Worcestershire Acute Hospitals NHS Trust

Quality Report

Worcestershire Royal Hospital
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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

Are services at this trust safe?	
Are services at this trust effective?	
Are services at this trust caring?	
Are services at this trust responsive?	
Are services at this trust well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) previously carried out a comprehensive inspection in November 2016, which found that overall; the trust had a rating of 'inadequate'.

We carried out an unannounced focused inspection on 11 and 12 April 2017. We also visited on 25 April 2017, specifically to interview key members of the trust's senior management team. This was in response to concerns found during our previous comprehensive inspection in November 2016 at Worcestershire Royal Hospital (WRH), the Alexandra Hospital (AH) and Kidderminster Hospital and Treatment Centre (KHTC) whereby the trust was served with a Section 29a Warning Notice. The Section 29a Warning Notice required the service to complete a number of actions to ensure compliance with the Health and Social Care Act 2008 Regulations. The trust had produced an action plan, which reflected these requirements as well as additional aims and objectives for the service. This inspection looked specifically at the issues identified in the warning notice and therefore no services were rated as a result of this inspection.

Focused inspections do not look at all five key questions; is it safe, is it effective, is it caring, is it responsive to people's needs and is it well-led, they focus on the areas indicated by the information that triggered the focused inspection.

The inspection focused on the following services: adult emergency department (ED), medical care, surgery, maternity and gynaecology and children and young people and the minor injuries unit at KHTC. We inspected parts of the five key questions for these services but did not rate them.

Areas where significant improvements included in the Section 29a Warning Notice had not been made were:

- The leadership and governance arrangements of the trust were not effective in identifying and mitigating risks or in providing assurance that actions were resulting in improvements to the safety and quality of patient care.
- Leaders did not act on known concerns at the pace required and were dependant on other organisations escalating areas of concern. There was not effective ownership of the need to establish effective systems to recognise, assess and mitigate risks to patient safety.
- Actions to address urgent concerns were either yet to be implemented or were not effective in reducing the risk as the data reported nationally and provided by the trust demonstrated there was subsequently no tangible improvement in performance.
- The trust had identified, and our review found, that the corporate risk register required significant review. Work had started on ensuring that it contains risks and not issues, however we found that there was a lack of consistency in how things were recorded.
- Actions already identified by the trust as necessary to mitigate patient care being compromised from overcrowding in the ED at WRH and AH were either yet to be implemented or were not effective in reducing the risk.
- There was no tangible improvement in performance, caring for patients in the corridors in the ED had become institutionalised and we found patient's privacy, dignity and effective care remained compromised. The trust senior leaders were not effectively addressing these risks through a whole hospital approach.
- The number of patients waiting between four and twelve hours to be admitted or discharged was consistently higher than the national average.
- In the emergency departments (ED) at WRH and AH, essential risk assessments were not always completed when required to keep patients safe from avoidable harm. There were not effective systems in place to assess and manage risks to patients in the ED at both hospitals. Staff did not always identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing.
- There was no appropriate mental health room available in the ED at WRH within which to safely care for patients.

Summary of findings

- The children's ED area at WRH was not consistently attended by staff except via CCTV surveillance to the nurses/doctors station in the major's area. Patients and their parents/carers were left alone after assessment and while they waited to see a doctor.
- There were insufficient numbers of consultants in the ED at WRH and AH on duty to meet national guidelines.
- Staff were not using privacy screens to respect patients' privacy and dignity whilst being cared for in the ED corridor area at WRH and AH. Patients were given meals in their hands by the staff but there was nowhere to rest plates and cups so they could eat their food with dignity. Routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by.
- In medical care and surgical wards visited at WRH and AH, venous thromboembolism assessments and 24-hour reassessments were not always carried out for all patients in line with trust and national guidance.
- We observed that staff did not always wash their hands before and after patient contact in ED, medical care and surgical wards in line with national guidance at WRH and AH.
- In the ED at WRH, time critical medications were not always administered to patients who had been assessed as needing them on time. In the surgery service at WRH, anticoagulation medicine had not always been administered as prescribed.
- Patients declining to take prescribed medication on Evergreen 1 ward and Beech ward at WRH were not always referred to medical staff for a review and were not always reviewed by medical staff. We raised this as an urgent concern with senior staff on the day of our inspection.
- Fridge temperatures for the storage of medicines in exceeded recommended ranges in some surgical areas visited and in the maternity and gynaecology service at WRH and AH, staff did not consistently follow trust processes for storing medicines at the recommended temperatures, despite there being policies in place.
- Although the trust's county wide perinatal mortality and morbidity meetings were minuted, there was no evidence that action was taken to address learning from case reviews. We were not assured an effective system was in place to ensure learning from these meetings was shared, and actions were taken to improve the safety and quality of patient care. In addition, these were not multidisciplinary and only attended by medical staff in the children and young people's service at WRH.
- Whilst some improvements were observed in completion of Paediatric Early Warning Scores charts, not all charts at WRH had been completed in accordance with trust policy. We also found there was not always evidence of appropriate escalation for medical review when required.
- In the paediatric ward at WRH, one to one care for patients with mental health needs was not consistently provided by a member of staff with appropriate training and reliance was, on occasion, placed on parents or carers.
- Senior leaders in surgery and medical care were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments (VTE) and hand hygiene. However, we saw examples throughout the service where compliance with trust and national guidance had not significantly improved.
- When risks had been escalated, there was a lack of follow up and resolution. Effective action following the reporting of high fridge temperatures for storage of medicines was not evident.

Additional areas of concern, that were not included in the Section 29a Warning Notice, that we found during this inspection were:

- Some risk assessment records in medical care wards at WRH were not routinely completed in their entirety, including elderly patient risk assessments and sepsis bundle assessments. We were not assured that inpatient wards were effectively following the trust's sepsis pathway when required.
- There was an inconsistent approach to following the ED's child and adult safeguarding processes. Staff training compliance for both adult and children's safeguarding was significantly worse than the trust target at both hospitals.
- Pain relief given to children in the ED was not evaluated for its effectiveness for all patients. There was no system in place to ensure medicines stored in the emergency gynaecology assessment unit were safe for patient use. Immediate action was taken by the trust once we raised this as a concern.

Summary of findings

- The recording of patients' weights on drug charts on some medical care wards at WRH had not improved. In the surgical service at WRH, some patients were prescribed inappropriate doses of anticoagulation medication without regard to their weight.
- Not all staff were up to date with the trust's medicines' management training.
- Resuscitation equipment was not fit for purpose in an emergency situation at the minor injuries unit at Kidderminster Hospital and Treatment Centre (KHTC). The defibrillator was not ready for use as the electronic pads had expired at midnight on the night previous to our inspection.
- On the haematology ward at WRH staff handled food with their hands without the use of
- In the maternity and gynaecology service, training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, compliance was still below the trust target of 90%, particularly with medical staff. In the children and young people's service, safeguarding children's level three training was below the trust's target of 90% and future training sessions had been cancelled. Compliance rates for this essential training were no better or worse in April 2017 in some staff teams compared to November 2016.
- In the surgery service at WRH, less than 10% of nursing staff and 30% of surgical staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Less than 20% of nursing and surgical staff had received this training. Staff compliance in the medical care service at WRH was 45% and AH was 42%, which was below the trust target of 90%. At KHTC only 33% of staff were up-to-date on this training.
- Patient records were left unsecured on a number of medical care wards we visited and there was a risk that personal information was available to members of the public. Visitors to surgical wards could see patient identification details on electronic white boards.
- Some surgical wards did not display their planned staff on duty only their actual staff on duty.
- The waiting room and toilet facilities for patients attending the emergency gynaecology assessment unit were mixed sex, as these were shared with the respiratory outpatient clinic. Furthermore, this assessment unit did not have appropriate facilities such as bathrooms, to facilitate personal care for patients who had to stay overnight at times of increased bed pressures.
- The children and young people's service became busy at times and staff said activity had increased since the service reconfiguration. However, there was limited monitoring of assessment and admission to inpatient areas. This meant that service leaders were not in a position to understand current and future performance and to be able to drive improvements for better patient outcomes.
- The risk register for the children and young people's service had been updated to include two additional risks identified during the November 2016 inspection, but not all risks found on this inspection had been identified, assessed, and recorded. For example, the increased activity in the service following the transformation process.

Areas where we found improvements included in the Section 29a Warning Notice had been made were:

- Staff felt supported to report incidents including occasions when they judged patients unsafe because the emergency department (ED) was 'overwhelmed'. An electronic patient safety matrix and ED occupancy tool was in place showing real time data about ED capacity, which gave oversight of the pressures in ED.
- The trust had implemented a 'Full Capacity Protocol' that was activated when the emergency department safety matrix status showed critical or overwhelmed status.
- Most patients were assessed within 15 minutes of arriving to the ED by senior nurses.
- Nurse breaks in the clinical decision unit were now covered by other nurses. Most ED staff were attentive, discrete as possible and considerate to patients.
- During this inspection, all 21 records looked on the acute stroke unit, Avon 3, Evergreen 1 and 2 wards showed NEWS charts were completed fully and patients were escalated for medical review appropriately when required.
- There had been improvements in the monitoring of medicines' fridge temperatures in medical care wards visited.
- All staff we saw in surgical clinical areas had 'arms bare below elbows'.

Summary of findings

- Infection control protocols were followed in the children and young people's service.
- There were appropriate arrangements in place for management of medicines in the children and young people's service, which included their safe storage.
- All patients admitted to the paediatric ward because of an episode of self-harm or attempted suicide had a risk assessment on file.

Areas of improvement, that were not included in the Section 29a Warning Notice, found from the last inspection were:

- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). This was being used as to drive improvement and had improved staff's understanding of safety and quality in the service.
- There was a senior initial assessment nursing system in place for patients arriving by ambulance to the ED. Staff told us the flow had improved since two 'ambulance access' cubicles were specifically allocated in the department.
- Health care assistants were undertaking comfort rounds for patients' cared for in the corridor area of ED, completing documentation and giving patients a leaflet explaining why they were waiting in a corridor.
- The ED was managed locally by the matron and senior ED consultant. Staff were very committed to their work and doing the best they could for their patients even under regular and consistent heavy pressure.
- The medical care service had taken steps to improve the management of medical patients on non-medical speciality wards.
- The medical care service had improved patient flow in WRH and AH to minimise patient moves.
- There were fewer reported surgical staff shortages and shortfalls were escalated and risk assessed so patients' needs were met.
- Effective systems had been introduced to ensure emergency equipment was checked daily in the maternity and gynaecology service. Equipment was well maintained and had been safety tested to ensure it was fit for purpose.
- The hospital did not have a dedicated gynaecology inpatient ward. This meant some patients stayed overnight in the outpatient emergency gynaecology assessment unit and were nursed in medical wards. However, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs.
- Daily ward rounds by a gynaecology consultant and nurse were carried out to ensure gynaecology patients were appropriately reviewed and managed, regardless of location within the trust.
- Staff caring for gynaecology patients on Beech B1 ward had received training on bereavement care, including early pregnancy loss and the management of miscarriage.
- Risks identified in the maternity and gynaecology service were reviewed regularly with mitigation and assurances in place. Staff were aware of the risks and the trust board had oversight of the main risks within the service.
- The majority of staff in the children and young people's service had been competency assessed in medical devices used to help patients breathe more easily.

