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For the attention of the Chief Executive
BY EMAIL to: rob.cooper1@nhs.net

Mr. R Cooper
Chief Executive
Worcestershire Acute Hospitals NHS Trust
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

27 January 2017

The Care Quality Commission
The Health and Social Care Act 2008
SECTION 29A WARNING NOTICE:
Provider: Worcestershire Acute Hospitals NHS Trust

Regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Management of blood and blood derived products
- Termination of pregnancy
- Family planning

Our reference: MRR1-3107518238
Account number: RWP

Dear Mr Cooper

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

This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by

Worcestershire Acute Hospitals NHS Trust for the regulated activities above requires significant improvement:

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

Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Regulated activities

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Management of blood and blood derived products
- Termination of pregnancy
- Family planning

Alexandra Hospital
Woodrow Drive
Redditch
B98 7UB

Regulated activities

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Management of blood and blood derived products
- Termination of pregnancy
- Family planning

Kidderminster Hospital and Treatment Centre
Bewdley Rd
Kidderminster

DY11 6RJ

Regulated activities

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

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

- The systems, processes and the operation of the governance arrangements in place are not effective in terms of:
    - identifying and mitigating risks to patients as outlined below and in relation to which significant improvement is required
    - providing assurance that actions are taken to improve safety and quality of patient care

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

Following the announced inspection visits as part of the comprehensive inspection of Worcestershire Acute Hospitals NHS Trust between 22 and 25 November 2016, feedback was provided by Bernadette Hanney, Head of Hospital Inspections, Peter Turkington, Chair of the inspection and Jo Naylor-Smith, Inspection Manager to the executive team of the trust on 25 November 2016 regarding the areas of key concern, which required addressing immediately, as referred to below. The concerns raised by CQC in this meeting were confirmed in writing in a letter sent to the trust by Bernadette Hanney, Head of Hospital Inspections on 1 December 2016.

Following the unannounced inspection visits, as part of the comprehensive inspection of Worcestershire Acute Hospitals NHS Trust on 7, 8 and 15 December 2016, feedback was provided by Jo Naylor-Smith, Inspection Manager to the Chief Nursing Officer and Deputy Chief Nursing Officer of the trust regarding the areas of key concern, as referred to below, which required addressing immediately. The concerns raised by CQC in this meeting were

confirmed in writing in a letter sent to the trust by Bernadette Hanney, Head of Hospital Inspections on 20 December 2016.

Due to the seriousness of our concerns Professor Sir Mike Richards wrote to NHS Improvement and NHS England on 21 December 2016 requesting they arrange a risk summit, which took place on the 22 December 2016.

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

Areas which demonstrate the lack of effective governance and the consequences of that

At the quality improvement review group meeting on the 30 September 2016 the trust presented their revised framework for governance and assurance; having recognised that improvements were required to strengthen the risk management and governance throughout the trust. During our inspection we found that the risk management and quality assurance processes were not sufficiently understood, embedded or supported by reliable performance data to ensure that the risks to safety, quality and sustainability are systemically identified and understood across all locations or divisions of the trust. Risk registers were not detailing all the risks and quality assurance processes were not identifying shortfalls and therefore remedial action is lacking. This demonstrates that the trust's governance system in relation to the management of risk is not operating effectively to ensure that senior leaders and the board have clear oversight of risks affecting the quality and safety of care of patients and the need for significant improvement remains.

The board cannot rely on the processes in place or the information they are receiving in order to take assurance that risks are identified and actions taken to reduce the risks to patients.

Examples of this are detailed below:

- The trust had determined to use National Early Warning Score (NEWS) and Paediatric Early Warning Scores (PEWS) systems in order to identify and escalate deteriorating patients; however this was not working effectively at Worcestershire Royal Hospital or the Alexandra Hospital, Redditch. The risk of a patient suffering harm as a result of their clinical deterioration not being identified and escalated appropriately was not on the relevant divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure

that senior leaders and the board have clear oversight of the risk of harm to the deteriorating patient.

