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For the attention of the Chief Executive
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Ms Michelle McKay
Worcestershire Acute Hospitals NHS Trust
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
Worcestershire
WR5 1DD

11 July 2017

**The Care Quality Commission**

**The Health and Social Care Act 2008**

## SECTION 29A WARNING NOTICE:

**Provider: Worcestershire Acute Hospitals NHS Trust**

**Regulated activities:**

- **Treatment of disease, disorder or injury**
- **Surgical procedures**
- **Maternity and midwifery services**
- **Assessment or medical treatment for persons detained under the Mental Health Act 1983**

Our reference: RGP1-4008098265
Account number: RWP

Dear Ms McKay

This notice is served under Section 29A of the Health and Social Care Act 2008.

**This Warning Notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by Worcestershire Acute Hospitals NHS Trust for the regulated activities above requires significant improvement:**

The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with the above Regulated Activities at the locations identified below:

**Worcestershire Royal Hospital**
Charles Hastings Way
Worcester
WR5 1DD

**Regulated activities**

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

**Alexandra Hospital**
Woodrow Drive
Redditch
B98 7UB

**Regulated activities**

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

**Kidderminster Hospital and Treatment Centre**
Bewdley Road
Kidderminster
DY11 6RJ

**Regulated activities**

- Treatment of disease, disorder or injury
- Surgical procedures

**The reasons for the Commission's view that the quality of health care you provide requires significant improvement are as follows:**

- The systems and staff practices to assess, monitor, and mitigate risks relating to the health, safety and welfare of patients receiving care and treatment are not operating effectively in the trust so as to protect patients from the risks of abuse and avoidable harm.
- Despite the actions taken in response to the Warning Notice served on 27 January 2017, and the assurances given by the trust at the Quality Improvement Review Group meetings chaired by NHS Improvement, there remain significant failings by the trust to demonstrate that significant and

sustained improvements have been made at the required pace in a number of areas of ongoing concern.

- These include a lack of ensuring learning from incidents, a lack of effective systems to assess and respond quickly to the risk of deteriorating patients, inadequate medicines' management processes, ineffective infection control measures, a failure to provide appropriate environments to meet the needs of all patients safely, and a failure to manage patient flow effectively in the trust's emergency departments.
- In the course of this inspection, we have also found further areas of concern that require significant improvement. These areas had been highlighted as areas of concern in the November 2016 inspection. These include significant failures to ensure all staff working in the trust have the required level of safeguarding vulnerable adult and children's training, suitability of emergency equipment at one hospital and a failure to ensure effective compliance with the fit and proper person's regulation.
- This represents continuing significant failings in the overall trust ownership of all ongoing areas of risk, coupled with ineffective governance processes, to allow full oversight at board level of all the potential risks to patients to be able to effectively monitor and drive improvements at the pace required.

Significant improvements are required to the quality of the health care provided by the trust in relation to the regulated activities set out in this Notice at the locations above, by way of a failure to have systems in place that operate effectively in order to address the points above.

We inspected Worcestershire Acute Hospitals NHS Trust on 11, 12 and on 25 April 2017, to check on your progress in complying with the requirements of the Section 29A Warning Notice ('the Notice') served on 27 January 2017. At that time, you were required to make significant improvements in the quality of healthcare provided in relation to the matters set out in the Notice, by 10 March 2017.

The information you have provided subsequent to the April 2017 inspection, together with the evidence gathered during the course of the inspection process, as set out in this Notice, demonstrates that there remains a need for a significant improvement in the quality of the healthcare provided by the trust in relation to the regulated activities at the locations cited in this Notice.

**Areas which demonstrate the consequences of failing to have systems in place that operate effectively to assess, monitor and mitigate risks relating to the health, safety and welfare of patients receiving care and treatment so as to protect patients from the risks of avoidable abuse and harm.**

**1. Learning from incidents:**

1.1. In November 2016, in the maternity and gynaecology service at Worcester Royal Hospital (WRH) and Alexandra Hospital (AH), we found that perinatal mortality and morbidity meetings were not formally minuted and any learning, including actions taken to prevent and/or minimise reoccurrence of incidents, were not clearly recorded. We also found that that service did not hold morbidity meetings within the obstetrics and gynaecology specialties. The trust assured us on 9 March 2017 that plans were in place for these meetings to be introduced from January 2017 and, a quality improvement plan (QIP) had been developed to ensure mortality and morbidity meetings were standardised, actions were taken and lessons learnt were shared.

