they felt was insufficient.

Patient/Relative Account 4 (Postcode WA5 4) – Majors Respiratory

The patient attended on the advice of their COPD nurse. They had asked to be conveyed to Whiston but were brought to Warrington due to a large ambulance queue at the alternative site. They reported no updates on waiting times. Overnight, they requested pain relief; it took an hour for staff to return, and they had to remind staff again before receiving it. The patient felt staff sometimes withdrew into the staff room and left corridor patients unattended. They had not received results or an update and had not seen a doctor since the previous night. They were not in a clinical bay and had no call bell, table or bedside cupboard; the nearby call bell was connected to an adjacent space. Ratings showed good times for triage, doctor and imaging, but poor experience around admission waits and communication. Additional notes described noisy bins without dampers and night-time computer use accompanied by laughter; the patient acknowledged staff need brief respite but felt the ward area was not the right place. Daytime staff were praised.

Patient/Relative Account 5 (Postcode WA3 7) – Majors Respiratory

The patient arrived around 1.30am and was in Majors within an hour. They had a knee operation in September and had continued problems with pain and low oxygen levels. They were unclear what was happening and had not yet seen a doctor. They described day staff and two-night staff members positively but criticised another night nurse's practice and lack of visible identification. Pain was severe; their own analgesia was not effective, and alternatives were not offered. They stated they should be on Orthopaedics for wound care and still had a clip in situ. The account included a separate episode a few weeks earlier in A&E that they described as "horrendous", where they felt cold and unsupported,

struggled to obtain a blanket and pain relief, and experienced what they perceived as an unhelpful interaction regarding procedure compliance. The patient, a retired nurse, stated the overall standard of care had not been acceptable.

Patient/Relative Account 6 (Postcode WA2 9) – Main Waiting Area

This patient was triaged rapidly but then waited three hours for results. No wait times were displayed or relayed. They reported being in pain but not being offered analgesia. They received conflicting updates about next steps, with one staff member advising they were waiting to see a doctor and another saying they were waiting to be moved on. They were unsure what could be improved beyond more consistent communication. Ratings reflected good triage but poor waits and communication thereafter. Prior outpatient experiences a few weeks earlier were described as disorganised, with some staff perceived as rude.