During the course of our inspection we reviewed a total of 23 sets of patient records from Avon 2 ward, Avon 3 ward, haematology ward, Evergreen ward, the theatre assessment unit and the acute stroke unit in Worcestershire Royal Hospital. We found NEWS charts were not completed in their entirety in seven records. This meant that there was not clear oversight of the deterioration of those patients. In the document entitled 'CQC actions post MR risk summit letter' (not dated but provided for the risk summit held on 22 December 2016), in relation to NEWS the trust has stated "We agree that this is not acceptable". Actions detailed included future training and development and to undertake more frequent audits and spot checks. The risks to patients as a result of these failings had not previously been identified by the trust.

- Within the paediatric ward at Worcestershire Royal Hospital, we reviewed three PEWS charts. We found that PEWS scores were not completed in their entirety in all three records and two records did not document the frequency that observations were required. Within the trust's PEWS audit in November 2016 it was noted that one patient had a PEWS score of above three and this had not been escalated.
  In the document 'CQC actions post MR risk summit letter' (not dated but provided for the risk summit held on 22 December 2016), in relation to the PEWS charts not being consistently completed, the trust stated that 'this tool is not fully embedded and a programme of work is rapid implementation is underway. Our buddy trust will return at the end of January to review our implementation/actions and provide assurance that the improvements have been made and sustained.' In the document provided to us on 11 January 2017, subsequent to the insufficient assurance surrounding these concerns being provided at the risk summit of 22 December 2016, the trust submitted an audit of PEWS charts carried out on week commencing 2 January 2017 showing that of 10 sets of records reviewed, 95% had PEWS scores recorded correctly. However the records did not provide evidence that all scores that indicated a patient's condition was deteriorating were escalated appropriately and not all patients with a high pain score were appropriately escalated or reviewed. Therefore there are not effective governance processes in place to ensure clear oversight of the management of the deterioration of paediatric patients.

- During our comprehensive inspection we found that the types of risk assessment referred to below for patients were not routinely completed for patients at Worcestershire Royal Hospital and the Alexandra Hospital. The systems to assess monitor and mitigate risks relating to the health, safety and welfare of service users receiving care are not

operating effectively, including protecting service users from abuse and avoidable harm.

- We reviewed 14 sets of patients' records from the emergency department within Worcestershire Royal Hospital. We found that dementia assessments had not been completed for four out of five patients who met the trust criteria for requiring assessment. In the document provided to us on 11 January 2017 the trust stated 'Dementia & Delirium Assessments are being monitored by the Dementia Team. The current standard is that 90% of patients over 75years old admitted as an emergency are assessed within 72 hours. Compliance in November was 88.6%, which increased to 92.2% in December. Although the dementia pathway had been reviewed to reduce paperwork and duplication, and was due to be relaunched in January 2017, the risk to patients not receiving dementia assessments was not present on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients such as those who met the criteria for a dementia assessment but did not receive one.

- Whilst pressure area risk assessments had been completed in all 14 sets of records reviewed, these were not consistently reviewed and total scores were not calculated or documented for five patients. Failure to follow pressure area prevention procedures (including risk assessments) resulting in harm had been on the corporate risk register (dated 21 November 2016) since April 2015, and was highlighted as a risk in the previous CQC comprehensive inspection (July 2015). In the document provided to us on 11 January 2017 the trust stated the actions it had taken since our previous inspection, and future proposals included training, further development of the monthly audit tool and review of the care and comfort documentation. There was no evidence that that the trust was aware that the gaps in the completion of pressure assessments related to follow-up assessments and appropriate escalation, rather than the initial assessment. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients suffering pressure ulcers due to inadequate review and escalation of pressure area risk assessments.

- Out of a total of 23 sets of patient's records reviewed from Avon 2 ward, Avon 3 ward, haematology ward, Evergreen ward, theatre assessment unit and the acute stroke unit Worcestershire Royal Hospital, we found that venous thromboembolism (VTE) assessments had not been completed for 13 patients. Out of 24 patients records reviewed from wards 10, 11, 14 and 18 at the Alexandra Hospital, nine did not have a

VTE risk assessment completed. In the document provided to us on 11 January 2017 the trust stated 'Trust performance in achieving the target of 95% compliance for VTE assessments is currently inconsistent. Despite previous emphasis on achieving VTE assessment status correctly, the compliance figures are still poor'. The trust proposed to establish a VTE rapid improvement working group and review and redesign the process of VTE data collection and recording. However the risk of patient harm as a result of not carrying out VTE assessments was not being managed on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients suffering a VTE due to lack of appropriate assessment.

