

# Warrington and Halton Hospitals NHS Foundation Trust

## Quality Report

Warrington Hospital  
Lovely Lane  
Warrington  
Cheshire  
WA5 1QG  
Tel:01925635911  
Website:www.whh.nhs.uk

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2017  
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This report describes our judgement of the quality of care at this trust. 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 trust	Requires improvement	
Are services at this trust safe?	Requires improvement	
Are services at this trust effective?	Requires improvement	
Are services at this trust caring?	Good	
Are services at this trust responsive?	Requires improvement	
Are services at this trust well-led?	Requires improvement	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We carried out an announced inspection of Warrington Hospital and Halton General Hospital between the 7 and 10 of March. In addition, we carried out an unannounced inspection between 3pm and 9pm on the 23 March 2017. This inspection was to follow up on the findings of our previous inspections in January and February 2015, when we rated the trust as requires improvement overall. We also looked at the governance and risk management support for all of the core services we inspected.

At this inspection we inspected the following services at Warrington Hospital:

- Urgent and Emergency Care
- Critical Care Services
- Services for Children and Young People
- Maternity and Gynaecology Services
- Medical Services [Including the care of older people]
- Surgery
- End of Life Services
- Outpatient and Diagnostic Services

At this inspection we inspected the following services at Halton General Hospital:

- Medical Services [including the care of older people]
- Surgery
- Outpatient and Diagnostic Services
- Urgent and Emergency Care Services

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed to our aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

We rated Warrington Hospital as requires improvement overall with Medicine [including older people's care]

Critical Care, Outpatient and Diagnostic services and Maternity and Gynaecology Services as requires improvement. We rated Surgery, End of Life Services and Services for Children and Young People as good.

We rated Halton General Hospital as Requires Improvement overall, with Medicine [including older people's care] and Outpatient and Diagnostic Services as Requires Improvement and Urgent Care Services and Surgery as Good.

We rated Warrington and Halton NHS Foundation Trust as Requires improvement. There had been progress since our previous inspection with improvements noted in urgent and emergency care, maternity, outpatients and diagnostics and critical care. However, the Trust continues to require improvement.

We saw some areas of outstanding practice including:

- The trust had developed the Paediatric Acute Response team to deliver care in a Health and Wellbeing Centre in central Warrington. This allowed children and young people to access procedures such as wound checks and administration of intravenous antibiotics in a more convenient location. It also allowed nurse-led review of a range of conditions such as neonatal jaundice and respiratory conditions in a community setting that would have previously necessitated attendance at hospital.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The public engagement work at the urgent care centre was innovative using the local rugby league clubs to promote the appropriate use of services on their website with Youtube videos.
- The environment on the Forget Me Not ward had been designed using the recommendations set out by The Kings Fund to be dementia friendly. The ward was designed to appear less like a hospital ward and

# Summary of findings

featured colour coded bay areas and a lounge and dining area designed to look like a home environment. There was access to an enclosed garden and a quiet room.

- The training of all the consultants within the accident and emergency department in the use of ultrasound for timely diagnosis of urgent conditions.
- Within the urgent and emergency care division, the use of the Edmonton frailty tool in the treatment of older people in the department and the wider health economy.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure that paper and electronic records are stored securely and are a complete and accurate record of patient care and treatment.
- The trust must ensure that staff receive the appropriate level of safeguarding training.

- Critical care services must improve compliance with advanced life support training updates and ensure that there is an appropriately trained member of staff available on every shift.
- The trust must ensure that the formal escalation plan to support staff in managing occupancy levels in critical care is fully implemented.
- The trust must ensure that there are appropriate numbers of staff available to match the dependency of patients on all occasions.
- The trust must ensure that all risks are formally identified and mitigated in a timely way as part of the risk management process.
- The trust must take action to ensure that all safety and quality assurance checks are completed and documented for all radiology equipment, in accordance with Ionising Radiations Regulations 1999.

**Professor Ted Baker**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Warrington and Halton Hospitals NHS Foundation Trust

The majority of emergency care and complex surgical care is based at Warrington Hospital whilst Halton General Hospital is a centre for routine surgery and is home to the Cheshire and Merseyside NHS Treatment Centre [CMTC] building where orthopaedic surgery is performed. Warrington and Halton NHS Foundation Trust serves a population of 330,000. Although both hospital sites specialise in particular aspects of care, outpatient clinics for all specialties are provided at both sites so

people can access their initial appointments close to home wherever possible. Warrington Hospital and Halton General Hospital are around 10 miles apart and are easily accessible via local motorway networks.

CQC inspected the trust using the new comprehensive inspection model in January 2015. This resulted in the trust overall, being rated as Requires Improvement with improvement needed in urgent care; medical care; maternity and outpatients and diagnostics. Since January 2015 the CQC has monitored the trust's progress.

## Our inspection team

**Chair:** Bill Cunliffe, Consultant colorectal surgeon with 6 years' experience as a medical director

**Head of Hospital Inspections:** Ann Ford, Care Quality Commission

The team included CQC Inspection Managers and inspectors, a variety of specialists: including consultants

in Surgery, Medicine, Paediatrics, end of life care, senior nurses, a non-executive director, a director of nursing, allied health professionals and experts in facilities management, governance, pharmacy, equality and diversity and experts by experience.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following eight core services at Warrington and Halton NHS

Foundation Trust:

- Accident and emergency
- Medical care (including older people's care)
- Surgery

- Critical care
- Maternity and gynaecology
- Services for children and young people
- Outpatient and Diagnostic Services
- End of Life Care

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services.

We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We spoke with people who used the service and the people close to them.

# Summary of findings

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Warrington and Halton NHS Trust.

## What people who use the trust's services say

We spoke with approximately 104 patients during our inspection across all services. Feedback was generally positive with patients telling us staff treated them with dignity and respect and they were all very comfortable with the level of care.

Many of the patients we spoke with praised staff for their caring compassionate attitude. We were told “I think it’s perfect what they do, treated as an individual, not a number they tell you what’s what” and “We are exceptionally impressed with the highly professional service over the last 20 to 25 years.” “We are really well cared for here” Another patient said “Nurses here can’t do better, it is relaxed, caring and helpful”.

Patients recognised staff were under pressure at times telling us ‘all the staff do an amazing job with the pressures they are under’. One patient told us how a porter was ‘jovial and sensitive to my needs’ during a delayed scan appointment. On the day case unit a number of patients praised the hospital and the care they received.

Relatives told us they were included in care relatives and said they felt there was a high standard of compassion among all the nurses and doctors. They recognised the anxieties the families had and tried to reassure them all the time. One relative told us “I can’t say enough about their kindness to of us.”