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

Importantly, the trust must:

- Ensure the governance systems allow full oversight at board level of the potential risk to patients. This must include the recognition, assessment, monitoring and mitigation of risk.
- Ensure the processes to check that the trust only employs 'fit and proper' staff are in place and effective.
- Ensure that patients in the EDs receive medication prescribed for them at the correct time and interval.
- Ensure that all patients' conditions are monitored effectively to enable any deterioration to be quickly identified and care and treatment is provided in a timely way.
- Ensure that staff complete all of the risk assessments and documentation required to assess the condition of patients and record their care and treatment.
- Ensure all patients have a venous thromboembolism (VTE) assessment and are reassessed 24 hours after admission in accordance with national guidance.
- Ensure that the privacy and dignity of all patients in the EDs is supported at all times, including when care is provided in corridor areas.

Summary of findings

- Ensure that systems or processes are fully established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety, and welfare of patients while using the EDs.
- Ensure mental health assessment room in the emergency department (WRH) is appropriate to meet needs of patients.
- Ensure the children's ED (WRH) area is consistently monitored by staff.
- Ensure patient weights are recorded on drug charts.
- Ensure there are processes in place to ensure that any medicine omissions are escalated appropriately to the medical team, including when patients refuse to take prescribed medication.
- Ensure all anticoagulation medication is administered as prescribed. All non-administrations must have a valid reason code.
- Ensure all medicines are stored at the correct temperature. Systems must be in place to ensure medication, which has been stored outside of manufactures recommended ranges, remains safe or is discarded.
- Ensure patient identifiable information is stored securely and not kept on display
- Ensure all staff comply with hand hygiene and the use of personal protective equipment policies.
- Ensure all staff are up-to-date on medicines' management training.
- Ensure all staff have completed their Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.
- Ensure all staff have completed the required level of safeguarding training.
- Ensure all patients in the children and young people's service with mental health needs have the appropriate level of staff one to one care in accordance with their risk assessments.
- Ensure paediatric assessment area activity is monitored effectively so the service can drive improvements in patient flow.
- Ensure the risk registers reflects all significant risks in the service and effective mitigating actions are in place to reduce potential risks to patients.
- Ensure safeguarding referrals are made when required for patients seen in the ED at WRH.
- Ensure equipment is safe for use in the minor injuries unit at KHTC.
- Ensure the sepsis pathway is fully embedded in inpatient wards.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

Due to level of concerns found across a number of services and because the quality of health care provided required significant improvement, we served the trust with a new Warning Notice under Section 29A of the Health and Social Care Act 2008.

The trust remains in special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital provides acute healthcare services to a population of around 580,000 in Worcestershire and the surrounding counties.

There are approximately 500 inpatient and day case beds, of which 70 are maternity and 18 are critical care. The hospital provides a comprehensive range of surgical, medical and rehabilitation services, including stroke services and cardiac stenting. The trust employs 5,053 staff, including 725 doctors, 1,843 nursing staff and 2,485 other staff.

In 2015/16, the trust had an income of £368,816,000 and costs of £428,732,000; meaning it had a deficit of £59,916,000 for the year. The deficit for the end of the financial year for 2016/17 was predicted to be £34,583,000.

Our first comprehensive inspection took place in July 2015, when Worcestershire Royal Hospital was rated as inadequate and the trust entered special measures. We carried out a second comprehensive inspection of the trust in November 2016 on this occasion; the trust was rated as inadequate and remained in special measures.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultants and nurses from surgical services and general medicine and emergency department doctors and nurses. The team also included an executive director and a governance specialist.

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 of people's needs?
- Is it well-led?

We reviewed a range of information we held about Worcestershire Acute Hospitals NHS Trust and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We spoke with people who used the services and those close to them to gather their views on the services provided. Some people also shared their experience by email and telephone.

We carried out this inspection as part of our programme of re-visiting hospitals to check improvements had been made. We undertook an unannounced inspection from 11 to 12 April 2017 and an announced inspection on 25 April 2017.

Summary of findings

What people who use the trust's services say

In the CQC inpatient survey 2016 (published May 2017) the trust performed about the same as other trusts for 9 of the 11 questions. Responses were received from 531 patients at Worcestershire Acute Hospitals NHS Trust. Two questions were worse than other trusts:

- for being given enough privacy when being examined or treated in the emergency department.
- waiting to get a bed on a ward.

The trust's overall score in the friends and family test for the percentage of patients who would recommend the trust was about the same as the England average between August 2015 and August 2016. However, the response rate was less than the national average at 16.4% compared to an England average of 24.7%.

Facts and data about this trust

The trust primarily serves the population of the county of Worcestershire with a current population of almost 580,000, providing a comprehensive range of surgical, medical and rehabilitation services.

The trust's main clinical commissioning groups (CCG) are NHS Redditch and Bromsgrove CCG, NHS Wyre Forest CCG and NHS South Worcestershire CCG.

The health of people in Worcestershire is varied compared to the England average. Deprivation is lower than average and about 15% (14,500) children live in poverty. Life expectancy for both men and women is similar to the England average.

As at August 2016, the trust employed 5,053.82 staff out of an establishment of 5,532.69, meaning the overall vacancy rate at the trust was 9%.

In the latest full financial year, the trust had an income of £368.8m and costs of £428.7m, meaning it had a deficit of £59.9m for the year. The trust predicts that it will have deficit of £ 34.5m in 2016/17.

In the last financial year the trust had:

- 120,278 A&E attendances.
- 139,022 inpatient admissions. (2014/15 financial year)
- 588,327 outpatient appointments.
- 5,767 births.
- 2,181 referrals to the specialist palliative care team.
- 51,444 surgical bed days.
- 1,945 critical care bed days (March to August 2016).

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts this key questions but did not rate it. We found significant improvements had not been made in these areas: • Essential risk assessments were not completed when required to keep patients safe from avoidable harm. There were not effective systems in place to assess and manage risks to patients in the ED at WRH. Venous thromboembolism (VTE) assessments and 24-hour reassessments were not always carried out for all patients in line with trust and national guidance in medical wards at WRH and at AH. At AH, nine out of 29 patient records reviewed lacked an initial VTE assessment. VTE risk assessments and 24 hour reassessments were not completed in line with national guidance in surgical wards at WRH and AH. • Staff did not follow good hand hygiene practice at all times in the ED at Worcestershire Royal Hospital (WRH). We observed that most staff did not generally wash their hands before and after patient contact on the acute stroke unit, Avon 2 ward and the medical assessment unit (MAU) in at WRH line with national guidance. We found the same on ward 12 and the medical assessment unit at the AH. Some staff did not clean their hands before or after patient contact and some staff wore personal protective equipment inappropriately in surgery wards at WRH and AH. • Whilst some improvements were observed in completion of Paediatric Early Warning Scores charts, not all charts had been completed in accordance with trust policy in the children and young people's service at WRH. We also found there was not always evidence of appropriate escalation for medical review when required. • In the children and young people's service at WRH, one to one care for patients with mental health needs was not consistently provided by a member of staff with appropriate training and reliance was, on occasion, placed on parents or carers. • There was no appropriate mental health room available within which to safely care for patients at WRH ED.	

Summary of findings

- The children's ED area at WRH was not consistently attended by staff except via CCTV surveillance to the nurses/doctors station in the major's area. Patients and their parents/carers were left alone after assessment and while they waited to see a doctor.
- There was minimal reporting of patient safety incidents relating to patients waiting on trolleys in corridors and when the ED at AH was over capacity. There was very little response from the hospital as a whole when the ED safety matrix showed that the department was overwhelmed.
- This was not sufficient medical cover to provide a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine at both WRH and AH.
- Resuscitation equipment was not fit for purpose in an emergency situation at Kidderminster Hospital and treatment centre (KHTC). The defibrillator was not ready for use as the electronic pads had expired at midnight on the night previous to our inspection.
- The trust had a process in place for the monitoring of fridge temperatures where medicines were stored. However, there was no evidence of follow-up processes when areas of concern had been highlighted at KHTC. Fridge temperatures for the storage of medicines exceeded recommended ranges in surgical areas visited at WRH and AH. Trust processes were not consistently followed across the maternity and gynaecology service at WRH and AH.
- Time critical medicines were not always given when required in some medical care wards at the AH and for patients who had been assessed as needing them on time in the WRH ED.
- In the children and young people's service at WRH and maternity and gynaecology service at WRH and AH, we found that whilst perinatal mortality and morbidity meetings were minuted and well attended, which was an improvement since the previous inspection, there was no evidence that action was taken to address learning from patient case reviews. Paediatric mortality and morbidity meetings were not multidisciplinary and only attended by medical staff. Despite assurances from the trust, we saw no evidence that obstetrics and gynaecology mortality and morbidity reviews were held at AH. There was inadequate investigation of, and learning from, serious incidents and inadequate mortality and morbidity reviews in the ED at AH. We were not assured an effective system was in place to ensure learning from perinatal mortality and morbidity meetings was shared, and actions were taken to improve the safety and quality of patient care.

We also found other areas of concern:

Summary of findings

- Staff did not always identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing in WRH ED. Some risk assessment templates were not routinely completed in their entirety, including elderly patient risk assessments and sepsis bundle assessments at WRH and AH medical care wards. We were not assured that the trust's sepsis pathway was always being followed when required.
- There was an inconsistent approach to following both the ED's child and adult safeguarding processes at WRH. Staff training compliance for both adult and children's safeguarding was significantly worse than the trust target for both WRH and AH. Safeguarding adults and children training for doctors and nurses in the ED at AH was inadequate.
- There was a lack of immediately accessible equipment for the care and treatment for patients being cared for in the corridor area of ED at AH.
- There was a risk that there would be no appropriately qualified doctors on duty if a child needed resuscitating at the ED at AH. There were fewer nurses than required for the numbers of patients in the ED at AH, particularly at night.
- Only 78% of patients were assessed by a member of ED staff at WRH within 15 minutes of arrival: this had not improved since the last inspection.
- We observed staff handling food on the haematology ward at WRH with their hands without the use of gloves which was not in line with national and trust guidelines.
- We found that the recording of patients' weights on drug charts had not improved in medical care wards at WRH or at the AH. Patients declining to take prescribed medication on medical care wards at WRH and AH were not always referred to medical staff for a review and were not always reviewed by medical staff. Doctors prescribed medication at the AH but did not always review drug charts to ensure patients were either taking their medication as prescribed or declining to take them. This meant that effective treatment was not always provided.
- Some patients were prescribed inappropriate doses of anticoagulation medication without regard to their weight in surgical wards at the WRH. Anticoagulation medications had not always been administered as prescribed in surgery areas at WRH and at AH.
- There was no system in place to ensure medicines stored in the emergency gynaecology assessment unit at WRH were safe for patient use. Immediate action was taken by the trust once we raised this as a concern.

Summary of findings

- Only 31% of staff in medical care wards at WRH and 24% of staff in medical care wards at AH were up-to-date on medicines' management training and this was significantly below the trust target of 90%. Not all staff had completed their medicines' management training in medical care wards at KHTC. Figures from the trust showed a completion rate of 30%. This meant that not all staff had up-to-date knowledge relating to potential risks associated with medicines.
- Patient records were left unsecured on a number of medical care wards we visited at WRH and AH and there was a risk that personal information was available to members of the public. Visitors to wards could see patient identification details on electronic white boards in surgical wards at both hospitals. This was raised as a concern during the last inspection in November 2016.
- Some surgical wards at WRH and AH did not display their planned staff on duty only their actual staff on duty.
- In surgical wards at WRH, less than 10% of nursing staff and 30% of medical staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). At AH, Less than 20% of nursing and medical staff had received training in Mental Capacity Act 2005 and Deprivation of Liberty.
- In the maternity and gynaecology service at WRH, training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, compliance was still below the trust target of 90%, particularly with medical staff.
- In the children and young people's service at WRH, safeguarding children's level three training was below the trust's target of 90% and future training sessions had been cancelled. Compliance rates for this essential training were no better or worse in April 2017 in some staff teams compared to November 2016.
- Some surgical nursing staff, who cared for gynaecology patients on the designated wards at AH, had not received any specific gynaecology training, such as management of surgical miscarriage and bereavement care. However, the gynaecology medical team were available for advice as needed.