1.2. However, we found in our April 2017 inspection, that this had not been applied consistently across the maternity and gynaecology service. The trust provided a schedule for perinatal, obstetrics and gynaecology mortality and morbidity meetings for the calendar year of 2017; nine perinatal, 11 obstetrics and 11 gynaecology mortality and morbidity meetings had been scheduled for the year of 2017. The obstetrics and gynaecology mortality and morbidity meetings were not held separately, but were included as a standing agenda item within monthly governance meetings. We saw that the monthly gynaecology clinical governance meetings included mortality and morbidity as a standing agenda item. We reviewed three sets of minutes for meetings held in January, February and March 2017. However, we saw no evidence that mortality and morbidity reviews were discussed, nor any evidence that any learning and improvement actions from mortality and morbidity reviews were identified. The minutes for the gynaecology clinical governance meeting held in February 2017 stated that this item was to be removed from the agenda. No explanation for this was provided when we requested this.

1.3. Similarly, we reviewed three sets of minutes for divisional governance meetings held in January, February and March 2017 and found no evidence that obstetrics and gynaecology mortality and morbidity reviews were discussed. The minutes we reviewed showed only issues relevant to perinatal mortality and morbidity were discussed, such as the child death overview panel report 2015/16. There was no evidence provided so we were not assured that obstetrics and gynaecology mortality and morbidity reviews were held.

1.4. We also requested the minutes of perinatal mortality and morbidity meetings held in January, February and March 2017, as per the trust's schedule, but were only provided with minutes for February and March 2017. Correspondence received from the trust in response to the Warning Notice, dated 9 March 2017, included a schedule of mortality and morbidity meetings in the appendix. This stated that a perinatal mortality and morbidity was due to take place on 06 January 2017. Therefore, we were unable to determine whether the January 2017 meeting was held.

1.5. The perinatal meeting minutes for February and March 2017 included a list of attendees and their designation. However, there was no

evidence that any actions were taken as a result of learning points identified. Nor was it evident which member of staff was responsible for ensuring actions were completed, or how any learning would be shared within the division. Therefore, there was no evidence of an effective system in place to ensure that learning from perinatal mortality and morbidity meetings was shared, and actions are taken to improve the safety and quality of patient care. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

1.6. At the AH, staff in the Emergency Department ('ED') told us that formal mortality and morbidity meetings had not taken place but cases and lessons learnt had been discussed in senior doctors' teaching sessions at the end of each month. However, there was no evidence of a process being in place for disseminating learning outside of this teaching session and so the majority of staff we spoke to unaware of any required changes to practice. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

**2. Assessing and responding to patient risk**

2.1. During our inspection in November 2016, we identified concerns with carrying out venous thromboembolism (VTE) assessments on admission and reassessment within 24 hours. The trust used a VTE and risk of bleeding assessment tool, which should be completed on admission and re-assessed within 24 hours of admission. The trust told us 9 March 2017, it had established a VTE rapid improvement working group. Actions from the group included a proposed new VTE assessment form, further education for medical staff, training for ward administrators on data input and regular audits and feedback to senior managers.

2.2. During our April 2017 inspection, in the ED at WRH, records for seven patients showed that the admitting ED team had recorded VTE assessments for only two of these patients. The service used a VTE and risk of bleeding assessment tool, which should be completed on admission and re-assessed within 24 hours of admission. We also found three out of five patients in a sample of seven for whom it would have been appropriate, did not have completed records of assessment for the elderly screening of dementia. Two of those patients were known to be living with dementia or Alzheimer's disease. Also, in the ED at WRH, from reviewing records, we found three of eight children had no PEWS recorded: these included a baby who had no observations recorded. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

2.3. During our April 2017 inspection of some medical care wards at WRH, we saw that no initial VTE assessments were recorded in seven out of a total of 21 records we viewed on the acute stroke unit, Evergreen 1 and Avon 3 ward. In addition, it was difficult to establish if

any patients had been reassessed within 24 hours of admission. This meant that there was no evidence to demonstrate that patients had received the relevant assessment to manage their care and patients' risk of thrombosis (blood clot) or risk of bleeding could not be determined. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

2.4. We also found in some medical wards at WRH and AH that some risk assessment templates were not routinely completed in their entirety, including elderly patient risk assessments and sepsis bundle assessments. We saw that some templates were left blank and did not include any patient assessment details. When risk assessments were completed, there were consistently no dates or signatures to indicate when they were completed (in seven out of 21 records seen). The trust had implemented the 'Guidelines for the management of Sepsis and Septic Shock in Adults', inpatient ward and ED suspected sepsis screening tools and inpatient ward and ED sepsis patient pathways in September 2016. These were available on the trust treatment pathways intranet site. The trust was in the process of data collection for quarter one (April to June 2017) for the 2017/18 Sepsis Commissioning for Quality and Innovation (CQUIN) and therefore did have data available to evidence compliance from April 2017 at the time of the April 2017 inspection. The trust provided data from inpatient wards that showed the percentage of adult patients who presented with severe sepsis, 'Red Flag' Sepsis or septic shock to the ED and were administered intravenous antibiotics within one hour of presentation and had an antibiotics review carried out by a competent decision maker by day three of them being prescribed was 15% in November 2016, and 33% in December 2016. We were not assured that inpatient wards were effectively following the trust's sepsis pathway when required.