## Facts and data about this trust

Warrington and Halton Hospitals NHS Foundation Trust forms part of Mid Mersey health economy and is 18.5 miles east of Liverpool, 16 miles west of Manchester and 8 miles south of St Helens with a turnover of £210m. The Trust manages two major hospitals - Warrington Hospital and Halton General Hospital. Warrington and Halton NHS Foundation Trust, serves a local population of over 330,000. Providing access to care for over 500,000 patients.

Within the Trust’s catchment geography are some areas with high levels of deprivation, with high levels of

incapacity due to chronic ill health and with higher than national benchmarked levels of hospital admissions for both emergency and elective care. The health of people across Warrington and Halton varies, but outcomes for people tend to be worse than the national average, particularly in the Halton area. Life expectancy for men and women in both the Warrington and Halton areas is worse than the national average. There is also a higher number of hospital stays due to self-harm and alcohol related harm in both areas, compared to the national average.

# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <ul style="list-style-type: none"><li>• During inspection, we found six separate breaches of Ionising Radiation Regulations 99, regulation 32, which refers to routine quality assurance of equipment used in diagnostic imaging.</li><li>• We found three breaches of Health and Safety Executive guidance note PM77 'Equipment used in connection with medical exposure' Regulation 36 in the CT department.</li><li>• We were not assured that critical care services were able to provide a member of staff who was up to date with advanced life support training on every shift. We found that advanced life support training for adults and children was not provided for any nursing staff. Additionally, only 55% of medical staff and 79% of acute response team staff had completed training updates.</li><li>• At the time of inspection we were not assured that there were sufficient controls in place to prevent the critical care service exceeding full capacity. This was because critical care services were not currently using a formal escalation policy.</li><li>• We found that level 3 safeguarding training for children had not been provided for any critical care staff despite procedures being in place to admit adolescents (16 to 18 year olds). This was not in line with the intercollegiate document (safeguarding children and young people; roles and competencies for healthcare staff, 2014).</li><li>• Staff in the critical care unit did not currently have access to an electronic safeguarding flagging system that was being used in other parts of the hospital as all patient records were paper based. This would be used to alert staff if there was a safeguarding concern about a patient. Staff informed us that they were reliant on the nurse and medical handovers to transfer this information as part of the admission and discharge procedure. Safeguarding concerns were also discussed during the twice daily safety huddle.</li><li>• Patients were at risk of being unlawfully deprived of their liberty or receiving care and treatment without consent to because staff did not follow the trust Mental Capacity Act procedure.</li><li>• In the Accident and Emergency Department, there was insufficient medical cover at night in the department though this had been addressed by the unannounced inspection.</li></ul>	<p><b>Requires improvement</b> </p>

# Summary of findings

- The mental health room in the Accident and Emergency department was not fit for purpose and there needed to be improved joint working between the staff in the urgent and emergency care department and the mental health teams.
- Medical staff within the Accident and Emergency Department had not achieved compliance with mandatory training with the lowest compliance 36% for Equality and Diversity and Mental Capacity Act and the highest for medicines management of 57%.

## However:

- With the outpatients and diagnostic service, we noted that significant improvement had been made in relation to the availability of records since the last inspection. Records audits now demonstrated an average of 99.7% of records being in clinic when required. Investigations were undertaken on every missing record.
- The incomplete referral to treatment targets for England is that 92% of patients have an appointment within 18 weeks. Between December 2015 and November 2016, 94.2% of patients had received an appointment within 18 weeks, the trust performed better than the England average consistently across the 12 month period recording over 97% for November and December 2016. Targets were met by the trust's development of waiting time initiative clinics.
- Within the Accident and Emergency Department, systems had been put in place to improve access and flow through the department and although targets were not been met there had been a continuous improvement in waiting times.

## Duty of Candour

- The Trust acknowledged that its processes for monitoring Duty of Candour lacked rigour. There was no formal system for ensuring that patients and/or their families were encouraged to ask questions to inform the root cause analysis investigation. This was reported to the Quality Committee during the week of the inspection. No monitoring of whether the 10-day timescale for initiating Duty of Candour was in place and the Board did not receive any information about this regulatory requirement.
- We requested evidence of Duty of Candour being applied for 5 incidents where moderate harm had been caused and 5 serious incidents. This presented a challenge for the Trust. The information was collated for the serious incidents alone and clearly demonstrated that Duty of Candour was not being initiated and/or recorded consistently. There was only 1 example of a letter to a family for Duty of Candour but this had

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come about as a result of a complaint, not via the Trust identifying the incident themselves. Despite all the known issues in complaints, a number of the serious incidents had originated via the complaints route and been escalated appropriately. The timeliness of responses remained an issue with the Duty of Candour example we were shown taking 5 months from the initial complaint to the sharing of the final investigation report. There were no examples of involvement with the patient or family to inform the scope of the investigation. The Trust acknowledged that this regulatory requirement was not being met in full; they believed that the ethos of being open with patients and families was well embedded but the systematic application of the regulatory requirements was not in place.

- We found that some moderate incidents and the application of Duty of Candour, had not been looked at by the Trust at all.
- Patients were at risk of being unlawfully deprived of their liberty or receiving care and treatment without consent to because staff did not follow the trust Mental Capacity Act procedure.

## Safeguarding

- In quarter three, only 75% of patients were screened for sepsis where the trust sepsis screening protocol should have been completed. Only 51.4% of patients with severe sepsis, red flag sepsis or septic shock received IV antibiotics within 90 minutes of identification. This had improved from the quarter two audit, which showed 48% had been screened and 50% had received antibiotics within 90 minutes. We reviewed one set of records where sepsis had been diagnosed and saw that there had been no screening for sepsis despite the patients presenting condition and that sepsis six had not been implemented for 48 hours.
- Staff in the critical care unit did not currently have access to an electronic safeguarding flagging system that was being used in other parts of the hospital as all patient records were paper based. This would be used to alert staff if there was a safeguarding concern about a patient. Staff within the unit, informed us that they were reliant on the nurse and medical handovers to transfer this information as part of the admission and discharge procedure. Safeguarding concerns were also discussed during the twice-daily safety huddle.
- There was a designated lead for safeguarding adults and children within the trust. Staff in acute care services were aware of their responsibilities in relation to adult and children's safeguarding. They were able to tell us where to gain advice

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and how to make a safeguarding referral. The safeguarding team were available for advice during normal working hours. A safeguarding hub was available on the trust intranet with additional information to support staff.