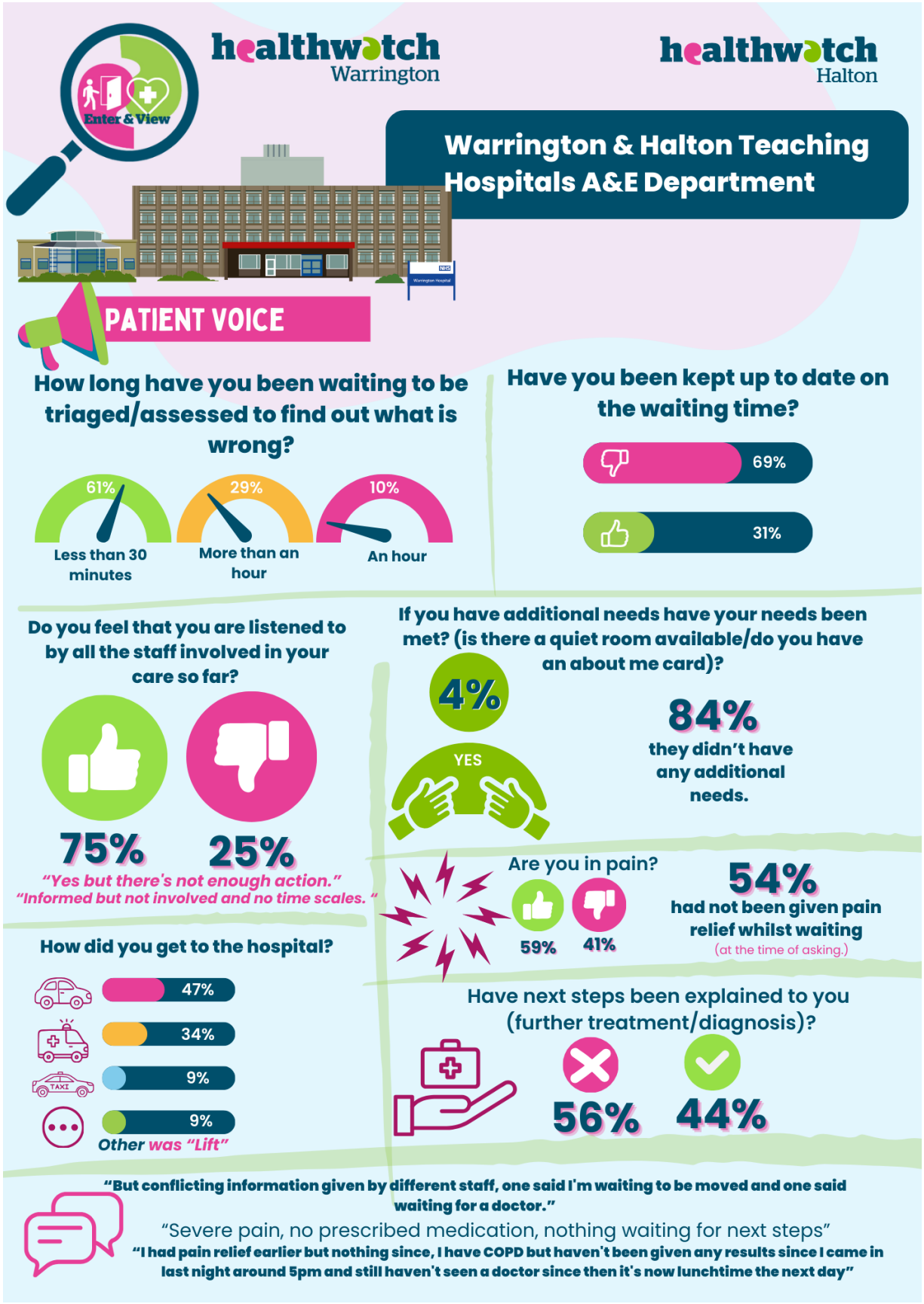
Patient/Relative Account 7 (Postcode WA12) – Waiting Room

The patient was triaged straight away at approximately 4am. They saw a doctor seven hours later and were returned to the waiting room pending blood results. They reported having spoken to very few staff and did not receive an explanation of diagnosis or next steps. Pain was described as “discomfort”; no pain relief was offered while waiting. When asked what would help, the patient suggested more doctors. Ratings recorded good triage but poor times to see a doctor, imaging, admission, and across explanation and communication. The patient stated they were given lunch only shortly before our interview and had not been offered breakfast or drinks earlier.

Patient/Relative Account 8 (Postcode WA1 3) – Waiting Room

The patient arrived at 8.30am and was triaged within 15–20 minutes. An HCA commenced observations, and a cannula was inserted; by 1.00pm, three sets of observations had been completed, but they reported no further information and had not seen a doctor. The patient had been in severe pain; they had vomited after taking painkillers at home and said no analgesia had been offered in A&E. They later learned they would need to request pain relief and had not realised that it is not routinely offered without a request, noting this was their first visit to A&E. Initial treatment steps were prompt, but thereafter the patient felt “left for

three hours with no communication." They suggested quicker updates and more medical staff. Ratings showed good triage but poor experience around waits, explanation and communication; staff were described as "nice", but communication needed to improve.



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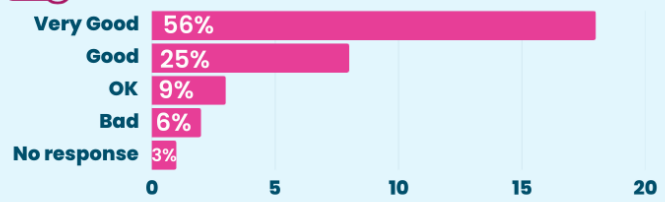
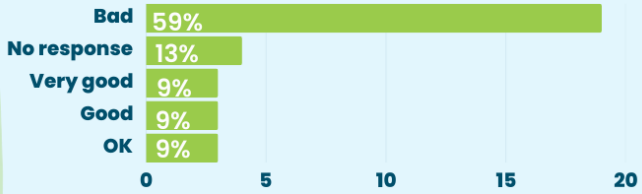
PATIENT EXPERIENCE RATINGS

Patients were asked to rate the following.