However, we observed improvements for the following:

Summary of findings

- Staff felt supported to report incidents including occasions when they judged patients to be unsafe because the ED at WRH was 'overwhelmed'. An electronic patient safety matrix and ED occupancy tool was in place showing real time data about ED capacity, which gave oversight of the pressures in ED.
- Appropriate systems were in place for the management of controlled drugs within the endoscopy unit at KHTC.
- Most patients were assessed within 15 minutes of arriving by senior nurses at WRH ED.
- Nurse breaks in the clinical decision unit at WRH ED were now covered by other nurses. Nurse staffing levels in the discharge lounge at AH met patients' needs. There were fewer reported staff shortages and shortfalls were escalated and risk assessed so patients' needs were met in surgical services at the WRH and AH.
- We observed good infection control precautions performed by all staff in clinical areas at the ED at AH.
- There were improved processes for the recording of medication that had been given to patients by ambulance crews at the ED at AH.
- Staff were now confident in the use of Paediatric Early Warning Scores at the ED at AH.
- During this inspection, all 21 records looked at on medical care wards at WRH showed NEWS charts were completed fully and patients were escalated for medical review appropriately when required. Improvements were noted in completed of NEWS records in the medical care wards visited at the AH.
- The medical care service had taken steps to improve the management of medical patients on non-medical speciality wards at WRH. The medical care service had improved patient flow at WRH to minimise patient moves.
- All staff we saw in clinical areas had 'arms bare below elbows' in surgical areas at WRH and at the AH.
- Patients undergoing surgery had the correct consent form. Patients who lacked capacity had evidence of a mental capacity assessment being completed.
- Effective systems had been introduced to ensure emergency equipment was checked daily in the maternity and gynaecology service at WRH. Equipment was well maintained and had been safety tested to ensure it was fit for purpose.
- The hospital did not have a dedicated gynaecology inpatient ward at WRH. This meant some patients stayed overnight in the outpatient emergency gynaecology assessment unit and were nursed in medical wards. However, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs.

- There had been an improvement in compliance with safeguarding children level three training in the maternity and gynaecology service at WRH and AH. Staff demonstrated awareness of safeguarding guidance, including female genital mutilation. Staff understood their responsibilities and were confident to raise concerns. However, training compliance was still below the trust target.
- Standards of cleanliness and hygiene were well maintained in the maternity and gynaecology service at WRH and AH. Staff adhered to infection control and prevention guidance. Equipment was well maintained and had been safety tested to ensure it was fit for purpose.
- There were appropriate arrangements in place for management of medicines, which included their safe storage in the children and young people's service at WRH,
- All patients admitted to the paediatric ward at WRH because of an episode of self-harm or attempted suicide had a risk assessment on file.
- The majority of staff had been competency assessed in medical devices used to help patients breathe more easily in the children and young people's service at WRH,
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). This was being used as to drive improvement and had improved staff's understanding of safety and quality in the service.

Duty of Candour

- We did not gather evidence for this as part of the inspection.

Safeguarding

- At WRH, there was an inconsistent approach to following both the ED's child and adult safeguarding processes. 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 nursing staff within the ED had not completed a valid level 3 safeguarding training course. Level 2 and 3 training had been completed online, when the requirement is for this to be face to face in line with national guidance. The trust provided information following this inspection that showed at the end of April 2017 for level 2 adults' safeguarding training, 15 out of 89 staff in the ED had completed face to face training (17%) and 24 had done online training (27%).

- For level 2 children's' safeguarding training, one out of 89 staff had completed face to face training (1%) with 19 out of 89 having online training (21%). For level 3 children's' safeguarding training, 41 out of 89 staff had completed face to face training (46%) with 46 out of 89 having online training (52%).
- 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.
- 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 this 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 in the Ed at AH.
- Two paediatric patient's records we looked at for the weekend before our visit to the ED at WRH, indicated consideration should be 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 with the matron who undertook to look into this and later informed us appropriate procedures were set in motion.
- In the clinical decisions unit (CDU) at WRH, we looked at five adult patient records as they had admitted from the ED and a safeguarding referral may have been appropriate: three did not have an adult safeguarding form completed.
- During our previous inspection of maternity and gynaecology at WRH, we found that arrangements were in place to safeguard adults and children from abuse that reflected legislation and local requirements. Staff generally understood their responsibilities and adhered to safeguarding policies and procedures. However, we also found not all staff had completed

the appropriate level of safeguarding children training. Furthermore, we found that there was poor awareness of female genital mutilation (FGM) and staff told us they had not received training in FGM identification or awareness.

- Training data provided during our previous inspection showed 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%.This did not meet with national recommendations, which state that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to safeguarding children level three ('Working together to safeguard children' (2015): Intercollegiate Document 'Safeguarding children and young people: roles and competences for health care staff' March 2014).
- As of April 2017, training data for the maternity and gynaecology service at WRH and AH showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, 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. Staff would be rebooked when sessions were made available.
- Staff were required to complete safeguarding adults and children training on trust induction, following commencement of employment, and refresher training every three years. Refresher safeguarding training was completed via e-learning modules, with some ad hoc sessions provided for safeguarding children training. The safeguarding children e-learning module was developed in collaboration with experts from six safeguarding children boards and had been updated to include FGM, radicalisation, forced marriage, child trafficking and child sexual exploitation (CSE).
- Not all staff who worked within paediatrics at WRH had completed their safeguarding children level three training. In July 2015 and November 2016 inspections, we identified that not all staff had completed the required level of safeguarding children training. Overall, some improvements had been made on this inspection we found with compliance with safeguarding children level three training was at 83%: however, this was still below the trust's target of 90%. In the November 2016 inspection, medical staff had achieved compliance of only 41%

compared to nursing staff who had achieved 79%: this was significantly lower for medical and nursing staff who worked in adult outpatients / surgery but treated children, at 15% and 6% respectively.

- In this 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.

Incidents

- At our inspection in November 2016, we found staff in the emergency department (ED) at WRH were discouraged from reporting incidents relating to high capacity and care in the corridor. This meant there was a risk of staff stopping reporting safety and capacity incidents. Medical staff were told in November 2016 by the trust governance team that their incident reports relating to patients being cared for in areas they considered to be unsafe were inappropriate and were being deleted. This had not been previously identified by the trust as a risk and did not appear on the divisional or corporate risk register. The trust provided us with information in January 2017, which detailed immediate and ongoing actions that had been taken to address this problem. These actions including reiteration to staff by senior managers that they should report incidents relating to high capacity and corridor care. On this inspection, we found that staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. This included to report when capacity in the ED was at risk of compromising patient safety when crowding and poor flow through the hospital overwhelmed the service.
- Data sent by the trust reported relating to the patient safety matrix showed critical or 'overwhelmed' 27 days out of 31 in the period 1 to 31 March 2017. During the two days of our visit on 11 and 12 April 2017, we saw between three and five patients at any time being cared for in the ED corridor. The trust referred to this as 'reverse queuing' as these patients had been seen and were waiting to be admitted to wards or safely discharged home.

- The matron showed us global risk assessment tool sheets, which were being first implemented in the department on the day of our visit. Senior sisters told us incidents of crowding in the ED were now reported through this global risk assessment tool. We spoke with a regular locum consultant who confirmed that they were encouraged and supported to report incidents by the lead consultant and most consultants did so. After our inspection visit, we asked the trust to send us an account of ED incident reports for the week of our visit when we had seen the ED declared as 'overwhelmed' on the trust's status matrix during both days. After the inspection, the trust sent us information that showed from January to March 2017, 15 incidents had been reported due to capacity concerns and staffing pressures in the ED. However, it was not clear to see if all staff were consistently reporting all incidents linked to when the ED was 'overwhelmed'.
- At the AH, there had been three serious incidents in the ED since our last inspection in November 2016. Although all had severe outcomes for the patients concerned, none had been investigated using root cause analysis or the NHS serious incident framework. This meant that the fundamental causes of the incidents had not been identified and so no action had been taken to prevent a recurrence. Only one consultant had recently received training in root cause analysis limiting the department's ability to learn from the causes of serious incidents. Despite the trust telling us that they now encouraged staff to report such incidents, only two concerns related to bed management issues had been reported for the ED at AH in January to March 2017. This was despite the fact that the department's own safety matrix showed that patient safety levels had been "critical" on twelve occasions and that the department had been "overwhelmed" on a further seven occasions during March 2017. This lack of reporting onto the trust-wide system meant that there was no established process to inform senior leaders of the degree of risk associated with an over capacity department and patients being cared for on trolleys in corridors. We were told that formal mortality and morbidity meetings had not taken place at the AH but cases and lessons learnt had been discussed in senior doctors teaching at the end of each month. However, there was no process of disseminating learning outside of this teaching session and so the majority of staff were unaware of any required changes to practice.
- During our comprehensive inspection in November 2016 of the maternity and gynaecology service at WRH, we found staff understood their responsibilities to raise concerns and felt

confident in doing so. Lessons were learned from incidents and action was taken to improve safety within the service. However, we also found perinatal mortality and morbidity meetings were not formally minuted and any learning, including actions taken to prevent and/or minimise reoccurrence, were not clearly recorded. Furthermore, when actions were identified, no timescales for completion were documented, nor was it evident which member of staff was responsible for ensuring actions were completed. This meant we were not assured there was a robust system in place to ensure learning from perinatal mortality and morbidity meetings was shared and actions were addressed. We also reported that the service did not hold morbidity meetings within maternity and gynaecology. We were told that plans were in place for these to be introduced in 2017. National bodies, such as the Royal College of Obstetricians and Gynaecologists (RCOG), recommend that maternity care providers hold regular multidisciplinary team meetings to review perinatal and maternal mortality and morbidity, so that patient safety and quality of care is improved.

- In response to concerns found during our previous inspection, a quality improvement plan (QIP) had been developed by the trust to ensure mortality and morbidity meetings were standardised, actions were taken and lessons learnt were shared at WRH and AH. However, we found that this had not been applied consistently across the maternity and gynaecology service at either hospital. The trust provided a schedule for perinatal, obstetrics and gynaecology mortality and morbidity meetings for 2017; nine perinatal, 11 obstetrics and 11 gynaecology mortality and morbidity meetings had been scheduled for 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.
- Similarly, we reviewed three sets of minutes for divisional governance meetings held in January, February and March 2017 and found no evidence that maternal mortality and

morbidity reviews were discussed. This may have been due to the fact that maternal mortality is rare. 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. Therefore, we could not be assured that obstetrics and gynaecology mortality and morbidity reviews were held. We reported this as a concern following our previous comprehensive inspection. We 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. Therefore, we were unable to determine whether the January 2017 meeting was held.