## Incidents

- The Trust is an average reporter of patient safety incidents based on the latest NRLS data, with incidents being uploaded in a timely manner. The Trust has a different profile in terms of harm caused than other trusts. For example, the number of incidents reported as causing 'no harm' at this Trust is 57.6% compared to the national average of 75.5%, 41.9% for 'low harm' compared to 21.6% nationally and 0.4% for 'moderate harm' compared to the 2.5% national average. We asked the Deputy Director of Integrated Governance and Quality what the Trust had done to understand this data and seek assurance around its grading of incidents. As the Head of Quality Governance is relatively new in post, it was confirmed that the Trust did not have assurance at this point around the grading of their incidents or an understanding of why this differed from the national profile.
- We had concerns that incidents of mortality, were not always being reviewed thoroughly or in a timely way. For example, the Critical Care service held monthly mortality review meetings that were used to review all patient deaths that had occurred in the unit. However, the management team informed us that four out of twelve of these meetings had been cancelled due to operational demand. Mortality reviews are important as they are used to identify any areas of improvement by reviewing the diagnosis as well as the care and treatment that had been delivered to the patient. Additionally, mortality reviews were not undertaken with members of multidisciplinary teams who had also been involved in the care of the patient. This meant that there was potential for learning opportunities to be missed.
- We found that there were pockets of good practice with regards to incident reporting and learning from incidents across the Trust alongside services that needed to improve. This was supported by the findings of the core service teams with areas such as Surgery and Children and Young People able to demonstrate understanding and improvement compared to services that were not reporting all appropriate incidents and did not understand how to grade them.

## Staffing

# Summary of findings

- Within the Urgent and Emergency Care division, there were times when there were insufficient registered nurses to care for patients. There were high numbers of medical staff vacancies and agency use was high. Patients did not always receive timely medical intervention, for example in cases of sepsis.
- Staffing within the neonatal unit did not meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM). We reviewed staff rotas on the neonatal unit between 1 January 2017 and 9 March 2017 and found that BAPM standards were met on 86 shifts from 136, a rate of 61.8%.
- We noted that the Accident and Emergency department was using the safer staffing model, this tool determines the number and skills of the staff needed to effectively manage and care for patients. The nursing establishment for the department was for 44 full time nurses and at the time of the inspection there were just under 39 full time equivalent nurses in post. In December 2016 the vacancy rate for nurse staffing was 21.9%.

## Are services at this trust effective?

**We rated effective as Requires Improvement because:**

- The overall combined elective and emergency caesarean section rate was above the national average of 26% (NHS Maternity Statistics, England: 2013-14) seven of the 12 month period. The previous CQC inspection highlighted this as a concern.
- There were a range of local policies, standard operating procedures and clinical guidelines that were out of date. For example we noted that local policies within the Critical Care department were out of date. This meant that there was a risk of them not reflecting up to date guidance.
- There was a trust wide Mental Capacity and Deprivation of Liberty Safeguard Operational Procedure in place which set out the legal requirements of the Mental Capacity Act (2005) and contained information and procedures for staff to follow when there was reason to doubt a patient's capacity to consent. We found that there was a widespread failure to act in accordance with this procedure and the Mental Capacity Act (2005).
- Between October 2015 and September 2016 the trust performed worse than the England average for the percentage of patients aged 1-17 years who had multiple emergency admissions for epilepsy.
- Critical care did not have a formal multidisciplinary team meeting in which all members of the team would attend. Additionally, all team members did not attend the daily ward

**Requires improvement**



# Summary of findings

round. This meant that nursing and medical staff had to handover patient information informally when needed. The management team had not made any plans to introduce multidisciplinary team meetings.

- Governance systems were not sufficiently embedded within the acute care division. The risk register was not effectively managed to show how risks to patients or the service were being reduced.

## However:

- We saw many examples of evidenced based care and treatment in outpatients and radiology. Clinical audits were performed in line with best practice and results frequently shared at a regional and national level.
- The incomplete Referral to Treatment Targets [RTT] for England state that 92% of patients have an appointment within 18 weeks. Between December 2015 and November 2016, 94.2% of patients had received an appointment within 18 weeks, the trust performed better than the England average consistently across the 12 month period recording over 97% for November and December 2016. RTT targets were met by the development of waiting time initiative clinics.
- The palliative care team based the care it provided on the National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults (2013). They also followed the NICE guidance, care of dying adults in the last day's life published in December 2015. The Trust had previously contributed to the National Care of the Dying Audit (NCDAH).
- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) guidelines. For example the national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50. Staff also assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE guidelines CG92.
- The National Paediatric Diabetes Audit 2014/15 showed that Warrington hospital performed better than the England average for the number of individuals who had controlled diabetes.

## Evidence based care and treatment:

- The trust used National Institute for Health and Care Excellence (NICE) guidelines to determine care and treatment provided and records we reviewed confirmed there were a number of evidence-based pathways in place.

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- There were a range of clinical care pathways that adhered to NICE guidance and guidance from the Royal College of Emergency Medicine (RCEM) and points relevant to this guidance in the pathways were highlighted in the documentation. These pathways included cardiac chest pain, fractured neck of femur, sepsis and stroke. One of the consultants was responsible for pathways and these were updated at regular intervals.
- The trust completed the trauma unit dashboard and this showed that the trust scored 88.9% of patients had rapid access to specialist major trauma care within 12 hours of the referral request. This compared to a national mean value of 71.4%. The trust scored highly in every area except one which was the proportion of patients receiving a computerised tomography (CT) scan within an hour of arrival in the department.
- Within the Maternity division, a retrospective audit took place from 1 October 2015 to 30 September 2016 to monitor compliance with national standards for the national Sickle cell and Thalassaemia program. The Key Performance Indicators (a measurable value that demonstrates how effectively the service is achieving key objectives) met the acceptable national standard and compliance rates. However, it did highlight data collection and analysis issues due to the introduction of the of a new IT system.

## **Patient outcomes:**

- Following sub-optimal findings from the RCEM sepsis audit in 2013/14, the sepsis pathway had been redeveloped with the consultant sepsis lead, a microbiologist, a pharmacist and the infection control nurse. There was a sepsis screening tool and every patient attending the majors area of the department had venous blood collected for a venous blood gas analysis, there was a near point testing machine for blood gases and blood sugar levels in the department. Following a diagnosis of sepsis, staff consulted with pharmacists on the administration of specific antibiotic therapy depending on the cause of the infection.
- The trust completed the trauma unit dashboard and this showed that the trust scored 88.9% of patients had rapid access to specialist major trauma care within 12 hours of the referral request. This compared to a national mean value of 71.4%. The trust scored highly in every area except one which was the proportion of patients receiving a computerised tomography (CT) scan within an hour of arrival in the department.
- Within the Urgent and Emergency Care division, a pathway had been developed for non-invasive ventilation (NIV) and the nurse

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skills had been identified to support this pathway. NIV is used to support patients in acute and chronic respiratory failure. A standard operating procedure was in place for the pathway. One of the consultants had developed a thoracic injury pathway which was now being used in the department.