2.5. At our April 2017 inspection, at WRH, we reviewed 30 patient records across all the surgical wards and found four patients' records that did not have a VTE risk assessment as part of that record. We also found three assessment charts that were left blank with no assessment boxes ticked other than a date and the doctors' initials. Records showed that a further 11 VTE assessments had been undertaken more than 48 hours after the patient had been admitted. These patients had been commenced on anticoagulation therapy which had been administered without a documented assessment on record, which may have meant that some patients may have received medication which was unsuitable for them.

2.6. VTE reassessments following 24 hours of hospital admission at WRH were not recorded as having been completed on patients in 29 out of 30 records reviewed.

2.7. At AH, we found that no initial VTE assessments were recorded as completed in nine out of 29 records on wards 5, 11, 12 and 18. In addition. There was no evidence to confirm in these cases that patients

had received the relevant assessment to manage their care and patients' risk of thrombosis (blood clot) or risk of bleeding could not be determined in the absence of a clear record. We also saw that seven out of 29 VTE forms had names and signatures, but contained no completed assessment with no boxes ticked to indicate whether the patient was either at risk of thrombosis (blood clot) or at risk of bleeding. This meant that some patients were at risk of not being treated according to their clinical risk in this respect. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

2.8. At AH, we reviewed 36 patient records across all the surgical wards and found all patient notes contained a VTE risk assessment. However, four assessment charts were left blank with no selection boxes ticked other than a date and the doctors' initials and a further four VTE assessments had been undertaken more than 48 hours after the patient had been admitted. One patient had their VTE assessment done in the outpatient clinic, six days prior to their admission. One VTE assessment had requested TEDS only (tight stockings which improve the blood flow in patients who are unable to move regularly), but pharmacological anticoagulation therapy had been prescribed and administered. VTE reassessments following 24 hours of hospital admission were not recorded as done in 35 out of the same 36 records reviewed. Therefore, although patients had a VTE assessment, these were not always done in line with national guidance and the trust's own VTE policy. We also found that patients had been prescribed and given medication to prevent VTEs, but there was no evidence that a risk assessment had been carried out. This meant some patients may have received medication which was unsuitable for them. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

2.9. We noted in your letter of 12 April 2017 following our verbal feedback to Michelle McKay, Chief Executive, that you had identified that whilst there was improvement in the initial completion of VTE risk assessments, there was little evidence of repeat assessment after 24 hours. With regard to the two areas of good practice that we fed back, you stated that you would ensure that this learning is shared across the organisation, but we have not received evidence of how this learning is to be shared within defined timescales to ensure significant improvements are sustained in this area of risk. The trust has not made significant improvements to address concerns identified in the November 2016 inspection.

2.10. In the trust's 'Report to the Quality Improvement Review Group (QIRG)' dated 15 June 2017, we noted that 87.36% of patients (against an 88% trajectory) had a VTE assessment in place. We note from the trust's Section 29A dashboard report dated 30 May 2017 that the trust was to recruit an advanced nurse practitioner to support VTE assessments, notes' completion and treatment. The case for needing this

new post had been assessed with the outcome of no further action being required at the time. It would therefore appear that the trust is no longer planning to recruit to this role. The trust stated that a clear and detailed action plan is in place to support safe assessment process with the date for completion was 30 May 2017. However, in the Section 29A dashboard, there is no expected date for completion of this action. The return to compliance date for the Section 29A Warning Notice was 10 March 2017. The trust has not made significant improvements at the pace required to address concerns identified in the November 2016 inspection to ensure patients are being protected from avoidable harm.

2.11. At WRH, we reviewed a sample of 13 patients' charts to assess the completion of Paediatric Early Warning Scores (PEWS) in the children and young people's service. The frequency of observations required had not been recorded for five patients. There was a delay in recording observations noted on two patients' charts and the score for another two patients' charts had not been totalled. We also noted that the PEWS for one child required escalation on eight occasions due to deterioration, but there was no evidence that appropriate escalation had taken place on two of the eight occasions. It was noted that the child had been prescribed and administered medication in accordance with protocol, so there was indirect evidence of escalation, however this escalation had not been documented on the patient's file in accordance with trust policy. Nursing staff undertook regular audits on the completion of PEWS charts and had observed an improving trend. The trust reported improvements in the completion of PEWS charts through its April 2017 audit, which demonstrated 100% compliance. However, in our inspection, we found that 80% of those patients with a score of higher than three had been escalated, which meant that 20% of patients requiring appropriate escalation for medical review had not.