- There was a lack of detailed assessment and provision of one to one care of children and young people who presented with mental health issues. Although inconsistent support from the child and adolescent mental health service (CAMHs) had been on the women and children's divisional risk register since 2009, this risk referred to inappropriate placements and delayed discharge of a young person presenting with mental health issues. The risks relating to a lack of detailed assessment and the provision of one to one care did not feature on the corporate risk register, from an appropriate member of staff, both of which could place a young person at risk of harm. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of this risk.

- We reviewed eight sets of patients' records from the paediatric ward at Worcestershire Royal Hospital. Three had an adult mental health risk assessment, three had an adolescent mental health risk assessment and two had no mental health risk assessment. There were no boxes to enable staff to tick which of the criteria were met or to record comments, therefore information had to be documented in the nursing records, which had not happened in two cases. This meant it was not clear how staff had concluded how they had reached their decision as to which criteria were actually met, so the assessment failed to provide systematic assurance that high quality care was being delivered. In the document provided to us on 11 January 2017 the trust provided a copy of the updated 'Mental health triage CYP scale', which was implemented since our inspection. This updated form did have additional boxes for the date, time and signature of the assessor, however there was still not the option to add comments.

  When patients on the paediatric ward at Worcestershire Royal Hospital were assessed to require one to one care from a registered mental

nurse (RMN) this was not always provided. In the document provided to us on 11 January 2017 the trust provided information of the number of shifts where a RMN was requested and was provided. In October 2016 it was 0%, November 2016 it was 61.5% and December it was 63.6%. From December 2016, the trust said it had started to document when a young person requires RMN one to one care and if that is not possible, which member of the paediatric nursing team was providing the one to one care. This could be either a trained or non-trained member of staff; however the trust did not provide a risk assessment to demonstrate that they had considered whether the member of staff had the skills to undertake this task safely.

- During our comprehensive inspection we found that there was a lack of an effective plan to address the significant capacity issues causing crowding in the emergency departments (EDs) at Worcestershire Royal Hospital and the Alexandra hospital in the short or medium term. The necessary 'full capacity protocol' was not being implemented during times of high demand where emergency departments were classified and documented as 'overwhelmed' by staff completing the daily safety matrix. This meant that escalation procedures were not effective to ensure risks were mitigated in relation to patients' safety. This risk was graded as 'high' on the corporate risk register (21 November 2016). It had been an active risk since November 2014. Although many actions to mitigate this risk had been completed, the significant capacity issues causing crowding in the EDs remained. In the document provided to us on 4 January 2017, the trust demonstrated that the full capacity protocol had been implemented daily from 19 December 2016 to 2 January 2017. In the 'CQC Action Plan Update' which was provided on 17 January 2017 ahead of the Risk Summit on 18 January 2017 the trust outlined additional actions it had taken to manage the overcrowding issues in the EDs, including implementing a capacity command, control and co-ordination hub is to have a robust overview of trust capacity issues and to manage daily objectives and actions. The trust had also created a number of 'medical hot clinics' so patients were not reviewed in the EDs and a trust operational daily dashboard to allow the executive team to monitor the capacity across the trust. However with these improvements in place, the trust was not able to demonstrate a significant improvement in reducing the overcrowding in the ED departments and therefore improving patient safety.

- The emergency department at Worcestershire Royal Hospital did not have a room specifically for treating patients with mental health conditions, in line with Royal College of Emergency Medicine guidance. There was a room that met some areas of this guidance however it did not meet the criteria referring to safe exit in an emergency and being free from ligature points. This room was only used when the mental

health liaison team were reviewing a patient, meaning patients who presented with mental health conditions were cared for in the main department. During our inspection on 24 November 2016 we observed one paediatric patient who presented with a mental health condition being cared for within the paediatric waiting area, and another patient who presented with mental health problems being cared for in the corridor. This practice had not been risk assessed and there were no plans in place to change it. The lack of an appropriate mental health room to care for patients was not on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk to patient safety.