- Between April 2016 and September 2016 the Critical Care unit performed similar to comparable trusts for early readmissions to the unit (within 48 hours of discharge). The unit's performance for late readmissions (after 48 hours) was also consistently similar to other trusts. This was important as it measures how safely patients were discharged from critical care and how effectively they had been managed outside of the unit, particularly if they have had a period of deterioration.

## **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- There was a trust wide Mental Capacity and Deprivation of Liberty Safeguard Operational Procedure in place, which set out the legal requirements of the Mental Capacity Act (2005) and contained information, and procedures for staff to follow when there was reason to doubt a patient's capacity to consent. We found that there was a widespread failure to act in accordance with this procedure and the Mental Capacity Act (2005) in areas we visited during our announced inspection. We found that staff had not completed capacity assessments based on the two stage test as set out in the Mental Capacity Act Code of Practice. On the Forget Me Not ward, we found that 15 patients had Deprivation of Liberty Safeguards (DoLS) in place but only two of these patients had a formal documented capacity assessment completed. On the stroke unit, there were six patients with DoLS in place and none of these had a capacity assessment. This meant that patients were at risk of being unlawfully deprived of their liberty.
- However when we returned on our unannounced inspection, we saw that capacity assessments had been completed correctly for each of the patients who had DoLS in place on the Forget Me Not ward. The ward manager also told us that staff were attending additional training from the local clinical commissioning group and there were plans to arrange further training specifically aimed at band 5 nurses.
- The trust reported that between January 2014 and December 2016 Mental Capacity Act (MCA) training had been completed by 77% of staff within Medical Care. This was below the trust target of 85%.
- Consent was taken from patients attending endoscopy on the day of the procedure. Patients told us they were given sufficient

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information about the procedure and time to ask questions. When we reviewed consent records during our inspection we saw that one patient had not signed the consent form although the procedure had been undertaken. We discussed this with the patient and staff at the time of the inspection and found that the consent process had been completed but the patient had not been asked to sign the consent form. This was immediately addressed by staff in endoscopy. We reviewed consent forms for two patients on the cardiac catheterisation lab and saw that these had been completed correctly.

## Multidisciplinary working

- A member of the critical care outreach team was responsible for following patients up who had been discharged to a ward. We spoke to a number of staff on various wards, who spoke highly of the support that they received from the outreach team. Staff informed us that they felt that the outreach service was effective at stabilising and managing patients outside of critical care. However, we noted that audits were not currently being completed to measure the effectiveness of this service.
- There were areas of the trust that did not have a formal multidisciplinary team meeting in which all members of the team would attend. Additionally, we found that in some areas of the trust, all team members did not always attend daily ward rounds. This posed a potential risk to patients as it meant that nursing and medical staff had to handover patient information informally.

## Are services at this trust caring?

### We rated caring as Good because:

- Staff were kind, caring and compassionate. Staff respected and maintained patients' privacy and dignity. Friends and family test response rates were high and results were generally positive. For example the coronary care unit and day case catheterisation laboratory both had average recommendation scores of 99% and above.
- A range of specialist nurses were available across the trust. These nurses provided additional information and emotional support. Staff made referrals for additional emotional support and sign posted patients or their relatives to other sources of support such as charitable organisations.
- Patients told us staff were kind and caring and they introduced themselves when they first met. Staff called patients by their names. We noted that staff took all possible steps to maintain patients' privacy and dignity and patients confirmed this.

Good



# Summary of findings

- Throughout the trust, we noted that, staff communicated with patients and relatives effectively ensuring that they understood all aspects of the care and treatment that was being provided.
- The Trust held an annual memorial service for relatives and friends of patients who had passed away in critical care services. Staff informed us that this had been well attended.
- We saw positive examples of staff providing emotional support to relatives, explaining information about a patients' condition in a way in which that they were able to easily understand.

## **However:**

- One family whose relative was living with dementia told us they had received conflicting information from different members of staff about the plans for their relatives care, and that they did not always receive enough information from medical staff.

## **Compassionate care**

- Staff described how they had supported a family from abroad who experienced a sudden illness and bereavement. Staff provided practical, emotional, spiritual and psychological care for the family who were alone a great distance away from home and went over and above what could be normally expected to facilitate the family's return home as easily as possible.
- There was a member of staff who had recently been awarded employee of the year by the Trust. They had co-ordinated and facilitated a complicated discharge for a patient who had been in critical care for a long period of time.

## **Understanding and involvement of patients and those close to them**

- Patients told us they were given enough information about their care and treatment. They were given opportunities to ask additional questions of nursing staff and consultants.
- Conversations regarding a patient's condition, care and treatment and prognosis were managed in a sensitive way. We saw an example of treatment being withdrawn and relatives being communicated with in a clear and compassionate manner by members of staff.
- There was an annual memorial service held for friends and relatives of patients who had passed away in critical care. Staff informed us that this had been well attended. We saw examples of when relatives had provided positive feedback about this, thanking staff for everything that they had done.

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## Emotional support

- Children scheduled for surgery would be cared for by the same nursing staff during their pre-operative outpatient appointment, inpatient admission for surgery and recovery period to ensure they had a familiar face and continuity of care.
- Any patient, following a miscarriage or stillbirth was referred to the bereavement midwife for clinical, practical and emotional support. The bereavement midwife allocated time to comfort and advise parents through sensitive issues such as memory items such as photos, pictures, cuddling their baby as well as providing support and advice around burial.
- There was a designated bereavement suite, which included a separate delivery room, for parents who had lost a baby. This included a large homely designed room away from the main ward with facilities for parents to remain with their baby should they wish. It was a sensitive environment and the decoration had been chosen and provided by a bereaved parents' charity.

## Are services at this trust responsive?

### We rated responsive as requires improvement because:

- The Urgent and Emergency Care division continued to experience challenges in relation to patient flow. The number of patients experiencing a delayed transfer of care had increased when comparing data from 2015 to 2016. This was despite a reduction in the overall number of patient admissions to medical services.
- At our last inspection we told the trust it must reduce the number of patient bed moves. When we compared data from 2015 to 2016 we saw that more patients experienced bed moves. This meant that the trust had not reduced the number of patient bed moves and that this issue had increased rather than decreased. Many of the ward moves happened overnight.
- As of the 20th February 2017, the Trust had 239 open complaints with only 66 of those under the 35-day Trust target for completion (this does not mean that these complaints would be responded to under the 35-day target).
- We found that a significant proportion of the complaints (80) had gone over 6 months past the 35-day target, with the remaining 93 between 35 days and 6 months. The oldest open complaint at the time of the inspection was over 2 years old (received in December 2014 - ref 7864), another from 2015 was noted and a number from early 2016.