2.12. In the trust's 'Report to the Quality Improvement Review Group (QIRG)' dated 15 June 2017, we note that 80% (against an 87% trajectory) of PEWS were correctly escalated. The return to compliance date for the Section 29a Warning Notice was 10 March 2017. The trust is not yet implementing an effective system to monitor the deterioration of patients in the service. This means there is a continuing need for significant improvement to ensure all patients are protected from avoidable harm.

2.13. At WRH, during the November 2016 inspection, we found that there was a lack of detailed assessment and provision of one to one care for children and young people who presented with mental health issues. Risk assessments were not always completed and on occasions, a risk assessment form for an adult was placed on file. Forms did not include a section to clearly record the degree of risk, and on only some occasions was this recorded in the patient notes.

2.14. During our April 2017 inspection, we found that the service had taken a series of actions to improve the safety and quality of care and

treatment provided for the children and young people on the ward. These actions included revising the mental health risk assessment so that staff could record the patient's level of risk to themselves and others on admission. We reviewed ten sets of patients' records from the paediatric ward at WRH. All 10 patients had a mental health risk assessment on file with the category of risk identified. However, this risk was recorded inconsistently within patient records. Some categories of risk were recorded in nursing records and others within the risk assessment document. This meant it was not always clear how staff had reached their decision as to which criteria were met as the standard risk assessment form had not always been used. The service has not made significant improvements to address concerns identified in the November 2016 inspection at the pace required to keep patients safe from avoidable harm.

3. **Medicines' management**

3.1. At our inspection in November 2016 at WRH, we found that doses of time critical medicines were not being administered to patients, including those with Parkinson's disease and diabetes whilst they were queueing in the ED corridor. The trust provided us with assurances in January 2017 that 'the supply of time critical medicines was a key priority and an audit of missed doses had been undertaken as part of the trust's 'Medicines Optimisation Audit Plan'. The trust presented a three-month plan stating how the administration of time critical medications would be incorporated into medicines' management training for staff and training outcomes would be monitored. On our April 2017 inspection, we found at WRH that two of three patients waiting in the ED 'reverse queue' for admission to a ward or for discharge after a therapist assessment had not had the required medicine on time. One patient with identified sepsis was four hours overdue for their second dose of antibiotics and second bag of IV fluids at the critical interval required and prescribed, and they were asking staff for these medications. This issue was raised by the inspector directly with the matron who ensured that the patient was safe at the time. We noted in your letter of 12 April 2017, following our verbal feedback regarding this incident of delayed administration of intravenous antibiotics and late commencement of intravenous fluids that stated in that an investigation had been instigated to review the circumstances of this and identify any lessons to be learnt. In the data request DR79, received 9 May 2017, actions listed to be taken were the ED matron was to undertake communication and learning exercise with all ED nursing staff by 26 May 2017, the divisional director of nursing (Medicine)/ED matron were to undertake a risk assessment to define the issue and undertake risk reduction strategy and the trust was to review processes for caring for sepsis patients and ensure they are fit for purpose if the patient is waiting for post take ward rounds. We have not received sufficient assurance of how these improvements will be achieved, within defined timescales, to

ensure significant improvements are sustained in to keep patients safe from avoidable harm.

3.2. In the medical care service at AH, we still saw gaps in the administration of time critical medication on ward 12 without explanation. We raised this with nursing staff during our inspection as an urgent concern.

3.3. We noted from the trust's Section 29A dashboard report dated 30 May 2017 that the time critical medication work stream in place to address the issue of patients' receiving time critical medicines on time had an original completion date of 31 March 2017. However, in the Section 29A dashboard, the expected date for completion of this action was now shown as 31 July 2017. This meant the earlier target completion date of 31 March 2017, and the return to compliance date for the Section 29A Warning Notice of 10 March 2017 had been missed. The trust has not made significant improvements to address concerns identified in the November 2016 inspection to ensure patients are protected from avoidable harm at the pace required.

3.4. During our inspection in November 2016, we found medicines that required refrigeration were not always kept at the correct temperature. The trust acknowledged it did not have proper oversight of fridge temperature monitoring and it undertook several measures to improve.