- During the November 2016 inspection, we identified that paediatric mortality and morbidity meetings were not held and mortality and morbidity issues were not discussed at other meetings. Once we raised this as a concern, the trust had taken action and in April 2017, we found that a paediatric mortality and morbidity meeting was now in place. Meetings were held quarterly, and minutes of the January 2017 meeting demonstrated that there was a discussion around individual cases, learning points were noted and actions agreed. However, we saw that meeting attendance was not multidisciplinary, with only medical staff attending the meetings.
- In response to our concerns regarding the lack of formal minutes for perinatal mortality and morbidity meetings found on our previous inspection of the children and young people's service at WRH, a member of the governance team had been employed to take the minutes. The meeting minutes for February and March 2017 included a list of attendees and their designation. This was an improvement from our previous inspection. The meetings were attended by members of the multidisciplinary team, including consultants, junior doctors, midwives, and student midwives. Case histories and learning points were documented. 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, we were not assured that an effective system was in place to ensure that learning from perinatal mortality and morbidity meetings was shared, and actions were taken to improve the safety and quality of patient care. We reported this as an urgent concern following our previous comprehensive inspection.
- The divisional director of nursing and midwifery told us the service was in the process of introducing the standardised

clinical outcome review tool (SCOR), developed by the Perinatal Institute. SCOR is a software tool, designed to facilitate the comprehensive review of perinatal deaths. It includes the identification of substandard care factors and system failures, and prompts an action plan to help implement multidisciplinary learning.

Staffing

- At our inspection in November 2016, we found that the ED at WRH had 3.7 whole time equivalent (WTE) full-time consultants, with one additional locum consultant. The trust provided us with the assurances in January 2017 that it was actively recruiting for substantive consultants replace the locums being used in the ED, however this risk remained. On this inspection, we found that this risk remained active on the ED's risk register. The number of substantive WTE consultants in the ED was 5.7 WTE. The trust had agreed that the consultant establishment at WRH was 8 WTE. The recruitment process to appoint up to the establishment of 8 WTE was underway. A business plan was required to recruit a further two consultants which would achieve the goal of 10 WTE. The business plan was in development. During the week, an ED consultant was on duty covering 9am to 7pm followed by locum consultant cover until 12pm. This achieved consultant cover of 15 hours per day, slightly below the Royal College of Emergency Medicine's emergency medicine recommendations to provide consultant presence in all EDs for 16 hours a day, seven days a week as a minimum. Staff told us this level was maintained over weekends also. We requested the ED consultant rota but this was not provided: the trust informed us that, during the week, ED consultants worked 9am to 7pm, and were on call for one week in five on the rota. An additional locum consultant worked 4pm to 12 midnight.The trust told us that, at weekends, a one in eight week rota was in place with ED consultants working 9am to 5pm ED, being on call for the remaining time. An additional locum consultant worked 4pm to 12 midnight.
- The AH employed one full-time consultant in the ED and obtained three others from a temporary staffing agency. This was not sufficient to provide a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine. Instead, there were two consultants from 9am to 5pm, with one staying until 7pm. After that time, they were on-call from home. Recently two new consultants had been appointed and were due to start work in September 2017. However, it was not clear whether they would replace two of the locum consultants or would be in addition to

them. Although the lead consultant hoped that there would be five consultants working in the department, this had not been confirmed in writing. The department had experienced difficulty in recruiting middle grade doctors. Two of the eight doctors were employed by a temporary staffing agency and a further two were temporary doctors from the hospital's staffing bank. Those that we spoke with told us that they had undergone an orientation period and were familiar with local working practices. No incidents associated with a shortage of senior doctors had been reported.

- There were no paediatricians (children's doctors) in the AH after 5pm. For this reason, it was intended that the ambulance service would not bring children with severe illnesses or injuries to the ED. However, the guidance given to ambulance crews by the trust was not comprehensive and was sometimes difficult to follow. At our last inspection, senior ED doctors in AH told us that, if a child needed to be resuscitated, this would be done by doctors from the adult intensive care unit. However, the trust did not provide data to assure us that there was always an intensive care doctor in the hospital with an advanced paediatric life support (APLS) qualification, if a child in ED needed resuscitating. After the inspection, the trust told us that the service used advice and guidance provided by the local NHS ambulance trust for appropriate transfers to Alexandra hospital for children following the paediatric in patient relocation. This document was not a WAHT document: it was the NHS ambulance trust tool that in use across the West Midlands, localised for Worcestershire.
- At our last inspection of the ED at AH, we had found that there were not enough nurses to look after the numbers of patients in the department. Although there had been some improvement, there were not always enough nurses in the major treatment area or the resuscitation room. Guidance issued by the National Institute for Health and Care Excellence (NICE) indicates that there should be one nurse for four patients in a major treatment area. At the AH, between midnight and 11.30am, each nurse looked after six or seven patients. There was one nurse to look after three patients in the resuscitation room whereas NICE guidance states that minimum staffing levels should be one nurse for two patients. At night, there was no nurse allocated to look after patients in the corridor and so the nurse in charge is the only person available to do this. During the night of our inspection, there were up to six patients in the

corridor between midnight and 8am. This meant that the nurse in charge of the department was trying to look after six patients in the corridor, assess new patients arriving by ambulance, and run the department as a whole.

- During our unannounced inspection in December 2016, we visited the discharge lounge at AH and raised concerns about staff and patient safety when untrained staff were left alone to care for patients. This was escalated to senior staff during our inspection and was followed by a warning notice. The trust responded that they have developed a risk assessment tool which documents if the allocated registered nurse has to leave the department for a short time and safer staffing is discussed at each bed meeting on both sites and recorded manually. During this inspection, we saw this issue had been addressed and appropriate staffing levels were in place.
- At our inspection in November 2016, we found that the clinical decision unit (CDU) at WRH was staffed by one registered nurse (RN) and one health care assistant (HCA) per shift. When the RN went on a break, the area was covered by only the HCA. This left one HCA caring for eight patients. Staff told us this was a regular occurrence. On this inspection, we found that the CDU had between seven to eight patients at all times and there was one nurse and one HCA on duty. Staff told us that all staff breaks were covered by another RN.
- In surgery at WRH and AH, nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using an electronic rostering tool. The surgical directorate used an acuity tool, dependency reviews, NICE guidelines and professional judgement to assess and plan staffing requirements. Vacancy rates in surgical services at WRH in March 2017 were 16%. This had increased from January 2017 when it was 9%. Vacancy rates in surgical services at the AH in March 2017 were 11%. This had increased from January 2017 when it was 6%. The nurse vacancy rate remained on the surgical risk register and actions to improve staffing which were reported to us during our November 2016 inspection to address this continued. This included the use of bank and agency staff and monthly reviews of recruitment. In March 2017, there were 744 unfilled nurse shifts and 339 unfilled healthcare assistant shifts in the surgical services at WRH. This is considerably worse than our last visit when the service reported that from May 2016 to October 2016, there were133 unfilled nurse shifts and 79 unfilled health care assistant shifts. In March 2017, there were 380 unfilled nurse shifts and 345 unfilled healthcare assistant shifts in the surgical services at AH. This is considerably worse than our last visit when the service reported that from May 2016

to October 2016, there were133 unfilled nurse shifts and 79 unfilled health care assistant shifts. Despite the number of unfilled shifts, and the new staffing application, the service reported no incidents due to staff shortages between January and March 2017.

- All surgical wards at WRH and AH displayed their actual staff numbers. However, the number of planned staff on duty each shift was not displayed on three of the six wards we visited. Staff on these wards were unaware of the reasons for this. Displaying both planned and actual staff is recommended to allow patients and visitors to identify when there are staff shortages and demonstrates greater transparency. During our visit, staff told us there were adequate staff on duty to meet the needs of the patients they were looking after. Wards that displayed both planned and actual staff numbers did have the appropriate number of nurses on duty most of the time. Any shortages identified had been put out to agency or the shift coordinator changed duty to work clinically and provide assistance with patient care.

Are services at this trust effective?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts this key questions but did not rate it.

We also found areas of concern:

- In the surgery service at WRH, less than 10% of nursing staff and 30% of surgical staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Less than 20% of nursing and surgical staff had received this training. Some staff said they had received training in MCA and DoLS. At the AH, less than 20% of nursing and medical staff had received training in Mental Capacity Act 2005 and Deprivation of Liberty. All staff said they were aware of the requirement to attend training and that they had booked sessions.
- Staff compliance in the medical care service at AH with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 42%, which was below the trust target of 90%. The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training in medical care wards at KHTC were mandatory training and only 33% of staff were up-to-date on this training.
- Pain relief given to children at WRH ED was not evaluated for its effectiveness for all patients

However, we observed improvements for the following:

- Fluid balance charts were mostly fully completed in medical are wards visited at WRH and this was an improvement from our last inspection.
- Patients undergoing surgery at WRH and at the AH had the correct consent form. Patients who lacked capacity had evidence of a mental capacity assessment being completed.
- The number of staff who had completed Mental Capacity Act and Deprivation of Liberty Safeguards training had improved in the maternity and gynaecology service at WRH and AH.
- The majority of staff in the children and young people's service had been competency assessed in medical devices used to help patients breathe more easily.
- Staff had documented competencies to work in the non-invasive ventilation unit at the AH. This was identified as an issue during our inspection in November 2016 and had improved during this inspection.

Evidence based care and treatment

- We did not gather evidence for this as part of the inspection.

Patient outcomes

- We did not gather evidence for this as part of the inspection.

Multidisciplinary working

- We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

- During the November 2016 inspection, we found that 41% of staff across the medical service at AH had completed their Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. During this inspection, we saw that 42% of staff had completed the MCA/DoLS training and this was below the trust target of 90%. At WRH, 45% of staff had completed this training.
- Staff understood their responsibilities in relation to gaining consent from patients, including those who lacked mental capacity to consent to their care and treatment. Staff said they would seek advice from a senior member of staff should a formal assessment of mental capacity require completing.
- In surgical services at WRH and AH, staff we spoke with understood consent, decision-making requirements, and guidance. There was an up to date consent policy for surgical treatment. WRH had four nationally recognised consent forms in use and staff were able to describe the different uses for these. For example, staff described what would be required for

patients who were unable to consent to surgery themselves. Some staff had not received training in MCA and DoLS but all were aware of their need to attend the training and some told us of training dates they had planned or booked. In surgery at WRH and AH, patients who required a mental capacity assessment or a dementia screen received this in line with the trust policy. Dementia screens are simple tools which can help staff identify patients who may have dementia. Junior nursing staff told us they would contact senior nurses for help if they were required to make an application for a DoLS for patient. All patients we reviewed were consented for surgery using the correct form.

- From April 2016 to March 2017, in surgical services at the WRH, 30% of medical staff and 10% of nursing staff had received training in Mental Capacity Act (MCA) and Deprivation of Liberty level 1. This was significantly below the trust target of 90%.From April 2016 to March 2017, in surgical services at AH, 16% of medical staff and 19% of nursing staff had received training in MCA and DoLS level 1. This was significantly below the trust target of 90%. At the AH, from April 2016 to March 2017 in surgery services at Alexandra Hospital, 16% of surgical staff and 19% of nursing staff had received training in MCA and DoLS level one.
- During our previous inspection, we found not all staff had completed MCA and Deprivation of Liberty Safeguards (DoLS) training in the maternity and gynaecology service at WRH and AH. Therefore, we were not assured all staff had up-to-date knowledge of MCA and DoLS. During this inspection, we saw evidence that the trust had taken action to address our concerns and we found some improvements had been made. All clinical staff, which included consultants, junior doctors, midwives, nurses and healthcare assistants, were required to complete MCA and DoLS training three yearly. We were told that between January and March 2017, training had been prioritised by the trust. As of April 2017, training data for WRH showed that 80% of midwifery staff, 100% of staff on the early pregnancy assessment unit, and 95% of gynaecology ward staff had completed MCA and DoLS training. As of April 2017, training data for AH showed that 80% of midwifery staff, 100% of staff on the early pregnancy assessment unit, and 75% of staff on the Elias Jones unit had completed MCA and DoLS training. This was an improvement from our previous inspection. Staff we spoke with had not had to make mental capacity assessments or DoLS applications, but knew who to contact for advice and support if they had any concerns regarding a person's mental capacity. We observed DoLS prompt cards, and the contact

details for MCA and DoLS leads displayed on staff noticeboards during our focused inspection. The trust had up-to-date policies regarding consent, MCA and DoLS. Staff could access these policies via the trust intranet.