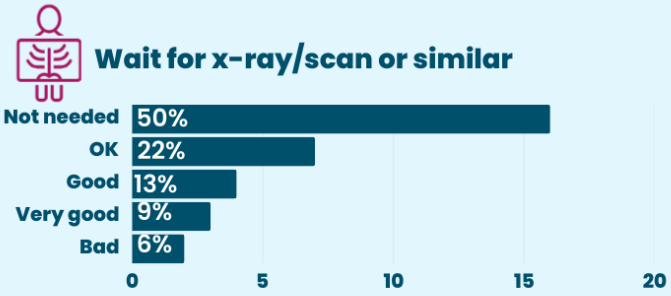
Wait to be triaged



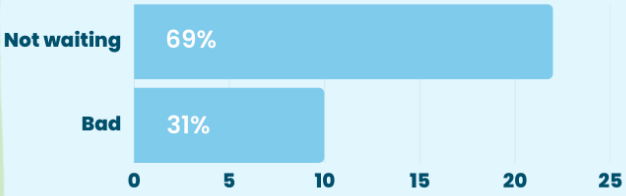
Wait to see a doctor



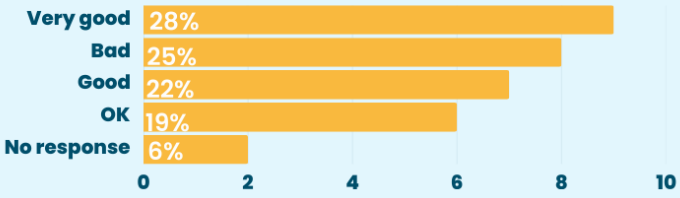
Wait for x-ray/scan or similar



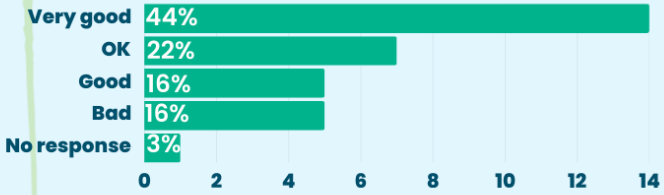
Wait to be admitted to a ward



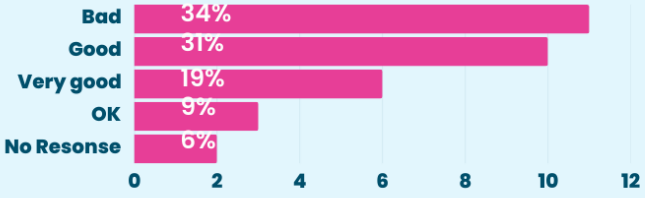
Being listened to during your appointment



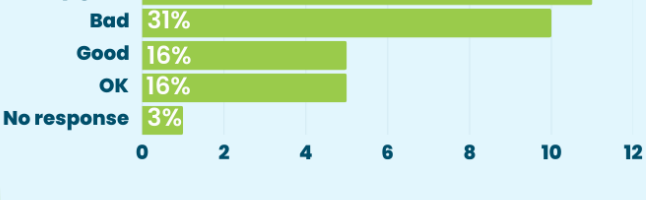
Care received by staff so far



Explaining your care/treatment



Communication



Staff attitude

"the nurses are lovely, nothing else positive, adding to already pressurised system, no night equipment and communication shocking"

Comments from patients

Waiting Times & Communication

- Many respondents reported **long waits** (some over 20 hours) and **poor communication** about expected wait times.
- Some were triaged quickly but then waited hours or days for further care.