3.5. During our April 2017 inspection, we found in surgical areas visited at WRH that temperatures were recorded on most days. However, two medication fridges out of four checked had recorded temperatures which exceeded the maximum of 8°C. For example, on Beech 1B ward, the fridge temperature exceeded this range for four consecutive days between 19 and 22 March 2017 and no action or escalation had been recorded. Additionally, on the same ward in January and February 2017, 15 days did not have a temperature recorded.

3.6. At AH, temperatures in surgical care areas were recorded on most days. However, five out of seven wards recorded medication fridge temperatures which exceeded the maximum of 8°C. For example, on ward 17, fridge temperatures were recorded at 10°C or above for 13 days in March 2017 and six days out of 10 in April 2017. On 30 March 2017, the recorded maximum temperature was 16°C. Staff documented that they had escalated the issue to estates and pharmacy. However, staff were unable to tell us of any actions taken to ensure the medications in the fridge remained safe to use.

3.7. During our inspection, we reviewed the refrigerator temperature records on the postnatal ward at WRH from 21 December 2016 to 12 April 2017 and found one occasion when the temperature had not been recorded (2 January 2017). We also found that from 21 December 2016 to 30 March 2017 only the current temperature had been recorded; minimum and maximum refrigerator temperatures had not been documented. This showed that trust policy was not consistently followed in all areas of the service.

3.8. Similarly, we found inconsistencies with the monitoring and recording of ambient room temperatures. We reviewed the ambient temperature records on the postnatal ward from 21 December 2016 to 12 April 2017 and found three occasions when the temperature had not been recorded (5, 11 and 12 January 2017). We also found that from 21 December 2016 to 11 April 2017 only the current temperature had been recorded; again, the minimum and maximum ambient room temperatures had not been documented. We reviewed the ambient temperature records on delivery suite from 1 to 12 April 2017 and found five occasions when only the current temperature had been documented. Trust policy was not consistently followed in all areas of this service.

3.9. We also found three occasions on the delivery suite and one occasion on the postnatal ward at WRH where there was no evidence that any action had been taken to address exceeded ambient room temperatures. The exceeded temperatures were all 'amber' rated (between 25°C and 29.9°C) and according to trust policy, the nurse in charge and estates department should have been informed.

3.10. During our inspection at AH, we found trust policy was not consistently followed in all areas of the maternity and gynaecology service. We reviewed the ambient room temperature records on the Elias Jones unit from 21 December 2016 to 11 April 2017. We found that from 21 December 2016 to 28 February 2017, only the current temperature had been recorded; minimum and maximum temperatures had not been documented. From 1 March to 11 April 2017, we found a further four occasions when only the current temperature had been recorded (13 to 16 March). We also found five occasions when the maximum ambient room temperature exceeded the recommended range, with no evidence that any action had been taken to address the exceeded ambient room temperature. The exceeded temperatures were all 'amber' rated (between 25°C and 29.9°C) and according to trust policy, the nurse in charge and estates department should have been informed.

3.11. At the KHTC, we saw there was a process in place for the monitoring of fridge temperatures where medicines were stored and this included escalation when the temperatures went out of range. However, there was no evidence of actions as a result of this escalation or confirmation of whether or not the drugs remained fit for use.

3.12. We note from the trust's Section 29a dashboard report dated 30 May 2017 that the trust was to agree local (ward/clinic) and central (estates/pharmacy) responses to temperature excursions. A policy for escalation was to be agreed at the medicine's optimisation group meeting on 13 June 2017. The dashboard states that the medicine's optimisation group and estates were monitoring this concern. The date for completion was 31 March 2017. In the dashboard, the expected target date for completion of this action is July 2017. However, the return to compliance date for the Section 29a Warning Notice of 10 March 2017 had been missed. The trust has not made significant improvements to address

concerns identified in the November 2016 inspection to ensure patients are protected from avoidable harm at the pace required.

**4. Infection and prevention control**

4.1. At the ED at WRH, we saw over the two days of our April 2017 inspection visit that staff at all levels and within all roles failed to routinely clean their hands when attending to patients and when entering and leaving clinical areas within the ED. For example, we observed six staff, including one in outdoor clothes who had just arrived on duty, pass through the door into the minor injuries streaming area without using the hand gel positioned on the wall on either side of the doors. Two of this group returned through the doors a few minutes later and did not use the hand gel on that occasion either. We noted staff routinely leave and enter the major injuries/illness streaming area without using hand gel. The service has not made significant improvements to address concerns identified in the November 2016 inspection in this regard.