Are services at this trust caring?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts this key questions but did not rate it. We found significant improvements had not been made in these areas:

- Staff were not using privacy screens to respect patients' privacy and dignity whilst being cared for in the ED corridor area at WRH and AH. Patients at WRH were given meals in their hands by the staff but there was nowhere to rest plates and cups so they could eat their food with dignity.

However, we observed improvements for the following:

- Most staff were attentive, discrete as possible and considerate to patients at WRH.
- Staff treated patients with compassion and respect in the ED at AH.

Compassionate care

- At our inspection in November 2016, we found that patients were routinely cared for within the ED corridor at WRH. Trolleys in the corridor had no space between them and no screens were used to maintain privacy. Confidential conversations relating to patients clinical care could be heard by all patients, non-clinical staff and visitors. There was no privacy for assessments or handovers. The trust provided us with assurances this issue was being addressed, but the documents provided after the inspection did not address the privacy and dignity issues involved in providing care in this corridor area.
- On this inspection, we found that adult patients were routinely cared for in the corridor of the department for long periods of time after decision to admit or awaiting therapist assessment for safe discharge. There was no space between the trollies and no screens around them. Staff did not use screens as a matter of course. We saw health care assistants undertaking comfort rounds, completing patient's documentation and giving patients a leaflet explaining why they were waiting in a corridor. Most staff were attentive, discrete as possible and considerate, for example fetching a dressing gown for a patient to help them

to the toilet. We observed only one diversion from this when a staff member who approached the patient, completed their notes and hurried away again without speaking or giving eye contact.

- We noted patients were given meals in their hands by the staff but there was nowhere to rest plates and cups so they could eat their food with dignity. We observed three adult patients being cared for on trollies in the corridor at breakfast time. One had a cup of hot tea in one hand and a slice of toast with a pat of butter and knife on a plate in the other hand. However, they had no means of spreading the butter or eating the toast, with both hands full and no place to rest anything. The patient told us staff had offered no assistance. A second, elderly patient had water provided but it was out of their reach. They told us they did not mind as although staff had taken them out of the corridor to a 'short' cubicle within the ED when they pressed the buzzer for a bed pan: they were reluctant to drink and go through the process again. A third patient on a trolley in the corridor 'bolted' the meal they were given with their head ducked down to look inconspicuous to the steady stream of people passing by.
- At AH ED, we saw many examples of patients treated with compassion, dignity and respect. Staff spoke in a courteous but friendly manner and worked hard to maintain patients' confidentiality. However, when the department was crowded, levels of privacy and dignity were reduced despite staff attempts to respect this. When urgent personal care was required staff would temporarily move patients from the corridor area to a cubicle in order that basic privacy and dignity could be preserved.
- Staff treated patients with care and compassion in all other core service areas that we visited.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

Are services at this trust responsive?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts this key questions but did not rate it. We found significant improvements had not been made in these areas:

- There was no effective plan in place to effectively manage the overcrowding in the ED at WRH and AH. The ED's patient safety matrix showed critical or 'overwhelmed' for much of the two days we visited the trust. Patients were being cared for on trollies in the ED corridor had become an institutionalised means of managing the 'flow' through the ED, including on occasions when ED cubicles were empty. The number of patients waiting between four and twelve hours to be admitted or discharged was consistently higher than the national average in the ED at WRH.
- At WRH and AH, adult patients were routinely cared for in the corridor of the ED for long periods of time after decision to admit or awaiting therapist assessment for safe discharge. There was no space between the trollies and no screens around them. This happened including during periods when cubicles providing better privacy were vacant within the ED at WRH. Routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by. There was very little privacy and confidentiality for patients waiting on trolleys in the corridor of the ED at AH.
- The trust had told us that a new 'Full Capacity Protocol' had been developed describing the actions to be taken when the AH and ED were full. This had not been completed and the trust appeared to take very little action on the many occasions when the ED was full and unable to treat any more patients. There remained long delays for patients at every stage of their assessment and treatment in the ED at AH. There had been no improvement in the ability to meet the national standard to admit or discharge 95% of patients within four hours. In February and March 2017, this had been achieved for only 80% of patients which was similar to our previous inspection. We observed six patients who spent between eight and 12 hours in the department.
- In response to high capacity demands for medical beds, the AH had converted a surgical ward to a medical ward: however, nurses said they did not always have the required skills to care for medical patients.

We also found other areas of concern:

- At WRH, there was no significant change in streaming for self-presenting patients to ED with an operating model based on urgent care GP streaming. The trust had told us that a frailty team to support the ED in AH was to be implemented in order to improve response for frail patients with complex health needs. This had not happened.

Summary of findings

- The waiting room and toilet facilities for patients attending the outpatient emergency gynaecology assessment unit (EGAU) at WRH were mixed sex, as these were shared with the respiratory outpatient clinic. Furthermore, the EGAU did not have appropriate facilities such as bathrooms, to facilitate personal care for patients who had to stay overnight at times of increased bed pressures.
- The children and young people's service at WRH became busy at times and staff said activity had increased since the service reconfiguration. However, there was limited monitoring of assessment and admission to inpatient areas at WRH.
- The trust's plans to develop a women's health unit at AH were behind schedule. However, it was hoped the unit would be operational by the end of April 2017.
- Staff caring for gynaecology patients on ward 14 and Birch ward at AH had not received additional gynaecology training, such as management of surgical miscarriage and bereavement care.

However, we observed improvements for the following:

- At WRH ED, there was a senior initial assessment nursing system in place for patients arriving by ambulance. Staff told us the flow had improved since two 'ambulance access' cubicles were specifically allocated in the department.
- There was a patient co-ordinator on duty at senior sister level responsible for managing the flow of patients. The ED matron at WRH reported two hourly the ED status to a capacity hub meeting that overviewed the situation across the trust throughout the day and night. Health care assistants were undertaking comfort rounds, completing documentation and giving patients a leaflet explaining why they were waiting in a corridor.
- Staff felt that increased availability of ambulatory emergency care had improved some aspects of patient flow through the ED at AH.
- The medical care service at WRH and AH had taken steps to improve the management of medical patients on non-medical speciality wards. The service had improved patient flow in the hospital to minimise patient moves. Most surgical wards at WRH and the AH reported having fewer medical outliers on their wards.
- The trust had addressed the mixed sex accommodation breaches in the surgical service at KHTC observed during our inspection on 22 to 25 November 2016.
- Daily ward rounds by a gynaecology consultant and nurse were carried out to ensure gynaecology patients were appropriately

reviewed and managed, regardless of location within the trust. Staff caring for gynaecology patients on Beech B1 ward at WRH had received training on bereavement care, including early pregnancy loss and the management of miscarriage.

- There was no gynaecology inpatient ward at WRH. The six nominated gynaecology beds on Beech B1 ward were not ring fenced. This meant there was a risk that gynaecology patients were cared for in the EGAU or general medical wards. However, following our inspection, the trust had taken action to ensure gynaecology patients were cared for in environments that were suitable for their needs.

Service planning and delivery to meet the needs of local people

- Changes had been made to the process of diverting ambulances from the WRH to the AH ED. Previously; there was no consultation with staff at AH when this happened. The first staff knew when ambulances were being diverted was when their arrival time was displayed on a computer screen at the staff base. This meant that there was no time to make plans to accommodate additional patients. Now, staff at the AH were asked if they are in a position to receive extra ambulance patients. If the department was already busy, a discussion would take place regarding the diversion process to be followed. For example, two ambulance patients an hour may be diverted or those referred by GPs who could be treated in the ambulatory emergency centre.
- There was a 'Full Capacity Protocol' implemented by the trust that defined the actions to be taken throughout the hospital when long delays occurred in the emergency department. This had proved to be ineffective and had not reduced frequent and severe crowding in the department. The trust had told us that a new protocol had been developed but senior ED staff at AH were unaware of this. No consultation had taken place. We asked the trust to send us a copy of the new protocol. The document we received was dated 2015 and so there was doubt that any new policy has been completed.
- A long promised frailty intervention team, aimed at treating frail elderly patients in their own home had still not been implemented to support the ED at AH. During the inspection, we met an elderly patient who spent 12 hours in the department while various specialist teams tried to decide whether she needed to be admitted to hospital. The patient's needs would have been better met by a frailty intervention team.

Summary of findings

- During our previous inspection, we found that gynaecology services were not always responsive to patients' needs at WRH. There was no gynaecology inpatient ward at the hospital. Gynaecology patients were cared for on the antenatal ward, Chestnut ward (mixed sex surgical maxillofacial ward), or any available bed in the hospital. Furthermore, the waiting room for EGAU was shared with the mixed sex respiratory outpatient clinic. This meant that women experiencing miscarriage or suspected ectopic pregnancy had to wait in a mixed waiting room.
- During this inspection, we were not assured that gynaecology patient needs were always met. The trust told us that gynaecology patients who required an inpatient bed were cared for in a female surgical bed. The trust had six beds designated for emergency gynaecology patients on Beech B1 ward (a surgical ward, predominantly for maxillofacial patients). A further four beds were ring-fenced for elective gynaecology patients on the antenatal ward. However, as we previously found on Chestnut ward, the designated gynaecology beds on Beech B1 ward were not ring-fenced. This meant there was still a risk that gynaecology patients could be cared for in environments that were not suitable for their needs, such as mixed sex wards. Following this inspection, we saw that the trust had produced operational flow charts to help ensure gynaecology patients were cared for in environments that were suitable for their needs. For example, a flow chart had been produced detailing the process for staff to follow when a patient was awaiting transfer from EGAU at WRH to an inpatient bed. All gynaecology patients must be discussed with a doctor to ensure they were suitable for transfer to a general medical ward. Any patients deemed suitable for transfer must then be discussed with the admitting ward, to ensure they were able to care for the patient and their presenting condition. The admitting ward were advised that a member of the gynaecology team would review the patient daily whilst on the ward. Contact numbers for the gynaecology team were also given should the admitting ward require assistance at any time. However, as these processes had been implemented following our focused inspection, we were unable to determine the impact they would have on service provision.
- We found standard operating procedures for EGAU and antenatal ward had been produced to help ensure gynaecology patients were cared for in an appropriate environment. Senior

staff told us that elective gynaecology patients were reviewed on a daily basis, one week prior to the patient's proposed admission date, to ensure they were allocated to the most appropriate ward.

- Following the previous inspection, we reported that the trust planned to relocate women's services at AH to the former delivery suite and neonatal unit in December 2016. During this inspection, we found this work was still ongoing. Staff told us it was hoped the women's health unit would be operational by the end of April 2017. Therefore, we were unable to determine the impact a women's health unit would have on service provision at AH.
- The divisional director of nursing and midwifery, matron for gynaecology, and bereavement lead midwife told us of plans to develop the bereavement service. This included the recruitment of two dedicated associate nurses (band 4) by the summer 2017, once they had completed training. Increased staffing levels would enable the service to expand bereavement care provision, including the development of follow up care for families who had suffered a pregnancy loss during the first trimester (week one to week 12 of pregnancy). At the time of our inspection, the additional associate nurses were not in post, and so we were unable to determine the impact these development plans would have on service provision.