- Patients who needed admission where there was not a bed available on the appropriate ward for the speciality they required, were sent to any ward where a bed was available without this being risk assessed.

- The theatre assessment unit at Worcestershire Royal Hospital accepted medical outliers. This area did not have the appropriate equipment, including a resuscitation trolley and other facilities, to care for a deteriorating patient. During the announced inspection, six out of eight patients did not meet the admission criteria for patients to be cared for in the clinical decision unit (CDU) at Worcestershire Royal Hospital. This meant the environment had been risk assessed and was not considered to be safe for the acuity level of six of the patients being cared for there. Gynaecology patients were cared for on the antenatal ward, chestnut ward (a surgical maxillofacial ward) or any available bed in the hospital. This meant that women could be having a miscarriage in a bay on a mixed sex ward. Reduced gynaecology capacity was documented on the women's and children's risk register, however clear plans were not established to prevent women being cared for in unsuitable areas.

- Whilst the risk that areas that are not designed for in-patient use and extra capacity beds are used to house patients throughout the hospital had been present on the medical divisional risk register since July 2015, actions such as the implementation of the full capacity protocol being actioned to ensure the reduction of risk to patient safety (marked as completed in April 2016) were not seen to be occurring during our comprehensive inspection. In the document provided to us on 4 January 2017, the trust demonstrated that the full hospital protocol had been implemented daily from 19 December 2016 to 2 January 2017. It stated that at 10am on 3 January 2017, 22 escalation beds were being used throughout Worcestershire Royal Hospital. There was no evidence that all these areas had been risk assessed, or what escalation areas were open at the Alexandra Hospital. This means that patients are at risk of

being cared for in environments that were not suitable for their needs, or that may not have the appropriate equipment available should their condition deteriorate. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of this patient safety issue.

- There were a lack of policies and procedures in place to outline staff roles and responsibilities for the care of paediatric patients whilst in the emergency department. During our comprehensive inspection, paediatric patients within the emergency department at Worcestershire Royal Hospital were left for periods of time with no staff available in the paediatric area. We observed three occasions during a night time inspection on 23 November 2016 where the paediatric nurse left the department for 22 minutes, 20 minutes and 14 minutes. During these times there were between two and four children in the paediatric area. This meant that if a patient deteriorated in that area it would not be recognised in a timely way. This risk had not been identified by senior nursing staff in the department and was not documented on the departmental risk register. This demonstrates that there are not systems in place to monitor and mitigate risks relating to the health, safety and welfare of paediatric patients receiving care in the department including protecting them from abuse and avoidable harm.

- Within the emergency departments at Worcestershire Royal Hospital and the Alexandra Hospital patients were routinely cared for in corridors and non-clinical areas that were accessible to a variety of non-clinical trust staff, other patients and visitors. We observed patients receiving care on trolleys with no space in between them, which meant that confidential conversations could be overheard by other patients and visitors during clinical assessments. Although privacy screens were available, staff informed us that if they were used other trolleys would not be able to pass due to the narrow corridor. We observed patients who were distressed and confused who were being cared for in this bright, noisy environment. Whilst a letter had been developed to provide patients with information regarding their care in the corridor, and at the Worcestershire Royal Hospital call buzzers had been installed in the corridors for patient use, this did not mitigate the lack of consideration for their dignity and privacy.

- There were no plans in place to improve privacy and dignity of patients being cared for in the corridor in the ED's. In the document 'CQC actions post MR risk summit letter' (not dated but provided for the risk summit held on 22 December 2016) the trust stated '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

included reverse queuing, ‘halo staff’ and care and comfort rounds, all of which were in place during our inspection; however patients’ privacy and dignity remained compromised. Although ‘the inability of clinicians to perform a full medical review due to lack of privacy resulting in the patient potentially not receiving optimal medical assessment’ was in a description of a risk associated with the local ambulance staff providing care to patients in the corridor on the medicine directorate risk register from May 2015, there were no specific actions relating to improving patients privacy and dignity when being cared for in the corridor. This demonstrates that the trust’s governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients experiencing a lack of privacy and dignity when being cared for in the corridors in the ED’s.