Comments from patients:

- "Waiting 17 hours and haven't been kept up to date."
- "It's not acceptable to be put in a corridor for 3 days at my age."
- "Nurse communication poor between each other, DR wait time has been 14 hours plus , initially turned away then next thing is I require surgery, and it could have killed me, I am really disappointed and disheartened by Warrington at the moment, never had problems before."
- "No signs for possible wait times."
- "Contradicting information from staff."
- "Triaged straight away now waiting 3 hours for results."
- "Triaged within 20 minutes that was at 08.30 this morning. I haven't seen a doctor but have had 3 observations taken by the HCA in the waiting area and had a canular put in. It's now 1pm"."
- "Seen by triage straight away at 4am this morning and now only just seen a doctor over 8 hours later but then put back into the waiting room. They said they are waiting for blood results to be read."
- "I came in at 1am on Tuesday morning and tests are still going on a day and half later and still on the corridor."
- "Have not been told what the waiting time is or may be."
- "Triage was quick but I have been waiting 3 days since mostly in this bed in a corridor."
- "Haven't been waiting long yet after triage but there are no signs for possible wait times so we don't know."
- "Haven't been updated but we haven't been here long."
- "Have been waiting for a day."

- "Saw a doctor for the first time at 10.15am and I arrived at hospital at 12pm yesterday. Was in the waiting area until 1am and I am now in a corridor on a bed."
- "My mum was brought in yesterday by ambulance about 5pm and put straight on the corridor and then was given a bed on the corridor about 10pm last night. She only has only been out of hospital 2 weeks. Previously she was in here for 4 weeks then moved to Halton for a week and then home and now she's back in again. The nurse initially said it would be 12 hours to see a doctor and we still haven't seen a doctor that was 18 hours ago but someone has put a drip in."
- "Have been told a 7 hour wait at the moment when I asked at triage."
- "Waiting for a Doctor from 23:00pm last night (10 hours)"
- "Have been waiting 14 hours."

Feeling listened to by staff

Comments from patients:

- "I do with the day staff and two of the night staff but one of the night staff is not good. I had issues with her last night."
- "I'm stuck at the end here, it isn't even a proper bay, there's no call button, no tray or table so I can't have a jug of water no side cupboard, I'm meant to keep hydrated how can you when you don't have fluids. I asked staff on nights for pain relief they turned back up an hour later no pain relief so I had to ask them again."
- "Initially I didn't feel listened to but later was fine."
- "Yes, but there's not enough action."
- "Yes, mostly but when it comes to pain meds no. I asked for pain meds and waited 2-3 hours twice."
- "By some but on the whole not really."
- "Sometimes I did."
- "So far staff have communicated well but I don't know how long the wait will be."
- Sorry, I was in agony with chest pains and I was ignored, care was requested but difficult to receive, I understand the NHS is busy however I needed additional support and it was not received.

- "Staff nurse on my hub has been incredible with all of the patients in here today fantastic support"

Pain Management

Comments from patients:

- "Asked for pain meds and waited 2–3 hours twice."
- "Severe pain, no prescribed medication."
- "I asked staff on nights for pain relief they turned back up an hour later no pain relief so I had to ask them again".
- "I was in agony when I came in and I was never offered or asked about pain relief they did nothing. I have just spoken to the HCA and he told me I needed to request it, it's my first time here I didn't know this"
- "They need to have better communication, I feel fobbed off. I asked for pain meds and had to wait 2-3 hours until I got them."

Staff Attitude & Care

- Generally positive feedback about staff:
  - "Staff have been incredible."
  - "Staff nurse and specialist have been brilliant."
  - "Staff are lovely."
- However, some negative experiences were noted:
  - "Staff were really rude to me."
  - "Night staff laughing and joking on the computer."
  - "No one is taking responsibility."

Environment & Facilities

- Many comments about **inadequate facilities**, especially for patients in corridors:
  - "No call button, no tray or table."
  - "Only one toilet for Majors and Corridors."
  - "Corridor not suitable for beds."

- Suggestions included:
    - More space, pillows, and quiet rooms.
    - Better signage and information boards.