## Requires improvement



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- Records indicated that between January 2016 and December 2016, there had been 75% delayed discharges from the critical care unit (greater than four hours following the decision being made that a patient is fit for discharge to a ward).
- Adult areas where children were seen with the exception of the ophthalmic clinic, lacked any child friendly decoration or activities.
- The Critical Care Unit had struggled to meet the standard set by the Department of Health in managing mixed sex accommodation appropriately. We saw examples of this during the inspection.
- Halton hospital clinic facilities were generally congested and there was insufficient seating for patients in some clinic areas. Managers said clinics were running at full capacity on a daily basis.
- High levels of sickness absence in band 5 outpatient staff had impact on the department's capacity to run additional late clinics.
- There was limited personalisation of care plans in the records we reviewed. Plans were largely pre-determined. An audit of patient records in January 2017 showed that only 26% of patients had a personalised dementia care plan in place.

## However:

- A Child and Adolescent Mental Health Service (CAMHS) worker was present in the paediatric emergency department between 5pm and 11pm seven days per week to ensure timely assessment of children and young people. Children and young people presenting at other times were assessed within 24 hours and if admission to the children's unit was required a Suicide Prevention Policy was in place to promote patient safety.
- The children's community respiratory team (CREST) provided a service to support parents and avoid admission to hospital if possible. The service saw children and young people with non-acute respiratory wheeze or asthma and provided an individualised asthma care pathway, supported inhaler technique and provided education for parents.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for incomplete pathways has been better than the England overall performance and better than the operational standard of 92%. The latest figures for January 2017 showed 93.3% of this group of patients were treated within 18 weeks versus the England average of 89.7%. Over the last 12 months the trust has met, and exceeded, the operational standard of 92% consistently, this is above the England average.

# Summary of findings

- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. In the most recent quarter, Q3 2016/17, a specialist saw 93.5% of patients within 2 weeks of an urgent GP referral.

## **Service planning and delivery to meet the needs of local people:**

- Medical services had been planned and developed with a number of local partners and networks to meet the needs of local people and also with consideration to the sustainability of services. For example, stroke services in the area had recently been reorganised via the stroke quality improvement group involving clinical commissioning groups (CCGs), other local trusts and the local stroke network. This meant that the hospital no longer offered a thrombolysis service to this patient group but continued to provide care to patients not eligible for thrombolysis or those needing rehabilitation.
- Full transitional care facilities were not available on the wards, which meant babies who required treatment such as phototherapy, or intravenous antibiotics were transferred to the neonatal unit. This was not in line with best practice, as it meant the mother and babies were separated.
- Clinic facilities at Halton hospital appeared generally busy. During inspection, we saw there was adequate seating in clinic A, the main outpatient waiting at Halton hospital. However, other clinic areas were much more congested and cramped. Clinic C had 23 seats in the waiting room, which was insufficient for the numbers of patients attending. Décor and furnishings appeared generally rather run down in clinic areas on the hospital site.

## **Meeting people's individual needs**

- Within the Critical Care unit, there was a nurse lead for delirium management. However, there had not been a specific audit of the total number of incidences of delirium or compliance with the use of the CAM-ICU tool which was used to measure the confusion and agitation levels of patients. We reviewed incident reports between January 2016 and December 2016, finding that there had been a high number of patients who had become agitated during their stay in critical care. When asked, the management team were unaware of this. This meant that there was the potential for service development opportunities being missed as well as incidences of delirium that could have potentially been avoided.

# Summary of findings

- We observed a patient undergoing a sensitive medically enhanced emotive procedure, sharing a six-bedded room on the gynaecology ward during our inspection. This did not assure us that privacy and dignity was maintained.
- Patients admitted for Termination of Pregnancy [TOP] that were more than 18 weeks pregnant, were cared for in a dedicated Butterfly Room on labour ward. Patients that were less than 18 weeks pregnant were cared for on the gynaecology wards. However, staff informed us that there was not enough space on the gynaecology wards to provide privacy to patients, especially those experiencing a miscarriage or TOP. A single side room was not always available which could lead to a delay in procedures.
- There was no named lead for learning disabilities within medical services. Senior staff recognised this was a gap in within the service. This meant that staff may have difficulty accessing advice, support and training to enable them to meet the needs of patients with a learning disability and may mean that the needs of this patient group were not considered when planning and developing services.

## Dementia

- There was limited personalisation of care plans in the records we reviewed. Plans were largely pre-determined. An audit of patient records in January 2017 showed that only 26% of patients had a personalised dementia care plan in place.
- Although there was a trust wide policy for those with a learning disability support for those with a learning disability was poor as there was no easy read material or pictures of procedures for patients in some departments.
- Records indicated that between January 2016 and December 2016, there had been 75% delayed discharges from the critical care unit (greater than four hours following the decision being made that a patient is fit for discharge to a ward).
- The environment on the Forget Me Not [specialist dementia] ward had been designed using the recommendations set out by The Kings Fund to be dementia friendly. The ward was designed to appear less like a hospital ward and featured colour coded bay areas and a lounge and dining area designed to look like a home environment. There was access to an enclosed garden and a quiet room.
- We found that staff on some wards did not follow the trust Mental Capacity and Deprivation of Liberty Safeguards Operational Procedure. Across the medical division we found

# Summary of findings

large numbers of patients were subject to Deprivation of Liberty Safeguards without an appropriate assessment of their capacity to consent. In other cases, best interest's decisions, were being made without an appropriate capacity assessment.

## Access and flow

- The Urgent and Emergency Care division continued to experience challenges in relation to patient flow. The number of patients experiencing a delayed transfer of care had increased when comparing data from 2015 to 2016. This was despite a reduction in the overall number of patient admissions to medical services.
- The Accident and Emergency department were not meeting the targets for time to initial assessment (emergency ambulance cases only) which should be less than 15 minutes. The figures were worse than the England average. Between June 2016 and February 2017 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes.
- The average bed occupancy rate across all medical wards was 98.2% between November 2016 and February 2017. Six wards had over 99% occupancy during this time period. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. The CCU had the lowest occupancy rate at 91.9%.
- At our last inspection we told the trust it must reduce the number of patient bed moves. Between January 2016 and December 2016, 64% of patients were moved once or more. This was an increase of 14% when we compared figures from 2015 to 2016. The number of patient moved two or more times had increased by 10% when compared with data from 2015. This meant that the trust had not reduced the number of patient bed moves and that this issue had increased rather than decreased.
- On average there were 28 patients experiencing a delayed transfer of care between December 2016 and February 2017. A delayed transfer of care is when a patient no longer requires an acute hospital bed but is still occupying the bed. The overall number of delayed transfers of care at the hospital in 2016 was 6,656, an increase of 965 from the previous year. The main reasons for delayed transfer during this period was patient or family choice or that patients were awaiting an assessment of their needs.
- We observed an audiology clinic held in a small clinic area, with insufficient seats available in the waiting area. This clinic was

# Summary of findings

very busy during the inspection, with children and adults attending for appointments. Staff told us there could be up to 35 patients waiting at once, resulting in patients having to stand in queues on the main corridor on these occasions. Staff would advise patients to wait in other areas, but this would mean a delay in appointment lists, from staff having to go and look for these patients.