4.2. We observed that most staff did not generally wash their hands before and after patient contact on the acute stroke unit, Avon 2 and the medical assessment unit (MAU) at WRH and on ward 12 and the MAU at AH. Although the medical care service had implemented processes to address the poor adherence to infection prevention and control practices, concerns remain regarding poor infection prevention and control practices. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

4.3. In the last inspection in November 2016, in surgical care at WRH and AH, we reported that some staff did not always follow the trust's infection prevention and control policy with regard to hand hygiene and the use of personal protective equipment (PPE). This concern remained the same during our April 2017 inspection. At the WRH, we saw some staff failed to clean their hands prior to contact with patients and their environment. We also saw staff using PPE inappropriately. For example, a nurse took a patient's blood glucose measurement without cleaning their hands before or after the procedure. They also did not apply any gloves to take the blood sample. This was not in line with the trust's infection control guidance. We saw staff taking patient observations on different patients and writing in their end of bed folders without cleaning their hands in between. At AH, we observed a nurse disconnected a patient from their oxygen tubing and did not clean their hands before or after carrying out this activity and a group of therapy staff assisted a patient to their walking frame without cleaning their hands afterwards. We saw a health care assistant wipe up liquid outside of a toilet wearing an apron and no gloves and then return to the patient without cleaning their hands. We also saw staff using PPE inappropriately and this included a doctor reviewing patient notes and meeting a patient on the ward while wearing their theatre cap and staff wearing the same pair of gloves and aprons while carrying out multiple tasks. The service has not made

significant improvements to address concerns identified in the November 2016 inspection.

4.4. We note in your letter of 12 April 2017 following our verbal feedback that you expressed your disappointment with regard to the infection prevention and control practices witnessed in many areas of the trust and across all staff groups. You stated you had taken steps to enlist the support of a senior infection prevention and control advisor from NHSI. You stated you will continue to encourage all staff members to challenge poor practice when it is observed. We have not received sufficient assurance of how these significant improvements will be achieved, within defined timescales, to ensure patients are kept safe from avoidable harm.

4.5. We note from the trust's Section 29A dashboard report dated 30 May 2017 that the information team advised that hand hygiene audits would be included in phase 5 of the safety and quality information dashboard (SQUID) which the trust stated would be implemented from June 2017. Hand hygiene audits were manually being undertaken. The trust's 'Report to Quality Improvement Review Group (QIRG)' dated 15 June 2017, states that 98.9% (against a 78% trajectory) of staff washed/gelled their hands before touching a patient. The trust's original expected date for completion was 5 April 2017. In the dashboard, there is not a date for the expected completion of this action. However, the return to compliance date for the Section 29A Warning Notice of 10 March 2017 had therefore been missed. However, there was a lack of assurance that all staff carried out effective handwashing prior to and after every patient contact, given that the dashboard does not contain detailed actions and timescales for ensuring this concern had been fully addressed and significant improvement had been made.

**5. Safety of premises and equipment**

5.1. At our inspection in November 2016, we found that there was not an appropriate mental health assessment room in the ED at WRH to care for patients presenting with mental health conditions. There was a room that complied with some of the national guidance but furniture was not secured, there were ligature points and exits were not clear from obstacles.

5.2. On our April 2017 inspection, staff told us the mental health designated assessment room at WRH was used for interviewing patients only and not for caring for them. The room had two exit doors and contained three chairs, a coffee table (unsecured) and had air conditioning. There were alarm buttons on the wall for the interviewer to summon assistance. We noted on the emergency medicine risk action report the only remaining ligature point as at February 2017 was an air conditioning duct and this was rated as 'low' risk and was to be reviewed in July 2017. The matron told us a number of stakeholders and external bodies had made recommendations about the room and changes had been made. A clinical lead doctor on duty told us patients were not left

alone in the mental health assessment room and the mental health team were happy about interviewing patients in this room. The suitability of the mental health assessment room within ED to meet national guidance had still not been addressed as risk to the safety of patients had not been recognised and addressed. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

## 6. Bed capacity and patient flow management

6.1. At our inspection in November 2016, we found patients at WRH were cared for in corridors in the ED for extended periods of time (during inspection some over 22 hours) due to the lack of flow out of the department. Trolleys in the corridor had no space between them. The trust provided us the 'Full Capacity Protocol' document that had been implemented daily from 19 December 2016 to 2 January 2017. The trust informed us of the additional actions it had taken to manage the overcrowding issues in the ED including implementing a capacity command, control and co-ordination hub in order to have a robust overview of trust capacity issues and to manage daily objectives and actions.