Additional Needs & Accessibility

Comments from patients:

- "Spinal cord injury left on stretcher with 1 pillow."
- "Epileptic patient exposed to flashing light."
- "My mum is 93 with Dementia and other medical health needs, there is nowhere else for her to go at the moment."
- "Don't have additional needs in terms of disabilities but required somewhere for patient to lay down"
- "yes and no, needed quiet room, not available, ok though"

Positive Experiences

- Some patients highlighted good aspects:
    - Quick triage.
    - Friendly and hardworking staff.
    - Drinks and meals provided in some cases.
    - "Care in the room has been amazing."
    - "Staff have been wonderful."
    - "Staff have been pleasant."
    - "Staff are lovely."

Areas for Improvement

- Common suggestions:
    - More doctors and quicker assessments.
    - Better communication and consistency.
    - Improved pain relief protocols.

- Enhanced facilities for corridor care.
- "Water, call bell, and table needed."
- "Better communication between nurses."

We asked what could be improved in your opinion?

Comments from patients included:

- "More doctors"
- "This hospital isn't designed for beds on corridors a bigger A&E to reduce the workload of staff."
- "Staff attitude and care and I still haven't seen a doctor."
- "I think there should be a different area for different levels of care once triaged, he needs a scan – that could be dealt with in a different area."
- "Nothing really, staff do what they can don't they."
- "The size of the facility needs to be improved."
- "In my opinion there needs to be more space, more staff and more pillows."
- "Communication is very poor and needs to be improved."
- "Being kept updated about wait times at the very least."
- "Better communication and quicker with pain meds."
- "The wait time and conditions. I have been in a bed in a corridor for a long time and all these other people too. It isn't right to be put in a corridor."
- "Communication needs to be improved so we know what is going on."
- "People could do with knowing potential wait times."
- "Offer of pain relief"

6. Additional Observations and Findings

Patient Information, Signage and Accessibility

The patient information and calling screen was not operational during the visit, reducing visibility of queue progression and increasing reliance on verbal announcements. The HCSW's approach to calling patients was not always audible or intelligible across the waiting room and may disadvantage people

with hearing impairment, cognitive impairment or those who are not confident English speakers. Core patient prompts were inconsistently visible, including advice that pain relief must be requested and that booked-in patients can access food and drink. There were no visible water stations in A&E; those waiting for extended periods would benefit from ready access to water. Two noticeboards with essential information were obscured by the HCSW privacy screen; a simple relocation would restore visibility. Given the number of uniform colours, an at-a-glance poster explaining roles by uniform would improve transparency.

Dignity and Comfort

Corridor care, while staffed by a designated nurse on each corridor and supported by named-nurse signage, did not provide call bells, oxygen points at the bedside or trays for food and drink. This has direct implications for dignity, safety and comfort, particularly during extended stays. The quiet space currently identified is not fit for purpose; it offers neither privacy nor adequate seating and is unlikely to meet the needs of people with dementia, sensory sensitivities or acute anxiety.

Clinical Pathways and Flow

Staff described triage standards as “almost always met” within 15 minutes, and our patient accounts broadly corroborate rapid initial triage. The overwhelming constraint appears to lie beyond first assessment: limited cubicle capacity, diagnostics, medical review and — most of all — downstream bed availability for those requiring admission. We were told that the four-hour standard is rarely met and that 60% of under 12-hour waits are met; a significant proportion of patients we interviewed had been in A&E for over 24 hours. The department holds five bed meetings per day and can escalate staffing needs to Silver. On the day of the visit there was a mixed model of permanent NHS and agency staff; the service reported approximately 30% staffing shortfall (around 15 vacancies). The lead nurse on duty, Yasmin, and her team were open, professional and constructive throughout the visit. We were advised the number of doctors present is coordinated by a separate team; it would be helpful for the nurse in charge to

have a simple daily brief on medical staffing numbers for situational awareness and to support patient communication.

Patient Information Tools

The “About Me” card, launched in September however was not visible in A&E. The About Me card was launched by Healthwatch Warrington in partnership with Warrington Hospital to support patients during their hospital visits. It is designed to let staff know about things that might the patient feel anxious, overwhelmed, or triggered during their appointment – more information on this can be found at https://www.healthwatchwarrington.co.uk/about-me.