## However:

- The declared figures included the urgent care centre at Halton and the Widnes walk-in centre, which both performed consistently well. The figure for the period April 2016 to June 2016 was 88.2% ( declared figure 92%) for July 2016 to September 2016 was 90.1% ( declared figure 93.4%) and for October 2016 to December 2016 was 84.2% ( declared figure 89.6%).
- The children's community respiratory team (CREST) provided a service to support parents and avoid admission to hospital if possible. The service saw children and young people with non-acute respiratory wheeze or asthma and provided an individualised asthma care pathway, supported inhaler technique and provided education for parents.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for non-admitted pathways has been better than the England overall performance. The latest figures for January 2017 showed 94.3% of this group of patients were treated within 18 weeks versus the England average of 89.3%.
- The trust has performed better than the England average for all of the 12 months preceding inspection. The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. In the most recent quarter, Q3 2016/17, a specialist saw 93.5% of patients within 2 weeks of an urgent GP referral.

## Learning from complaints and concerns:

- The Trust senior management team told us about the concerns they had with regards to the complaints process. The new Chief Nurse had identified a significant back log in responding to complainants. This was reported to the Board of Directors in February 2017. As of the 20th February 2017, the Trust had 239 open complaints with only 66 of those under the 35-day Trust target for completion (this does not mean that these complaints would be responded to under the 35-day target). A significant proportion of the complaints (80) had gone over 6 months past the 35-day target, with the remaining 93 between

# Summary of findings

35 days and 6 months. The oldest open complaint at the time of the inspection was over 2 years old (received in December 2014 - ref 7864), another from 2015 was noted and a number from early 2016.

- We were told that the department had been under resourced for a long period of time and that this was in the process of being addressed. As a result of the basic complaints response process being ineffective, there was a lack of focus on learning from complaints and preventing were in place to improve the complaints process and overall learning. The Head of Quality Governance acknowledged that thematic analysis was limited at this stage due to the length of time that many of the complaints have been in the system and that actions had already been taken by the time complaints were finally responded to.
- A sample of around 10 complaints was provided by the Trust. It was clear to see the difference between the responses previously issued and more recent responses. The older responses were very defensive and did not always address the issues raised; this was compounded with the length of time taken to respond. The responses that we have reviewed that have been sent in the last month or two were much more apologetic, explained issues in a way that could be understood by the complainant and were more thorough in terms of addressing all concerns raised. The timescales were clearly still an issue at the time of the inspection but it was encouraging to see the marked difference in quality of responses.

## Are services at this trust well-led?

### We rated well-led as requires improvement because:

- There were seven risks on the divisional risk register relating to paediatrics and neonatology at the time of our inspection. All had action plans to mitigate risk and review dates however three risks had been on the risk register for more than two years.
- Governance systems were not sufficiently embedded within the acute care division. The risk register was not effectively managed to show how risks to patients or the service were being reduced.
- The Deputy Director of Integrated Governance and Quality acknowledged that risk management was an area for improvement. Our findings on review of the risk register

Requires improvement



# Summary of findings

confirmed this, we found risk descriptions were poor in terms of condition, cause and consequence, controls and gaps in controls were not identified and actions and timescales were not included.

- We noted that the majority of risks had the same risk rating for the initial risk rating and the residual risk rating.
- Some risks had been on the risk register for some time, with the oldest risk being from January 2011 (0089) in relation to Pharmacy staffing. This risk was rated as a '16,' likely to cause major harm
- We were told by senior managers, that a full training needs analysis would be undertaken for risk management to inform an educational plan. It was acknowledged that effective check and challenge in relation to risks had not been in place within the organisation.
- There had been insufficient oversight of compliance with the trust Mental Capacity Act and DoLS policy. The policy set out the responsibility of the adult safeguarding team and trust MCA lead to monitor this policy. We found that these responsibilities had not been completed in full. For example, the policy stated that the adult safeguarding lead or patient safety manager should monitor mental capacity assessments and applications for deprivation of liberty safeguards and this should be undertaken twice yearly as part of safeguarding assurances. This had not been completed effectively to allow identification of a widespread failure to follow trust policy.
- Further work was needed to strengthen some aspects of governance and assurance processes to ensure that the leadership team were confident that all changes to practice and improvements introduced were being adopted and embedded. For example, changes in practice following Never Events.
- Many staff in radiology did not know who their business manager was, observing that the clinical business unit lead did not have time available to proactively manage the department. Some consultants said, they had not been provided with any clarity regarding the management structure, which had been established 12 months previously.

## However:

- The development of community services such as the Paediatric Acute Response Team (PART) and the children's community respiratory team (CREST) in collaboration with a local community trust was part of the trust's paediatric strategy to develop outreach services.

# Summary of findings

- We examined a range of Board papers and found that these were in the process of being aligned to the trust goals. Papers covered a range of operational and strategic issues from staffing updates, corporate and strategic risks and progress on performance, including patient experience feedback.
- Staff generally reported positive experiences of working for the trust and said they were supported by their line managers. For example staff we spoke with, said the new outpatient matron had made a notable difference since joining the trust seven weeks previously.

## **Vision and strategy**

- The trust mission was to provide high quality, safe and integrated healthcare. There were an established set of values at the trust that were to work as one, excellence, accountable, role models and embrace change. Pin badge awards were issued to staff who displayed these values consistently.
- Although not all staff were fully aware of the trust mission and values, most were aware that providing good quality care was central to this.
- There were divisional objectives focussed around the trust's key focuses of quality, people and sustainability. We noted that although there were objectives and associated actions in place, there were not always specific measurable outcomes attached to these objectives. For example, one of the measures of success was listed as a reduction in delayed transfers of care and there were no targets defined for the reduction in nursing or medical vacancies.
- Critical care had an informal vision and strategy to improve the services provided. However, we found that this plan was not documented in either departmental documentation or in the divisional business plan. This meant that we were unsure how the strategy was being monitored and measured. Staff we spoke with were unsure of what the strategy was.