6.2. Whilst these processes had been put in place, we found on our April 2017 inspection, we found at both WRH and AH that patients were still being cared for on trolleys in the corridor whilst waiting for admission to a ward or for therapist input prior to a safe discharge. Patients were also being cared for in the corridor whilst awaiting a cubicle in the 'Majors' area of the ED at both hospitals. There was a patient co-ordinator on duty at senior sister level, who was responsible for managing the flow of patients. The patient safety matrix showed critical or 'overwhelmed'/level three escalation for much of the two days we visited at WRH.

6.3. Data from the trust showed that in December 2016 and January 2017 almost 60% of ambulance crew staff waited for more than 30 minutes after arrival to handover their patient to the WRH ED staff. Data collected by the local NHS trust ambulance service showed for February 2017 that 118 patients waited for more than one hour to be handed over to the ED staff at WRH and in March 2017, it was 52 patients.

6.4. There was no effective plan in place to effectively manage the overcrowding in the ED at both hospitals. Patients being cared for on trolleys in the ED corridor had become an accepted means of managing the 'flow' through the ED, including on occasions when ED cubicles were empty. The service has not made significant improvements to address concerns identified in the November 2016 inspection at the pace required.

6.5. At the AH, the ED used a safety matrix to determine whether current conditions promoted patient safety. Information such as patient numbers, ambulance arrivals, patient acuity and available staff were entered into the matrix on a two hourly basis. In 2016, this had been paper based and was only used for monitoring purposes. In March 2017,

it became part of the hospital computer system so that senior staff in other parts of the hospital could see immediately if patient safety was at risk. However, nurses on duty during the inspection told us that this innovation had not changed the hospital's response when the matrix showed that risk was increasing. They did not know which staff in the hospital were meant to monitor the on-line information from the matrix. For example, on the night of our inspection on 11 April 2017, the matrix showed that the department was "overwhelmed" between midnight and 8am. This was due to large numbers of ambulances arriving, patients being cared for in the corridor, and several highly dependent patients in the department. The new matrix did not display any guidance for staff in these circumstances and the response from the hospital was no different than previously. When the department was full, it was sometimes necessary for patients brought by ambulance to wait in the corridor. At our previous inspection, we found there was a lack of emergency equipment immediately accessible for patients being cared for in the corridor area; for example, there was no medical suction equipment nearby. This situation was unchanged on this inspection. The service has not made significant improvements to address concerns identified in the November 2016 inspection.

6.6. In your letter of 12 April 2017, following our verbal feedback regarding the normalisation of the care of patients in the ED corridor, you stated that the review of patient flow continued to be a high priority for the trust. You said that you were reviewing the current practice of available space with ED to further prevent the need for patients being cared for in the corridor. The trust's updated 'Way Forward Plan' dated 7 June 2017 stated that a 'Capacity and Demand' proposal was approved in May, with an analysis of capacity and demand to be carried out in June with the proposed implementation of new scheduling and job planning in July 2017. The return to compliance date for the Section 29a Warning Notice was 10 March 2017. The trust has not made significant improvements to address concerns identified in the November 2016 inspection at the pace required.

Other concerns identified during this inspection requiring significant improvements are:

**7. Safeguarding**

*7.1.* Staff training compliance for both adult and children's safeguarding was significantly worse than the trust target. At our inspection in November 2016, we found that no nursing staff within the ED at WRH had not completed a valid level three safeguarding children training course. Level two and three training had been completed online, when national guidance is for this to be face to face training. The trust provided data as of the end of April 2017 regarding safeguarding training which showed that at WRH safeguarding children's level three compliance for

medical staff was 29% (seven doctors had completed this training out of 24). Safeguarding children's level three compliance for nursing staff was 81% (73 nurses had completed out of 90). Safeguarding adults training level two compliance was 16% for medical staff and 51% for nursing staff. The trust told us that the ED had a plan to achieve 100% compliance with safeguarding training based on available courses and was expected to be completed by October 2017. Two paediatric patients' records we looked at for the weekend before our April 2017 inspection, indicated consideration should have been given to a safeguarding referral. One patient was entered in the health visitors' book for a follow up visit; the other was not followed up or referred to the local safeguarding authority. We raised this as an urgent concern with the matron. The trust has not made therefore made significant improvements to address concerns identified in the November 2016 inspection to keep vulnerable adults and children and young people protected from avoidable abuse.

*7.2.* In 2016, the trust had been unable to provide us with records of safeguarding training undertaken by ED staff at AH. Therefore, we were unable to establish if staff were trained to an appropriate level of safeguarding to undertake their job roles and keep people safe from harm or abuse. However, staff verbally told us that they had only been trained at levels one or two. Senior ED staff are required to have the more advanced level three training but this had not been provided by the trust. At our April 2017 inspection, the ED matron told us that no further training had taken place. Level three training was planned but that no definite dates had been agreed. The trust provided data as of the end of April 2017 regarding safeguarding training. Safeguarding children's level three compliance for medical staff was 7% (one doctor had completed this training out of 15). Safeguarding children's level three compliance for nursing staff was 47% (20 nurses had completed out of 42). Safeguarding adults training level two compliance was 0% for medical staff and 41% for nursing staff. The trust has not made therefore made significant improvements to address concerns identified in the November 2016 inspection to keep vulnerable adults and children and young people protected from avoidable abuse.