- The trust was not reporting the number of occurrences of unjustified mixing in relation to sleeping accommodation to NHS England, as required from 1 December 2010. This demonstrates that the trust’s governance system in relation to the provision of patient’s privacy and dignity does not operate effectively to ensure that senior leaders and the board have clear oversight of this risk.

- In the theatre admissions area at Kidderminster Hospital and Treatment Centre, mixed sex accommodation breaches were observed. Patients that were undressed in theatre gowns and dressing gowns waiting for surgery could be seen by other patients of the opposite sex and by patients and visitors in the waiting area. Sleeping accommodation includes areas where patients are admitted and cared for even where they do not stay overnight and therefore includes all admissions and assessment units. Although there were plans to redesign the area to ensure privacy and dignity was maintained and to prevent mixed sex breaches, there was not a clear timescale of when this would commence. This had not been identified as a risk on the divisional risk register and the trust had not reported this practice as mixed sex accommodation breaches.

- There were not effective procedures in place to ensure that the names of children admitted to the emergency department at Worcestershire Royal Hospital were checked on the child protection risk register. The child protection risk registers were paper based and stored in the triage room in the department which was not always accessible as patients were assessed there. During the announced inspection we saw three occasions where staff did not check the risk register for children admitted to the department via ambulance. This had not been identified as a risk and actions had not been taken to ensure the trust had a system in place to ensure all children entering the department were

being protected from abuse and improper treatment. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients who were known to be 'at risk' but were not identified.

- We observed poor adherence to infection prevention and control practices with doctors not 'arms bare below the elbow', a lack of hand washing and incorrect use of personal protective equipment at Worcestershire Royal Hospital and the Alexandra Hospital. In the 'CQC Action Plan Update' which was provided on 17 January 2017 ahead of the Risk Summit on 18 January 2017 the trust stated that it and staff from NHS Improvement had carried out hand hygiene audits infection audits since the comprehensive inspection. Results ranged from 0% compliance on Ward 11 (WRH) on 11 January 2017 to 43% compliance in the ED at the Alexandra Hospital on 11 January 2017 to 100% compliance on Ward 12 (WRH) on 7 January 2017. The trust concluded from these audits that there was correct knowledge in place relating to 'bare below the elbows' and hand hygiene but there was a failure, trust wide to undertake best practice. The trust stated that it was developing a re-launch of a hand hygiene campaign and raising infection prevention and control focus by way of a 30, 60 & 90 day plan. This risk had not been previously identified and did not feature on the corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of there being insufficient procedures to prevent the spread of infection.

- The trust did not have effective oversight of incident reporting and management, including categorisation of risk and harm. Not all incidents that were required to be reported externally as 'serious' were correctly classified and externally reported. This means the trust does not have effective systems in place to assess, mitigate and improve the quality and safety of the services it provides because investigations are not carried out in sufficient depth to inform changes in practice to prevent reoccurrence or avoidable harm.

- We reviewed an incident from the vascular high dependency unit (VHDU) at Worcestershire Royal Hospital where a patient required immediate treatment to reverse the effects of controlled medication which was administered incorrectly. This was not classified or reported as a serious incident, in line with NHS England: serious incident framework (2015). An incident relating to missing controlled drugs from the paediatric ward at Worcestershire Royal Hospital had not been reported to external authorities. Following review of the incident report it was identified that 54 codeine tablets were unaccounted for. The only

actions noted following this were that the matron was notified and the controlled drugs book rectified with new number of tablets. Failure to meet the NHS England Serious Incident Framework for identifying managing and investigating incidents resulting in failure to learn from incidents leading to preventable harm was added to the corporate risk register (21 November 2016) in August 2015. Although many actions were documented as completed, the incidents detailed above demonstrate that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk that lessons will not be learned if incidents are not categorised correctly and externally reported appropriately.