Nursing and administrative staff either were not aware of it or said it had not yet been implemented in A&E. Information on Martha’s Rule was not visible to patients or carers. Both tools are intended to support safety, communication and escalation in a way that empowers patients and families; making them visible and accessible would be beneficial.

Miscellaneous

Vending machines accepted cash only, which may exclude some patients and visitors. A number of waiting-area seats were out of action and required replacement. A leak was observed on the DDU. One ladies’ toilet had an unusable sanitary bin, bagged and sealed, requiring immediate replacement. The main patient demographic observed was older people, particularly those over 65, which has implications for seating, signage, hydration, toileting access and the design of quieter spaces.

7. Summary and Recommendations

Summary

Warrington Hospital’s A&E was observed operating under sustained and significant pressure, with demand outstripping physical capacity and staff numbers. Patients were typically triaged quickly, but many then waited long periods for medical review, diagnostics, results and admission. Communication gaps were a persistent theme: people frequently did not know how long they

would be waiting, received conflicting information about next steps, or were unaware that they needed to request pain relief and could access refreshments. Corridor care helped to create capacity but compromised privacy, dignity and access to basic safety features. The physical environment shows signs of wear and tear; seating and toilets require timely maintenance, and visual information needs to be clearer and more accessible.

Staff were generally praised for their professionalism and kindness, particularly during the day. Some concerns were raised about aspects of night-time practice, responsiveness and noise. The service is clearly impacted by hospital-wide flow constraints, with exit block from wards contributing to long A&E stays. The department's leadership was open and constructive during our visit and outlined governance mechanisms such as multiple daily bed meetings and escalation routes; however, the persistence of very long waits suggests that system-level actions beyond A&E will also be required.

Recommendations

1. Reduce prolonged A&E stays by improving patient flow throughout the hospital system.

- Ensure real-time senior review of medically fit patients on wards.
- Implement proactive discharge planning earlier in the day.
- Increase the use of same-day emergency care and assessment areas to prevent unnecessary overnight stays.

2. Strengthen patient communication within A&E.

- Restore and maintain the patient information and calling screen.
- Provide regular verbal updates on waiting times and next steps.
- Display key messages clearly, including information that pain relief and refreshments are available to those booked in.

- Install visible water stations and ensure patients waiting for extended periods are routinely offered drinks.

3. Improve the dignity and safety of patients receiving corridor care.

- Introduce portable call systems and ensure access to oxygen where clinically required.
- Provide clip-on trays for food and fluids.
- Carry out regular intentional rounding to check pain, positioning, hydration, and toileting needs.

4. Redesign the designated "quiet space."

- Ensure the area meets the needs of patients with dementia, sensory sensitivities, or acute anxiety.
- Include a privacy screen or curtain, comfortable seating for both the patient and carer, and calming visual elements.

5. Optimise the waiting area environment.

- Relocate obscured noticeboards to visible areas.
- Add posters explaining staff roles by uniform colour.
- Ensure vending machines accept both card and cash.
- Replace broken chairs to restore seating capacity.
- Check toilets daily and promptly repair or replace faulty fixtures, including sanitary bins.
- Maintain fully stocked glove dispensers and ensure wheelchairs are available in the foyer.

6. Enhance inclusivity in communication.

- Ensure staff calling names for observations speak clearly and at a measured pace.
- Move through the waiting area when needed to improve audibility.
- Pay particular attention to accessibility for patients with hearing loss or learning disabilities.

- Support the HCSW role with clear communication protocols and a consistent re-check process.

7. Implement and promote key patient safety tools.

- Make the “About Me” card visible and actively used across the department.
- Display information about “Martha’s Rule” prominently within A&E to help patients and families understand escalation routes.
- Ensure the nurse in charge receives a daily summary of medical staffing numbers in A&E to support operational oversight and provide patients with more accurate updates about expected medical review times.

Note of Thanks

We are grateful to Lead Nurse Yasmin and the A&E team for their openness, professionalism and assistance throughout the visit. We recognise the intense pressures under which staff are operating and appreciate their continued dedication to patient care.

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