7.3. At WRH, training data for the maternity and gynaecology service showed at our previous comprehensive inspection that 44% of midwifery staff and 0% of medical staff had completed safeguarding children level two training, and 51% of midwifery staff and 19% of medical staff had completed safeguarding children level three training. The trust target was 90%.Trusts need to have regard to national guidance in the Intercollegiate Document published by the RCPCH entitled 'Safeguarding children and young people: roles and competences for health care staff, (March 201). This states that all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating

the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

7.4. As of April 2017, training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. Compliance was still below the trust target of 90%. Senior staff told us safeguarding children training sessions had recently been cancelled by the safeguarding team. The trust has not made significant improvements to address concerns identified in the November 2016 inspection.

7.5. In the children and young people's service at WRH, we raised concerns about poor compliance with safeguarding training. In our April 2017 inspection, we saw that compliance with level three safeguarding training had shown no improvement or had declined in some specific staff groups. Training completion for neonatal nursing and support staff, paediatric ward nursing and support staff as well as paediatric medical staff was 72%, 75%, and 41% respectively. Compliance with training for medical and nursing staff who worked in adult outpatients / surgery but treated children was 6% overall. This was significantly below the trust target of 90%. We were informed by the trust that all future training sessions for level three safeguarding children had been cancelled due to the lack of trainers available to run the sessions. We note that NHS England are now proposing support with the delivery of level three safeguarding training but this is an area requiring significant improvement.

**8. Fit and proper persons**

8.1. Four out of five executive and non-executive personal files reviewed in line with the Fit and Proper Person regulation were incomplete. There was not a process in place to ensure that directors and non-directors fulfilled this requirement.

8.2. We noted in your letter of 12 April 2017 following our verbal feedback that you have carried out risk assessments on those individuals identified as not having a current Disclosure and Barring Service check. You stated you had instigated a full fit and proper persons' process review to ensure full compliance and a robust system for the future. We have not received sufficient assurance and details of how these improvements will be achieved, within defined timescales, to ensure significant improvements are sustained in this area of risk. The trust has not made significant improvements to address concerns identified in the November 2016 inspection.

**9. Fitness of equipment**

9.1. Resuscitation equipment in the minor injuries unit at Kidderminster Hospital and Treatment Centre was not fit for purpose in an emergency situation. The defibrillator was not ready for use as the electronic pads had expired at midnight on the night previous to our inspection. This was

not communicated to the day staff, meaning the equipment failure would not be identified and rectified until it was checked by the night staff the following evening.

**You are required to make the significant improvements identified above regarding the quality of healthcare provided by 30 September 2017.**

**Please note: If you fail to comply with the above requirement and thereby fail to make significant improvement to the quality of the health care you provide within the given timescale(s) we will decide what further action to take against you. Possible action includes, the Commission informing the Trust Development Authority, now part of NHS Improvement, that the Commission is satisfied that there is a serious failure by the trust to provide services that are of sufficient quality to be provided under the NHS Act 2006, and seeking to discuss and agree with the Authority, that a recommendation be made to the Secretary of State for the Secretary to appoint a trust special administrator in the interests of the health service because of that serious failure.**

We will notify the public that you have been served this Warning Notice by including a reference to it in the inspection report. We may also publish a summary more widely unless there is a good reason not to.

You can make representations where you think the Notice has been served wrongly. This could be because you think the Notice contains an error, is based on inaccurate facts, that it should not have been served, or is an unreasonable response. You may also make representations if you consider the Notice should not be published more widely.

Any representations should be made to us in writing within 10 working days of the date this Notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number RGP1-4008098265.

If you have any questions about this Notice, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you contact us, please make sure you quote our reference number (RGP1-4008098265) as it may cause delay if you are not able to give it to us.

Yours sincerely

**Edward Baker**
**Deputy Chief Inspector of Hospitals**

cc.
Dale Bywater, NHS Improvement
Maggie Boyd, NHS Improvement
Paul Watson, NHS England
Jacqueline Barnes, NHS England
Simon Trickett, NHS Redditch and Bromsgrove CCG and Wyre Forest CCG
Carl Ellson – NHS South Worcestershire CCG