Meeting people's individual needs

- Adult patients were routinely cared for in the corridor of the ED at WRH and AH for long periods of time after decision to admit or awaiting therapist assessment for safe discharge. There was no space between the trollies and no screens around them. Patients who had been assessed in the senior initial assessment nursing (SIAN) area were positioned in another queue alongside the nurse's desk when they needed to wait for a cubicle in the major's area. SIAN was a streaming process for patients arriving by ambulance, being led by senior nurses.
- We saw this consistently over two days of our visit at WRH and heard staff speak about it as part of a natural process within the department. This meant routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by to the X ray area. When the ED at AH was very busy patients arriving by ambulance often had to wait on trolleys in the corridor. Staff told us that this happened several times a week and trust data showed it had happened over several hours on seven different days during March 2017.

- Trolleys in corridor at the ED at WRH and AH had no space between them and there was no room to use screens in order to maintain privacy. Confidential conversations relating to patients clinical care could be overheard. Doctors described having to take blood and taking clinical histories while patients were in the corridor.
- Staff we spoke to on ward 14 and Birch ward at AH, where elective (planned) and day case gynaecology patients were admitted, told us they had not received any specific gynaecology training such as management of surgical miscarriage and bereavement care. Therefore, we were not assured the service always met individual patient needs. However, we were told that the gynaecology medical team reviewed patients daily and could be contacted for advice via the on-call system, 24 hours a day as needed. We reviewed the medical records of the one gynaecology patient who had been admitted to ward 14 and saw evidence of daily gynaecology medical review. Staff told us that patients undergoing surgical management of miscarriage were allocated a side room on ward 14 at AH, so that a partner, relative or friend could stay with them to provide additional support whilst they underwent treatment. After the inspection, the trust told us thatthe skill mix on this combined female trauma/Gynaecology ward did comprise of nurses who had had gynaecology training and could care for a post operation patient following elective gynaecology surgery.

Dementia

- We did not gather evidence for this as part of the inspection.

Access and flow

- At our inspection in November 2016 at WRH, we found patients were cared for in corridors in the ED for extended periods of time (during inspection some over 22 hours) due to lack of flow out of the department. The trust provided us with assurances that a 'Full Capacity Protocol' had been implemented daily from 19 December 2016 to 2 January 2017. The trust outlined 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.
- On this inspection at WRH, we found that patients were being cared for on trollies in the corridor waiting admission to wards or therapist input for safe discharge. Patients were also being

cared for in the corridor beyond the SIAN area whilst awaiting a cubicle in the major area of the ED. There was a patient co-ordinator on duty at senior sister level 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. This situation was confirmed in 'priority' discussions at the capacity hub meetings in place and that we attended at 9am and 12noon on 12 April 2017. The ED matron reported to the capacity hub meeting from the two hourly ED review at 12 noon that the situation was 'under control', the 'overwhelmed' status had triggered because of the number and length of time patients were waiting in the 'reverse queue ' in the corridor.

- Data showed in December 2017 and January 2017 almost 60% of ambulance crew waited for more than 30 minutes after arrival to handover their patient to the ED staff at WRH. Data collected by the local NHS trust ambulance service showed in February 2017, that 118 patients waited for more than one hour to handed over to the ED staff at the and in March 2017, it was 52 patients.
- The ED at AH's ability to take over the care of patients arriving by ambulance had improved. In November 2016, 40 patients had had to wait for over an hour to be handed over from ambulance crews to ED staff. Although this had increased to 61 patients in January 2017, it had decreased to 11 in February and 8 in March 2017. The percentage of patients waiting more than 30 minutes had decreased from 15% in November 2016 to 9% in March 2017.
- Emergency departments in England are expected to ensure that 95% of their patients are admitted, transferred or discharged within four hours of arrival. There had been little improvement in the department's ability to meet this standard. For the year ending November 2016, 82% of patients were admitted or discharged within four hours at the ED at AH. This was worse than the England average of 90%. In February 2017, this decreased to 76% and in March 2017 it was 84%.
- The percentage of patients who spent more than four hours from admission to transfer from the ED at WRH in December 2016 fell to 75% from the previous month and then rose slightly to 77% in January 2017, against an England average of approximately 86% for the same period.
- For December 2016 and January 2017, the number of patients waiting four to twelve hours from the decision to admit to admission was respectively 32% and 45% against the England average of 17% and 20% for the same period for the ED at WRH. The figures were 45% in February 2017 and 40% in March 2017.

- Between February 2016 and January 2017, trustwide data showed that 312 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2017, when 167 patients waited more than 12 hours. This is part of a longer increasing trend covering November and December 2016, when 37 and 84 patients waited more than 12 hours respectively.
- Data sent to us by the trust showed for February 2017, 41% speciality medical attendance requests within the ED at WRH were responded to within the target time of 60 minutes, and in March 2017, this had increased slightly to 50%. The average waiting time to see a speciality doctor was two hours and eight minutes in February 2017 and two hours and one minute in March 2017. Response times from specialist doctors had declined at AH. In 2016, internal monitoring showed that 49% of specialist doctors arrived within an hour when emergency patients were referred to them. In March 2017, it was 46%.
- When we visited the ED at WRH unannounced on 11 April 2017 at 9.30am, we noted six patients had been waiting in the ED for admission/discharge in excess of four hours, of those three had waited in excess of 10 hours. Seven out of ten patients waiting at 8.30am were referrals for the medical care service and by 2.10pm, three of those remained waiting. When we completed our visit at 3pm on 12 April 2017, the matron told us she had 20 patients awaiting admission to medical, surgical or ears nose and throat wards.
- We noted over both days of our inspection that patients were being cared for on trollies in the corridor, including at times when there were free cubicles within the ED major's area and empty treatment rooms within the minors' area. For example, at 10.0am on 12 April 2017, five examination rooms in the minor's area were empty and there were only two people waiting in the main ED reception area. No patients were waiting in the corridor in the SIAN area, there was one patient in an ambulance triage cubicle and one cubicle free in 'high care'. However, there were still three patients being cared for on trollies in the corridor in the 'reverse queue'.
- Adult patients were routinely cared for in the corridor of the ED at WRH for long periods of time after decision to admit or awaiting therapist assessment. For example, we spoke with one patient who told us at 2.30pm they were being taken to the medical assessment unit (MAU) by a porter: they said they had been in the corridor queue since 4am that morning.
- We saw the 'reverse queuing' in operation consistently over two days of our visit and heard staff speak about it as part of a natural process within the department. They were proactive in

getting patients out into the corridor area as a progress in flow. So entrenched was this within the ED's culture, even the weekly divisional safety and risk review meeting minutes refer to 'patients being admitted to the corridor'. The paper patient's records filing system had seven slots labelled for 'corridor patients'.

- ED staff at WRH told us the flow had improved since two ambulance access cubicles were specifically allocated in the department. However, we noted at times during our two day inspection visit that patients were queuing on trollies in the corridor after undergoing their SIAN process led by senior sisters. At one point in the middle of the afternoon, we saw five patients in this position.
- There was no consultant-led senior initial assessment team in place to stream patients to the appropriate point of delivery focusing on maximising flow to non-emergency department assessment units and/ or the minors unit. There was no significant change in streaming for self-presenting patients with an operating model based on urgent care GP streaming.
- Staff told us that patient flow through the ED at AH had improved slightly in recent months. Senior staff thought this might be due to extended opening hours of the ambulatory emergency centre and a reduced number of ambulances being diverted from the Worcestershire Royal Hospital. However, they had not seen any figures confirming this impression.
- There was no agreed method for solving treatment delays caused by differences in opinion between senior doctors at AH. During our inspection, we observed two patients who were in the department for more than 10 hours because specialty staff could not agree on treatment actions. We observed a further four patients in the ED at AH who had spent between eight hours and 12 hours in the department due to delayed responses from specialist doctors as well as a lack of empty beds on a ward.
- The medical care service at WRH had improved patient flow in the hospital to minimise patient moves. There were 918 medical patient moves at night from 10pm to 6am with an average move of 229 per month which was a significant drop from 3,293 moves across all medical wards with average bed moves of 411 (13%) per month identified during our last inspection in November 2016.
- The discharge lounge (medical day case unit) was used as an escalation area for patients who required overnight stay due to a lack of beds on medical wards at times of peak demand. Data provided by the trust showed that the discharge lounge was

occupied overnight from January to March 2017 at different intervals by 29 medical patients. Standard operating procedures governing the use of escalation areas at WRH were requested, but were not provided by the trust.

- During this inspection, data provided by the trust showed from January 2017 to April 2017, a total of 918 medical patients at the three hospitals were transferred to another ward from 10pm to 6am at night with an average bed moves of 229 per month. This was an improvement from the last inspection.
- Medical patients on surgical wards at WRH were routinely reviewed by medical doctors. We saw evidence that where they were unwell and escalated to medical staff by nurses, they were reviewed in a timely manner. These patients were included as part of the medical consultant's ward rounds. Appropriate admission criteria for patients using these areas were in place. The Theatre Assessment Unit was not being used as an escalation area for medical patients at the time of this inspection.
- Following our previous inspection, we reported that gynaecology patients at WRH were often nursed on general medical wards. We requested the number of gynaecology outliers from December 2016 to March 2017 but were told this information was not routinely collected. The trust did report a total of 19 gynaecology outliers for March 2017; eight patients were admitted to the surgical care decisions unit, and the remaining 11 were admitted to 'other' wards. We were told that gynaecology outliers were discussed at each bed meeting, held four times a day. This was to ensure transfer to a designated gynaecology bed was expedited and appropriate care was provided whilst they were cared for on other wards. A gynaecology consultant and nurse undertook a daily ward round to ensure all gynaecology patients were appropriately reviewed and managed, regardless of patient location. Wards could also contact the EGAU for medical or nursing advice and support 24 hours a day, seven days a week. Staff we spoke with confirmed this during our inspection. There were no gynaecology outliers during this inspection. We reviewed the medical records of the one gynaecology patient who had been admitted to Beech B1 ward and saw evidence of daily gynaecology consultant review.
- In response to concerns raised following our previous inspection, the trust told us they carried out individual patient risk assessments on outliers to ensure they were placed in a safe environment that met their clinical needs. The term 'outlier' refers to a patient who has been placed on a non-speciality ward, due to a lack of speciality beds. We requested

the risk assessments for all gynaecology outliers from December 2016 to March 2017 but were told that no specific outlier risk assessments had been carried out. This meant we could not be assured that all patients were cared for in environments that were suitable for their needs, such as single sex wards.

- On this inspection, we saw that the trust had produced a flow chart, which advised staff of the assessment process for patients awaiting transfer from EGAU to an inpatient area. According to the flow chart, pregnant patients were only to be admitted to Beech B1 ward, where staff were experienced with pregnancy related problems. If no beds were available on Beech B1 ward, the patient should remain on EGAU with experienced staff. The trust had also produced a flow chart detailing the risk assessment process for patients staying overnight in the EGAU. Therefore, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs. However, we were unable to determine the impact these processes had on care provision as they had not been implemented at the time of our focused inspection.
- During the November 2016 inspection, we found the children and young people's service at WRH became busy at times and staff said activity had increased since the service reconfiguration, although data was not available. This had affected the paediatric ward at WRH in particular. Flow through the department did not always work well and the assessment area often exceeded capacity. Staff told us there had been little detailed planning as to how this would be managed following the service reconfiguration. After the inspection, the trust provided us with evidence of paediatric activity used for planning by the Emergency Paediatric Reconfiguration group during July to September 2016. The data demonstrated the consideration for the patient flows between emergency departments and the wards (Ward 1, Alexandra Hospital and Riverbank ward, WRH) and the overall paediatric admissions based on practice at the time. Admissions to the paediatric ward at WRH were either via a planned admission process or through an emergency admission from a direct GP referral or through the emergency department (ED). The bay consisted of three assessment beds and three seated areas. We were told capacity was regularly exceeded and patients frequently waited in the corridor and assessments regularly took place in the treatment room, intended for inpatients only. After the

inspection, the trust provided us with the service's analysis of paediatric activity (in January 2017) that was being used to further develop appropriate pathways with primary care and commissioners.