- Medical staff were told in an email dated 16 November 2016 from 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. In the 'CQC Action Plan Update' which was provided on 17 January 2017 ahead of the Risk Summit on 18 January 2017 the trust detailed immediate and ongoing actions that it had taken to address this problem including reiteration to staff by the chief operating officer, clinical director of the EDs and matrons that they should report incidents relating to high capacity and corridor care. However the impact of these actions had yet to be assessed. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk to patients receiving corridor care due to high capacity in the ED's as not all these incidents were being reported.

- Morbidity and mortality meetings were not consistently carried out or recorded across the trust. We observed that at perinatal morbidity and mortality meetings minutes were not taken and necessary actions and learning was not clearly recorded. The emergency department at Alexandra Hospital did not carry out or take part in morbidity and mortality meetings. This meant that any learning from these meetings was not shared and no-one was accountable for the completion of the actions agreed. This did not appear on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of not sharing learning from the care of patients who had died or suffered significant harm in these areas.

- During our comprehensive inspection we found patients were being placed at risk of avoidable harm from using equipment that had not been serviced, maintained tested or calibrated. The neonatal resuscitation trolley on the delivery suite at Worcestershire Royal Hospital did not always have essential checks carried out. We reviewed checklists from 1 September 2016 to 22 November 2016 and found that during this time the neonatal resuscitation trolley had not been checked on 10 occasions. Audit procedures for resuscitation equipment were not effective as it had not been identified that daily checks were not always being completed. Not all equipment had been completed had evidence of medical servicing and portable appliance testing within the safety date displayed. In the Meadow Birth Centre and delivery suite at Worcestershire Royal Hospital and the Midwifery Assessment Unit at the Alexandra Hospital we found a total of 11 pieces of equipment had not been tested within the date indicated. This had not been identified as a risk and did not appear on the divisional risk register. This means there are not effective governance systems in place to ensure that all equipment used for providing care or treatment to a patient was safe for such use.

- During our comprehensive inspection we found there was unsafe storage of medication with poor monitoring, escalation and insight into the effect of storing drugs above or below the recommended temperatures. This means the trust cannot be sure that all medicines stored both in fridges and at ambient temperatures in treatment rooms are safe to be administered to patients.

- On the Evergreen ward at Worcestershire Royal Hospital the temperature of the medicine refrigerator was not recorded daily. Over 24 days only 12 days temperature records were documented which were within the safe range of 2-8°C. In the Elias Jones unit at the Alexandra Hospital, the temperature of the treatment room (where drugs were stored at ambient temperatures) was not recorded daily and when the room temperature was higher than the safe level for the storage of drugs this was recorded but not escalated.

- In the Minor Injury Unit (MIU) at Kidderminster Hospital and Treatment Centre records showed fridge temperature checks had been completed daily however we found the maximum fridge temperatures recorded had exceeded the recommended maximum safe temperature eight degrees Celsius on a total of 60 days between August and November 2016. There was a risk that Tetanus vaccines, stored in the fridge, were less effective or ineffective as they had not been stored at the recommended temperature. Staff were not aware of this risk and had not escalated high temperatures to pharmacy in line with the trust's medicines policy. Staff told us that pharmacy staff regularly visited the MIU and inspected

the place of storage in line with the medicines policy however the fridge temperatures had not been highlighted. Following the escalation of this matter, the trust said on 24 November 2016 “the fridge is operating at a temperature within acceptable parameters and no medications had been affected.” After further enquiries from CQC, on 13 December 2016 and 11 January 2017 we were told ‘Those medicines affected were removed and resupplied’. We are not aware of any action taken by the trust to contact any patients who have received drugs (including vaccines) which have been stored at incorrect temperatures, to review any harm that may have been sustained. This shows that there are not effective processes in place to ensure that the trust policy on medicines management is being adhered to, and this had not been recognised as a risk. This also demonstrates that the trust’s governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients receiving medication that had been stored at incorrect temperatures.