## **Governance, risk management and quality measurement**

- The Board Assurance Framework was clearly a new document and to some extent a work in progress with being the first iteration. The document did capture the risks that the Executive Team raised with us and the risks were aligned to the strategic objectives. However, there was no clear alignment with the corporate risk register, no gaps in controls and no indicator of the assurance outcomes. The mitigating actions did not always address the causes of the risk. There were no dates for

# Summary of findings

identification of the risk although this was largely due to them all being newly identified risks. The target risk ratings were for the end of 2017/18 so we could not test progress towards achieving these.

- The Deputy Director of Integrated Governance and Quality acknowledged that risk management was an area for improvement. Our findings on review of the risk register were confirmed as being the position the Trust identified. Risk descriptions were poor in terms of condition, cause and consequence, controls and gaps in controls were not identified and actions and timescales were not included. The majority of risks had the same risk rating for the initial risk rating and the residual risk rating. We confirmed that the initial risk rating for the Trust was the inherent risk, before any controls being applied and that the residual risk rating was the current risk rating. Some risks had been on the risk register for some time, with the oldest risk being from January 2011 (0089) in relation to Pharmacy staffing. This risk was rated as a '16,' likely to cause major harm. It was acknowledged that this was not the case and that many of the risks were rated inappropriately. For example, there were a number of health and safety risks that were rated highly, despite having effective controls in place.
- There had been insufficient oversight of compliance with the trust Mental Capacity Act and DoLS policy. The policy set out the responsibility of the adult safeguarding team and trust MCA lead to monitor this policy. We found that these responsibilities had not been completed in full. For example, the policy stated that the adult safeguarding lead or patient safety manager should monitor mental capacity assessments and applications for deprivation of liberty safeguards and this should be undertaken twice yearly as part of safeguarding assurances. This had not been completed effectively to allow identification of a widespread failure to follow trust policy.
- We were told by senior managers, that a full training needs analysis would be undertaken for risk management to inform an educational plan. It was acknowledged that effective check and challenge in relation to risks had not been in place within the organisation.
- Senior managers told us that a new complaints team was being recruited to along with a new Head of Patient Safety.
- Although there were formal audits completed that included infection control. We saw no evidence that managers had a formal system or process of oversight, that ensured the cleanliness of equipment, and system checks were maintained.

# Summary of findings

- Governance systems were not sufficiently embedded within the acute care division. The risk register was not effectively managed to show how risks to patients or the service were being reduced.
- There were seven risks on the divisional risk register relating to paediatrics and neonatology at the time of our inspection. All had action plans to mitigate risk and review dates however three risks had been on the risk register for more than two years.

## **Leadership of the trust:**

- All Trust staff were very candid with us during the inspection about their challenges. None of the issues raised in relation to governance were a surprise to the organisation and many had improvement plans or ideas in place. The Trust had agreed plans to introduce a Quality Academy to train and support the delivery of quality improvement plans.
- The majority of medical care was managed within the acute care division via four separate clinical business units. Some medical care such as rheumatology, endoscopy and gastroenterology are managed by business units within the Surgery and Women's and Children's Health division. This change in management structure had come into effect in April 2016. Services had been allocated to a CBU based on a patient pathway rather than the traditional hospital model of medicine and surgery. Each CBU was led by a nurse, doctor and operations manager.

## **Culture within the trust**

- Senior managers told us that the Trust had a family feel and staff liked working here. However, we noted that the latest staff survey put the Trust in the worst 20% for staff recommending the Trust as a place to work or receive treatment.
- The staff Friends and Family test was sent out to all members of staff in the trust. Between January 2015 and January 2016 only 273 of the 4,200 workforce had completed the test. Results showed that the number of staff who would recommend the trust as a place to receive care to their friends or family was 56%.
- Leaders in the urgent and emergency care CBU were keen to foster a culture of positive learning. They described "amazing and awesome" as one of the ways they were developing this culture, where success was celebrated rather than only focusing on learning from negative events.

# Summary of findings

- There was a whistleblowing policy in place and we saw evidence that the trust were responsive with concerns raised by staff under the policy.

## **Equalities and Diversity – including Workforce Race Equality Standard**

- There was current equality and diversity strategy in place within the trust for 2015 to 2019.
- The trust reports that in 2016 the overall workforce consisted of 8.5% BME staff, a slight increase from 8.3% reported in 2015.
- It is a requirement within the national contract for trusts to publish their results for the Workforce Race Equality Standard (WRES). The WRES data for 2015 to 2016 was publically available on the trust website. In 2016 BME staff are not under represented within all bands of the none clinical workforce. However we noted that there are no BME staff employed at Band 8a, within a total of 55 posts. This aspect of the workforce demographic mirrors what the trust reported in 2015.
- The WRES data showed that black and minority ethnic staff (BME) were employed in higher proportions in lower pay bands (1 to 4) within the trust. BME staff were highly underrepresented in senior management roles. There are no board members from a BME background within the trust.
- There had been an improvement in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the 12 months prior to our inspection, which had been reduced from 37.5% to 26.09%.
- There had been a significant increase in the percentage of BME staff experiencing harassment, bullying or abuse from staff in the 12 months prior to our inspection, which had increased from 12.5% to 21.74%. By contrast, the comparative data for white staff showed an increase from 19.4% to 18%.
- The percentage of white staff that believe the trust provided equal opportunities for career progression and promotion has increased from 89% to 93% prior to our inspection. Over the same period the percentage figure for BME staff was 93%. The trust's overall performance against this indicator is 93%, the joint second best score for a trust within the sector nationally.

## **Fit and Proper Persons**

- There was a policy for the application of the Fit and Proper Person regulation (September 2014) which states that it will apply to all directors and “equivalents”.
- We reviewed all the director and non-executive director files and found that the process was implemented regarding external recruitment and internal promotions.

# Summary of findings

## Public engagement

- The hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. The Friends and Family Test (FFT) showed the percentage of patients and families that would recommend the service. We saw that some wards displayed this information at the ward entrances.
- The urgent and emergency care departments at Warrington and Halton were working with players and staff from two local rugby league clubs. The department was promoting awareness of the different urgent care services and when to use these services appropriately. Filming was due to take place for YouTube videos, which would be promoted via the social media platforms at one of the rugby clubs.
- Staff at Halton had adopted the 'Hello my name is...' K G campaign badges and notices to improve communication with patients and visitors. We saw staff wearing badges and most staff introducing themselves to patients. However, we also observed staff in some areas who did not introduce themselves to patients and whose name badges were not worn to be clearly visible.
- Staff gave patients an impact questionnaire to complete if they had been subject to a breach of the Department of Health mixed sex standard. This was used to assess how much they had been affected by this. Results from this were used when possible to improve service delivery.