- During the November 2016 inspection, we observed the assessment area was often very busy. We did not observe this in our April 2017. However, staff we spoke with, told us although there were days when the service saw less patients in the assessment area, it could still become busy and that the concerns found at the last inspection remained. We were told by staff as an example that the assessment area had been extremely busy on Sunday 9 April 2017. We reviewed the assessment records for that day, of which only a small number had been completed. We discussed this with staff who informed us that these forms were not completed consistently. Therefore, it was not possible for us to verify the extent of the concerns raised with us.
- Managers at the service had undertaken an audit of the activity of the assessment unit. Staff said the ward could become overcrowded at times, which also could affect the admission process to inpatient areas. Effective monitoring of assessment and inpatient activity was limited, so the service was not be in a position to use this data to make effective future plans and to drive improvements in the service.
- During our last inspection of surgery at KHTC, we found patient privacy and dignity was not always maintained in the theatre admissions area, where we observed mixed sex accommodation breaches. Patients that were undressed in theatre gowns and dressing gowns waiting for surgery could be seen by other people, those of the opposite sex and by patients and visitors in the waiting area. During this focussed follow up inspection we saw that staff had developed a temporary work-around to avoid mixed sex breaches in the theatre admissions area and that there were plans in place to redesign the area. Although the redesign work had not yet commenced, staff we spoke to said that the work would be undertaken soon. Staff said they were aware of the need to report any mixed sex breaches and told us how they always tried to separate male and female patients as best they could.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Summary of findings

Are services at this trust well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts this key questions but did not rate it. We found significant improvements had not been made in these areas:

- The leadership and governance arrangements of the trust were not effective in identifying and mitigating risks or in providing assurance that actions were resulting in improvements to the safety and quality of patient care.
- Leaders did not act on known concerns at the pace required and were dependant on other organisations escalating areas of concern. There was not effective ownership of the need to establish effective systems to recognise, assess and mitigate risks to patient safety.
- Actions to address urgent concerns were either yet to be implemented or were not effective in reducing the risk as the data reported nationally and provided by the trust demonstrated there was subsequently no tangible improvement in performance.
- The trust had identified, and our review found, that the corporate risk register required significant review. Work had started on ensuring that it contains risks and not issues, however we found that there was a lack of consistency in how things were recorded.
- Actions already identified by the trust as necessary to mitigate patient care being compromised from overcrowding in the ED at WRH and AH were either yet to be implemented or were not effective in reducing the risk.
- There was no tangible improvement in performance, caring for patients in the corridors in the ED had become institutionalised and we found patient's privacy, dignity and effective care remained compromised.
- The trust senior leaders were not effectively addressing these risks through a whole hospital approach.
- The ED safety and capacity matrix data was not regularly reported to the trust board and collection of this data was having little impact on how the risks were being managed by the trust's senior managers.
- There had been no clinical governance or performance management meetings since our last inspection in the ED at AH. High levels of clinical activity in the ED meant there was little time for governance and risk management. There was little understanding of the processes for escalating significant risks to divisional or board level. Doubt remained regarding the degree of oversight of ED risks at AH by senior leaders within the trust.

- The medical service leadership team at WRH and AH had not addressed all concerns and risks identified as areas for improvement in our last inspection. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care. Senior leaders in surgery at WRH and AH were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments (VTE) and hand hygiene. However, we saw examples throughout the service where compliance with trust and national guidance had not significantly improved. When risks had been escalated, there was a lack of follow up and resolution. Effective action following the reporting of high fridge temperatures for storage of medicines was not evident.

However, we observed improvements for the following:

- The ED at WRH was managed locally by the matron and senior ED consultant. Staff were very committed to their work and doing the best they could for their patients even under regular and consistent heavy pressure. The lead consultant and matron in the ED at AH were highly visible within the department and led clinical activity. The matron had recently implemented new clinical audits.
- The trust's new chief nurse had met with ED staff and displayed commitment to addressing immediate as well as medium term problems.
- The trust had put in place an electronic safety and capacity matrix that reported data about the ED flow in real time: this enabled the executive team to have a clear line of sight to the risks at any and all times.
- The trust had implemented a 'Full Capacity Protocol' that was activated when the emergency department safety matrix status showed critical or overwhelmed status.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). This was being used as to drive improvement and had improved staff's understanding of safety and quality in the service.
- Risks identified in the maternity and gynaecology service at WRH and at AH were reviewed regularly with mitigation and assurances in place. Staff were aware of the risks and the trust board had oversight of the main risks within the service.
- The risk register for the children and young people's service at WRH had been updated to include two additional risks identified during the November 2016 inspection, but not all risks found on this inspection had been identified, assessed and recorded. For example, the increased activity in the service following the transformation process. There was limited

oversight and planning with regards to the increased activity in the service. This meant that service leaders were not in a position to understand current and future performance and to be able to drive improvements for better patient outcomes.

Leadership of the trust

- Since the November 2016 inspection the board had continued instability with continuing changes at executive level. However in March 2017, the substantive chief executive and chief nursing officer took up post, a new interim chief operating officer started in April 2017 and the substantive medical chief medical officer was due to start in May 2017. Two new non-executive directors started in January 2017. Clearly it was too early to assess the impact of these key roles but they did have a shared vision and list of priorities.
- The leadership and governance arrangements of the trust were not effective in identifying and mitigating risks or in providing assurance that actions were resulting in improvements to the safety and quality of patient care.
- Leaders did not act on known concerns at the pace required and were dependant on other organisations escalating areas of concern. There was not effective ownership of the need to establish effective systems to recognise, assess and mitigate risks to patient safety.
- Local leadership of the emergency department (ED) at AH was trusted and stable: however there was only one substantive consultant in post. The lead consultant and matron were highly visible and led clinical activity. We were told by a senior doctor, that the divisional director now worked in the department once a week. A new chief nurse had recently been appointed at the trust. Within a week of arriving, they had visited the emergency department and talked to staff. A discussion took place with senior staff about action that could be taken by the trust's executive team to improve patient flow, thus reducing the severity of a crowded department. As a result improvements had been made to the speed of response by specialty doctors and the process of diverting ambulances from the WRH to the AH.
- We found that the leaders in medical care and surgery services at WRH and AH had not always responded and acted upon known concerns. For example, during our last inspection in November 2016, we identified issues with lack of oversight for venous thromboembolism (VTE) assessment and hand hygiene. During this inspection, we still found poor practice in these areas. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care.

Summary of findings

Vision and strategy

- At just two weeks into the post the chief executive was continuing her assessment of the trust and drafting a plan for the way forward. Her aim was to take the plan to the May board meeting. Board minutes from May 2017 show this was achieved.

Governance, risk management and quality measurement

- In the November 2016, we found poor linkage between the board assurance framework and the risk registers with actions either not implemented or not effective in reducing the risk as there was a lack of tangible improvement in performance. Since then the trust had looked at its governance systems and made some changes however with the recent new appointments to the leadership team it was apparent that these were not embedded and indeed the new team recognised that further work was required to make the governance processes more effective.
- The trust had identified, and our review found, that the corporate risk register required significant review. Work had started on ensuring that it contains risks and not issues, however we found that there was a lack of consistency in how things were recorded. For example in the risk relating to 'increased pressure in emergency demand' against the gaps in assurance was a list of further information and assurance that was being sought from various group rather than what the gaps actually were. For the risk relating to 'delayed admission to ITU', which had been on the risk register since 2014 had not entries against gaps in controls or gaps in assurance.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). Staff we spoke with were aware of SQuID and demonstrated how to access the dashboard on the trust intranet. The dashboard was developed to include performance indicators specific to the service. This was used as a drive for improvement and had improved staff's understanding of safety and quality in the service. However, despite the introduction of this quality dashboard, some issues identified had shown no improvement and there was insufficient oversight and management of these risks. For example, there was lack of oversight VTE assessments, recording of patient weights on drug charts and inconsistent compliance with hand hygiene. This demonstrated that the service's governance system in relation to the management of VTE risk and hand hygiene did not operate effectively to ensure that senior leaders effectively managed the risk of harm to patients.

Summary of findings

- On our inspection in November 2016, we noted in the board assurance framework (BAF) risk report provided for that month (risk number 2790) had a risk rated as 'high' which stated "as a result of high occupancy levels, patient care may be compromised". This had been on the trust risk register since 2 February 2015. The impact was detailed as 'overcrowding in ED, increased quality and safety risk due to suboptimal location of patients, multiple transfers between wards/departments/sites, lack of privacy and dignity for patients, and increased length of stay'. Actions to reduce this risk included improving patient flow by increasing ambulatory care provision, redesigning the bed model in the service, and improving the discharge processes. The expected completion of these actions was 31 December 2016.
- We found that these actions were either yet to be implemented or were not effective in reducing the risk as the data reported nationally and provided by the trust demonstrated there was subsequently no tangible improvement in performance. The trust further assured us in December 2016 that "we are concerned about the need to place patients in the corridor and recognise that this does not provide the privacy and dignity our patients deserve". Actions proposed by the trust to improve the situation included 'reverse queuing, 'halo staff' and care and comfort rounds'. However, all of these strategies were in place during our November 2016 inspection and patients' privacy and dignity remained compromised despite these actions. At this inspection, we found the situation had not significantly improved in that patients were still being cared for in the corridor of WRH and AH EDs, patients' privacy, dignity and in some cases effective care, remained compromised and this practice had become institutionalised within the flow management arrangement.
- On 27 April 2017, the trust electronic safety matrix report sent to us showed in real time, that the number of patients on trollies at any one time in the 24 period ranged from 16 to 30. At the time of peak of pressure between 7pm and 8pm, there were 58 patients in the ED (excluding the clinical decisions unit): 33 of these were on trollies and 14 were waiting for beds in the hospital.
- We asked the trust to send us the current emergency medicine risk register. We noted there were four 'high' (red rated) risks on this directly related to patient flow through the department but no corresponding identification of these risks on the risk register for the medicine division. This suggested the 'overwhelmed' ED, patients being cared for in corridors, long

waits to see a speciality doctor and long waits for admission to medical wards were being managed by the trust senior leaders as the risk for only the emergency medicine division and not the whole hospital system.

- The trust had a 'Full Capacity Protocol' that could be activated between 7am and 5pm. We noted during our inspection visit that the matron went from the two hourly ED review to a capacity hub meeting when the emergency department safety matrix status was showing critical or overwhelmed. The capacity hub meetings had representation from all divisions present including surgical and medical specialities. These meetings overviewed the situation across the trust at 9am, 12 noon, 4pm, 6pm and one overnight with the potential to escalate to the local clinical care group's (CCG) on call director when the ED capacity level reached level four.
- Risk managers told us they had 'requested that a specific report on ED crowding and the safety matrix was made available to the trust board every month; however, this has not been done and the service has not progressed it either.'
- There had been no improvement in the governance framework required to support good quality care in the ED at AH. One of the locum consultants had recently been appointed as clinical governance lead but had not yet taken up their duties in this regard. There had been no formal clinical governance meetings but we were told that clinical governance was an agenda item on monthly ED seniors' meetings. These had not taken place since November 2016 and so there had been no overview of clinical governance in that period. Performance data such as patient waiting times for treatment or admission were not routinely monitored in the department. Risks, incidents and complaints were discussed at divisional meetings but these were not attended by staff from the ED at AH.
- The ED at AH maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. Four risks had a high current risk level. They were associated with an overcrowded department, long delays for patients, ambulance patients waiting in corridors and out-of-hours mental health services. Although the ED was part of the Division of Medicine, none of these risks appeared on the divisional risk register. It was not clear whether senior managers within the hospital were aware of these risks to patient safety. The matron had recently started to carry out web-based clinical audits in order to check the quality of patient records, clinical

observations, skin integrity maps and infection control measures. As a result, doctors had been issued with name stamps so that their entries in patient records could be identified more easily.