- Doses of time critical medication were not being administered to patients at the correct time. In the emergency department at Worcestershire Royal Hospital we found two instances where patients did not receive Parkinson’s and diabetic medication, as they were being cared for prolonged periods in the corridor where medicine rounds did not occur. On ward 5 at the Alexandra Hospital a patient had missed doses of Parkinson’s medication, anticoagulants and intravenous antibiotics on two consecutive days. The trust was not aware of this risk and there were no effective governance systems in place to ensure the safety of patients by administering their medication as prescribed. In the document provided to us on 11 January 2017 the trust stated that the ‘supply of time critical medicines is a key priority and an audit of missed doses has been undertaken as part of the trust Medicines Optimisation Audit Plan, with associated recommendations presented to the Divisional Directors of Nursing’. The results of the audit were not provided however the trust presented a three month plan stating how the administration of time critical medications would be incorporated into medicines management training, would be a focus of the medicines safety newsletter and training outcomes would be monitored. The trust did not confirm if this has been added to the corporate risk register to ensure that there was sufficient senior leader and board oversight of this risk and the actions taken to mitigate it.

- The emergency department at Worcestershire Royal Hospital had 3.7 whole time equivalent (WTE) full-time consultants, with one additional locum consultant. The emergency department at Alexandra Hospital had one WTE full-time consultant, with three additional locum consultants. These levels of consultants were not sufficient to meet with the Royal

College of Emergency Medicine's (RCEM's) emergency medicine consultants' workforce recommendations to provide consultant presence in all emergency departments for 16 hours a day, seven days a week as a minimum. This meant that the trust was failing to ensure sufficient numbers of suitably qualified, competent, skilled and experienced consultants were deployed in order to meet the requirements of the emergency department's planned establishment and the RCEM's consultants' workforce recommendations. This risk was raised at our previous inspection and has been on the divisional risk register since March 2016. The trust is actively recruiting for substantive consultants replace the locums in the ED, however this risk remains.

- During our inspection we had concerns about staff and patient safety when untrained staff were left alone to care for patients. The discharge lounge at the Alexandra Hospital, on 7 December 2016 was being staffed by one bank healthcare support worker (HSW) (establishment reported as one trained nurse plus a HSW). She was working alone, unable to get a prompt response from senior management through the bleep system, and had no cover for meal or comfort breaks. In the clinical decisions unit at Worcestershire Royal Hospital, untrained staff were left alone to care for patients while trained staff took their meal breaks. Staff in both areas informed us this was a regular occurrence. In the document 'CQC actions post MR risk summit letter' (not dated but provided for the risk summit held on 22 December 2016) the trust agreed that this was not acceptable and said they were 'reviewing the staffing requirement via the nurse leadership in these areas to ensure compliance with safe staffing'. This risk had not been identified by senior nursing staff in the departments and was not documented on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients being cared for by staff who did not have the appropriate training to do so.

- In the BAF risk report provided on 22 November 2016 risk 2790, rated as 'high' stated "As a result of high occupancy levels, patient care may be compromised". This has been on the 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, increased length of stay. Actions included; improving patient flow by increasing ambulatory care provision, redesigning the bed model, and improving the discharge processes. Expected completion was 31December 2016. These actions are either yet to be implemented or are not effective in reducing the risk as the data demonstrates there is no tangible improvement in performance. The ED's at Worcestershire

Royal Hospital and the Alexandra Hospital remain overcrowded with the overall trust four hour target of 95% of admitting, transferring for discharging patients not been met and being consistently reported as less than the England average. The overall trust performance against this target was; August 2016 83.5%, September 2016 82.2%, October 2016 80.9%, November 2016 78.9% and 19 December 2016 to 12 January 2017 at 73.2%. Occasions where a patient is waiting on a trolley for more than 12 hours after a decision has been made to admit them are increasing with 38 breaches recorded in November 2016, 86 in December 2016 and 113 in the first two weeks of January 2017. This means the trust does not have assurance that actions were improving patient care.

For the reasons set out above, the Commission is of the view that the quality of health care you provide requires significant improvement.

You are required to make the significant improvements identified above regarding the quality of healthcare by 10 March 2017.

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

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

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

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

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number MRR1-3107518238

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

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

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

If you contact us, please make sure you quote our reference number MRR1-3107518238 as it may cause delay if you are not able to give it to us.

Yours sincerely

Edward Baker
Deputy Chief Inspector of Hospitals.

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