## Staff engagement

- The trust participated in the NHS staff survey to gather their views. The survey asks 34 questions and the results analysed and compared with other trusts across England. The results from the 2016 NHS staff survey showed that the trust performed better than other trusts in 10 questions, about the same in 17 questions, and worse in seven questions. Areas that the trust performed better included, staff satisfaction with their level of responsibility and involvement, and support from their immediate managers. Areas where the trust scored worse included the quality of non-mandatory training and the response rate from staff to the survey (33%). This was below the England average was 41%.
- The trust used pin badge awards to recognise individuals who consistently displayed the trusts' values. Long service was recognised through the trust's "Thank you" awards.
- All departments were very busy and we found in some departments, senior management had introduced stress risk

# Summary of findings

assessments that were completed on line. If the scores were high there was input from the occupational health department. The risk assessments were mandatory and carried out every year.

## **Innovation, improvement and sustainability**

- The critical care service currently had 48% of registered nurses who had achieved a critical care nursing qualification. This was slightly below the Intensive Care Society (ICS) standard of 50%. The management team informed us that a business case had been submitted for eight places on a university course for further nursing staff to attend. However, due to financial restrictions, only two places had been agreed. This meant that if there was a continual turnover of nursing staff, there was a risk that the number of staff who had completed this course would fall significantly below the ICS standard.
- The development of community services such as the Paediatric Acute Response Team (PART) and the children's community respiratory team (CREST) in collaboration with a local community trust was part of the trusts paediatric strategy to develop outreach services.
- The trust planning to pursue the Calderdale Framework a systematic, objective method of reviewing skill, role and service design, ensuring safe, effective and productive patient centred care, in order to address staffing challenges, with the aim of looking at alternative posts. Such as, Advanced Paediatric Nurse Practitioner (APNP) and Advanced Neonatal Nurse Practitioners (ANNP's) and more working in collaboration with tertiary and community colleagues.
- The acute care division was actively managing the number of registered nurse vacancies using a recruitment and retention strategy, alongside reviewing the roles of nurses on medical wards. Some of the changes they had implemented included increasing phlebotomy cover, ward clerk hours and band two healthcare workers to release time for the nurses to carry out registered nursing duties.
- The stroke team had developed the Warrington stroke scale. This is a scale used to categorise patients and care for them on an appropriate pathway following a stroke. The team were working with a local university to validate the scale.

# Overview of ratings

## Our ratings for Warrington Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
<b>Overall</b>	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

## Our ratings for Halton General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Requires improvement	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
<b>Overall</b>	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

# Overview of ratings

## Our ratings for Warrington and Halton Hospitals NHS Foundation Trust

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

# Outstanding practice and areas for improvement

## Outstanding practice

The trust had developed the Paediatric Acute Response team to deliver care in a health and wellbeing centre in central Warrington. This allowed children and young people to access procedures such as wound checks and administration of intravenous antibiotics in a more convenient location. It also allowed nurse-led review of a range of conditions such as neonatal jaundice and respiratory conditions in a community setting that would have previously necessitated attendance at hospital.

Within the urgent and emergency care division, the use of the Edmonton frailty tool in the treatment of older people in the department and the wider health economy.

The training of all the consultants within the accident and emergency department in the use of ultrasound for timely diagnosis of urgent conditions.

The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

The environment on the Forget Me Not ward had been designed using the recommendations set out by The Kings Fund to be dementia friendly. The ward was designed to appear less like a hospital ward and featured colour coded bay areas and a lounge and dining area designed to look like a home environment. There was access to an enclosed garden and a quiet room.

## Areas for improvement

### Action the trust MUST take to improve

- The trust must ensure staffing levels are maintained in accordance with national professional standards.
- The trust must ensure that there is one nurse on duty on the children's unit trained in Advanced Paediatric Life Support on each shift.
- Critical care services must improve compliance with advanced life support training updates and ensure that there is an appropriately trained member of staff available on every shift.
- The trust must ensure that the formal escalation plan to support staff in managing occupancy levels in critical care is fully implemented.
- The trust must ensure that there are appropriate numbers of staff available to match the dependency of patients on all occasions.
- The trust must ensure that all risks are formally identified and mitigated in a timely way as part of the risk management process.
- The trust must ensure that staff receive training on the Mental Capacity Act (2005) and that staff work in accordance with The Act.
- The trust must ensure that paper and electronic records are stored securely and are a complete and accurate record of patient care and treatment.
- The trust must ensure that staff receive the appropriate level of safeguarding training.
- The trust must ensure that the formal escalation plan to support staff in managing occupancy levels in critical care is fully implemented.
- The trust must ensure that there are appropriate numbers of staff available to match the dependency of patients on all occasions.
- The trust must take action to ensure that all safety and quality assurance checks are completed and documented for all radiology equipment, in accordance with Ionising Radiations Regulations 1999.

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

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)  
Regulation 11 (1) (3) Need for consent

**How the regulation was not being met:**

Staff did not seek consent appropriately with sufficient regard to the Mental Capacity Act 2005. The trust did not ensure that staff acted in accordance with the Mental Capacity Act 2005.

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (e) Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way;

**How the regulation was not being met:**

The trust did not ensure that the equipment used for providing care or treatment to a service user is safe for such use and used in a safe way;

We found the CR reader was located outside the X ray room in the Cheshire and Merseyside Treatment Centre presenting a risk of radiation exposure.

Quality Assurance checks in accordance with IRR99 regulations for radiology equipment were not up to date.

This section is primarily information for the provider

## Requirement notices

Records of daily checks of resuscitation equipment were not maintained consistently in radiology departments.

Ultrasound machines in radiology had been deemed unsafe and these had not been replaced for eight months.

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing  
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 (1) (2) (a): Staffing

**How the regulation was not being met:**

Sufficient numbers of suitably qualified, competent and experienced persons must be deployed.

This was because there were a low number of staff who were up to date with advanced life support training. This meant that the service could not always ensure that there was an appropriately trained person on every shift.

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 13(1) (2) (3) Safeguarding service users from abuse and improper treatment

**How the regulation was not being met:**

People who used the service were not protected against the risk of abuse and improper treatment because medical staff had not received the correct level of safeguarding training.

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

## Requirement notices

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 (2) (b): Good Governance

**How the regulation was not being met:**

Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others.

This was because all risks that the trust currently faced had not been formally identified with appropriate controls implemented to control the level of risk posed. The level of risk that had been identified had not always been reduced in a timely manner.

Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17 (2) (c)( d) (Part 3) Good Governance

**How the regulation was not being met:**

The trust did not ensure that hospital staff maintained an accurate and complete record in respect of each patient and of decisions taken in relation to the care and treatment provided. The trust did not ensure that records were maintained securely

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Safeguarding service users from abuse and improper treatment

**How the regulation was not being met:**

People who used the service were not protected against the risk of abuse and improper treatment because medical staff had not received the correct level of safeguarding training.