- During our last inspection, we identified issues with poor escalation of the national early warning scores (NEWS), poor assessment and reassessment of VTE after 24 hours and insufficient recording of patient weights on drug charts. The trust told us that audit processes for NEWS have been supplemented by weekly notes audits which also review NEWS compliance and had launched a web based assurance system to highlight performance around quality and safety. During this inspection, we still found poor practice in these areas. This meant that whilst some improvement had been made, overall, there was insufficient oversight and management of risk to patient safety.
- The last inspection highlighted concerns with inadequate storage of medicines and generally this had improved in some areas. For example, medication was stored in a fridge in the acute stroke unit where temperatures were either below or above manufacturers recommended fridge temperatures. During this inspection, we saw the fridge had been replaced and temperatures were recorded and up-to-date. However, on Evergreen ward 1 at WRH, we saw that recording of fridge temperatures remained inconsistent.
- Similarly, effective action following the reporting of high fridge temperatures for storage of medicines was not evident. Staff demonstrated they had reported high temperatures but were unable to tell us if any action had been taken to ensure the medications within the fridge remained safe to use. This shows that there were not effective processes in place to ensure that the trust policy on medicines management was being adhered to, and this had not been recognised as a risk.
- The quality improvement plan for April 2017 identified that NEWS and VTE assessments had been added to the risk register.
- The trust had a divisional framework for governance arrangements in medical care services. During the last inspection, sharing of information was not established at ward level. During this inspection, this had improved in some areas at WRH and ward managers attended divisional meetings. There was evidence of ownership and improvement at ward level.
- Following our previous inspection, we reported that not all of the risks at WRH we identified, such as gynaecology patients being nursed in other wards or staying overnight in the outpatient emergency gynaecology assessment unit (EGAU), were recorded on the risk register. This meant we were not

assured the trust had oversight of all risks affecting the quality and safety of patient care, nor that remedial actions had been identified to mitigate these risks. During this inspection, we found improvements had been made. We saw that the trust board had oversight of the main risks within the service. The loss of the gynaecology ward at the hospital, following the emergency reconfiguration of maternity services, was included on the divisional and corporate (trust wide) risk register. The potential impact on the safety and/or quality of patient care provision was detailed against this risk, and included, for example, the use of EGAU for patients overnight when there was a lack of inpatient bed capacity. Actions taken to mitigate risks associated with the loss of the gynaecology ward were also included.

- As of April 2017, the maternity and gynaecology service had identified 15 risks, which included the inability to meet contracted activity within gynaecology due to insufficient medical, nursing and physical capacity, and the use of delivery suite rooms for bereaved families. Actions taken to mitigate risks, review dates, progress and assessment of the risk level were included. We saw evidence that the divisional risk register was reviewed regularly at monthly governance meetings. Staff we spoke with were aware of risks within the service, such as the increased risk of neonatal abduction due to an insufficient number of baby security tags. Staff on the postnatal ward were able to describe actions in place to mitigate this risk.
- The children and young people's service had a risk register in place. Identified risks included appropriate level of detail and had been scored according to their likelihood and impact. During the November 2016 inspection, we saw that not all significant risks had been identified or recorded on the register. In our April 2017 inspection, we observed that service leaders had included two additional risks which related to paediatric early warning scores and patients who attended the ward with identified mental health concerns.
- However, the service still failed to fully consider other significant risks, for example, the increase in demand from the recent service reconfiguration including the pressures this placed on staff as well as full consideration of the potential risks to patients. This demonstrated a lack of structure for identifying and recording new or emerging risks. There was limited oversight and effective planning with regards to increased activity in the service. This meant that service leaders were not in a position to understand performance and to be able to drive improvements for better patient outcomes.

Culture within the trust

Summary of findings

- Improving the culture across the trust has been recognised by the board as a significant issue in driving improvements. Senior managers were looking at a behaviour change management programme with an initial workshop in April and a programme of events over the next few months.

Equalities and Diversity – including Workforce Race Equality Standard

- We did not gather evidence for this for this inspection.

Fit and Proper Persons

- Trusts are required to meet the Fit and Proper Persons Requirement (Regulation 19 of the Health and Social Care Act) Regulations 2014. This regulation ensures directors of NHS organisations are fit and proper to carry out this important role.
- At the inspection in November 2016, we found that there were omissions in the personal files of the executive team. When we returned on the unannounced inspection in December 2016, we reviewed these files again and found them to be in order and meeting the requirements of the regulation.
- At this inspection, we reviewed the files of the three executive directors and two non-executive directors. Two files were satisfactory, three files did not contain the required Disclosure and Barring (DBS) checks and one of these files had a significant number of other check missing. This was raised with the trust at the time and immediate actions put into place for example the supervision of staff with no recorded DBS checks.

Public engagement

- We did not gather evidence for this for this inspection.

Staff engagement

- We did not gather evidence for this for this inspection.

Innovation, improvement and sustainability

- We did not gather evidence for this for this inspection

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- To ensure that all patients' conditions are monitored effectively to enable any deterioration to be quickly identified and care and treatment is provided in a timely way.
- To ensure that staff complete all of the risk assessments and documentation required to assess the condition of patients and record their care and treatment.
- Ensure all patients have a venous thromboembolism (VTE) assessment and are reassessed 24 hours after admission in accordance with national guidance.
- To ensure that the privacy and dignity of all patients in the ED is supported at all times, including when care is provided in corridor areas.
- To ensure mental health assessment room in the emergency department is appropriate to meet needs of patients.
- Ensure the children's ED area is consistently monitored by staff via appropriate CCTV surveillance at the nurses/doctors station in the major's area.
- To ensure that systems or processes are fully established and operated effectively to assess, monitor and improve the quality and safety of the services provided within the ED.
- To ensure that systems or processes are fully established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients while using the ED.
- To ensure that patients in the ED receive medication prescribed for them at the correct time and interval.
- Ensure patient weights are recorded on drug charts.
- Ensure there are processes in place to ensure that any medicine omissions are escalated appropriately to the medical team.
- Ensure all anticoagulation medication is administered as prescribed. All non-administrations must have a valid reason code.
- Ensure all medicines are stored at the correct temperature. Systems must be in place to ensure medication, which has been stored outside of manufactures recommended ranges, remains safe or is discarded.
- Where patients refuse to take prescribed medication, ensure it is escalated to the medical team for a review.
- Ensure patient identifiable information is stored securely and not kept on display.
- Ensure all staff comply with hand hygiene and the use of personal protective equipment policies.
- Ensure all staff are up-to-date on medicines' management training.
- Ensure all staff have completed their Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.
- Ensure all staff have completed the required level of safeguarding training for vulnerable adults and children.
- Ensure all patients in the children and young people's service with mental health needs have the appropriate level of staff one to one care in accordance with their risk assessments.
- Ensure paediatric assessment area activity is monitored effectively so the service can drive improvements in patient flow.
- Ensure the risk registers reflects all significant risks in the children and young people's service and effective mitigating actions are in place to reduce potential risks to patients.
- Ensure safeguarding referrals are made when required for patients seen in the ED.
- Ensure all equipment is safe for use in the KHTC minor injuries unit.
- Ensure the sepsis pathway is fully embedded in inpatient wards.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The service was not meeting this regulation because:** • Patients' privacy and dignity was not respected whilst being cared for in the corridor area of the emergency departments at WRH and AH. • Some medical care wards did not ensure that patient privacy, dignity, and confidentiality were maintained at all times because other patients and relatives could hear handovers. • Patient identifiable information was not stored securely and kept on display in some medical care and surgical wards at WRH and AH.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service was not meeting this regulation because:** • Essential risk assessments and documentation required to assess the condition of patients and record their care and treatment was not being consistently carried out. • Patients' conditions in the emergency department were not being monitored effectively to enable any deterioration to be quickly identified and care and treatment is provided in a timely way. • The mental health assessment room in the emergency department was not appropriate to meet needs of patients. • Medicines were not stored or administered in a timely was when required. • Patient weights were not recorded on drug charts. • Anticoagulation medication was not always administered as prescribed.

This section is primarily information for the provider

Requirement notices

- Not all staff complied with hand hygiene and the use of personal protective equipment policies.
- Risk assessments were not undertaken for young patients with mental health needs and one to one care from a suitably trained professional was not always provided.
- Staff did not comply with infection prevention and control measures across services at WRH and AH.
- Resuscitation equipment in the minor injuries unit at KHTC was not fit for use.
- Effective actions were not taken when medicines' fridge temperatures in the minor injuries unit at KHTC were not within the required range.
- The sepsis pathway was not embedded in inpatient wards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The service was not meeting this regulation because:** • Not all staff were trained to the required level of for adults and children safeguarding. • Safeguarding referrals were not always made when required for patients seen in the ED. • Safeguarding adults and children training for doctors and nurses in the ED was inadequate.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The service was not meeting this regulation because:** • Not all staff were compliant with medicines management and mental capacity act/deprivation of liberty safeguards (MCA/DoLS) training. • The children's area in the emergency department was not consistently attended by staff except via CCTV surveillance to the nurses/doctors station in the major's area. Patients and their parents/carers were left alone after assessment and while they waited to see a doctor.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service was not meeting this regulation because:** • Poor oversight of services which included medicine management and mental capacity and Deprivation of Liberty Safeguards training. • Medical records were not always stored securely in all areas. • The medical service leadership team had not addressed all issues identified as areas for improvement in our last inspection. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care. • Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments (VTE), records' management, completion of drug charts and compliance with hand hygiene. However, we saw examples throughout surgery and medical care where national guidance had not been followed. When risks had been escalated, there was a lack of follow up and resolution. • Despite assurances from the trust, CQC saw no evidence that obstetrics and gynaecology mortality and morbidity reviews were held. Furthermore, whilst perinatal mortality and morbidity meetings were minuted, CQC were not assured that action was taken to address any learning identified from case reviews. • The risk registers failed to identify all risks faced by the service in the children and young people's service. • There was a lack of oversight and understanding of activity in paediatric assessment area to fully identify potential issues with flow and capacity in the hospital. • To ensure that systems or processes were not fully established and operated effectively to assess, monitor, and improve the quality and safety of the services provided within the emergency department. • Systems or processes were not fully established and operated effectively to assess, monitor, and mitigate the risks relating to the health, safety, and welfare of patients within the emergency department, medical care and the children and young people's service.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: • Effective oversight and application of the requirements of this regulation were not in place. • Staff files did not contain the required employment and suitability to work checks

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
This warning notice served to notify the trust that the Care Quality Commission formed the view that the quality of health care provided by the trust for the regulated activities detailed required significant improvement. How the regulation was not being met: • Significant risks remained that the trust had not recognised, assessed, monitored and mitigated. This represented significant failings in the overall hospital governance processes, as the trust was not aware of the level of risk regarding multiple concerns until CQC raised these as urgent concerns. • The governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.	31 September 2017