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BY EMAIL
For the Attention of the Clare Culpin

Clare Culpin
Acting Chief Executive
Kettering General Hospital NHS Foundation Trust
Rothwell Road
Kettering
NN16 8UZ

18 November 2016

The Care Quality Commission
The Health and Social Care Act 2008
SECTION 29A WARNING NOTICE:
Provider name: Kettering General Hospital NHS Foundation Trust

Regulated Activities**:**

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

Our reference: MRR1-3000184665
Account number: RNQ

Dear Ms Culpin,

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 Kettering General Hospital NHS Foundation Trust (’the 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 health care being provided in accordance with the above Regulated Activities at the location identified below:

1. Kettering General Hospital
   Rothwell Road
   Kettering
   NN16 8UZ

The reason for the Commission's view that the quality of health care you provide requires significant improvement at Kettering General Hospital is as follows:

- The systems to assess, monitor and mitigate risks relating to the health, safety and welfare of patients receiving care and treatment are not operating effectively so as to protect patients from the risks of avoidable abuse and harm. Despite the new, updated risk registers being implemented by the trust, significant risks remain that the trust have not recognised, assessed, monitored and mitigated. This represents significant failings in the overall trust governance processes as the trust was not aware of the level of risk regarding multiple concerns until we raised these as urgent concerns, despite the recent review and update of the corporate and clinical business unit (CBU) risk registers on 25 and 27 October 2016. The governance systems in place are not sufficient to allow full oversight at board level of the potential risk to patients.

Significant improvements are required in relation to the quality of the health care provided by the trust in relation to the regulated activity set out in this Notice at the location of Kettering General Hospital, by way of having established systems in place that operate effectively in order to address the point above.

Following the comprehensive inspection of Kettering General hospital between 12 and 14 October 2016, feedback was provided to the executive team of the trust on 14 October 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 Inspection on 18 October 2016.

Following the unannounced inspection visits, as part of the comprehensive inspection of Kettering General hospital, on 24 October 2016, feedback was provided to the Executive team of the trust on 24 October 2016 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 Inspection on 28 October 2016.

A letter requesting information, regarding the key areas of concern for the children and young people's service, the emergency department and staffing on the

Coronary Care Unit, was sent to the trust on 25 October 2016 by Fiona Allinson, Head of Hospital Inspections.

A meeting took place, via teleconference, on 28 October 2016 attended by Bernadette Hanney, Head of Hospital Inspection and Phil Terry, Inspection Manager of CQC and Clare Culpin, Acting Chief Executive of the trust, to follow up on the concerns raised in our letter of 25 October 2016 and to seek further clarification from you on the progress that had been made with regards to the identification and management of risk. During the meeting, you informed us about the progress in the key areas of concern in the children and young people's service and the emergency department, and we also requested clarification regarding the prioritisation system for patients awaiting outpatients' appointments and the competency of staff in the phlebotomy service to undertake procedures with children.

A further meeting took place, via teleconference, on 2 November 2016 attended by Bernadette Hanney, Head of Hospital Inspection and Phil Terry, Inspection Manager of CQC and Clare Culpin, Acting Chief Executive of the trust, to follow up on the concerns raised in our meeting on 28 October 2016 and to seek further clarification from the trust on the further progress that had been made with regards to the identification and management of risk.

The information you have provided together with the evidence gathered during the course of the inspection process, which is 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 matters set out at point 1 above.

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

1. **Mental health assessment room in the emergency department**

   1.1 During our inspection on 12 to 14 October 2016, we found that the trust was in the process of updating the dedicated mental health assessment room. This was due to be completed on 21 October 2016 and we were told that it was designed to meet the Royal College of Emergency Medicine (RCEM) guidelines. At the time of our inspection, there was no formal process in place to manage patients who presented a risk to themselves due to environmental factors and staff used whichever space was available in the department. There was no process to assess the risks to the patient, other service users and staff.

   1.2 In our letter to the trust on 18 October 2016, confirming the verbal feedback provided to the trust on 14 October 2016, we identified that the lack of a dedicated mental health assessment room in the emergency department was a concern. Whilst it was acknowledged that this was in the process of

being rectified, there was no risk assessment of the placement of patients in the interim.

1.3 On our unannounced inspection on 24 October 2016, we found that the dedicated mental health assessment room was not in line with RCEM guidelines. The trust had not identified these risk areas. Specifically, there was a ligature point in the ceiling; movable metal furniture (one three seater bench and one two seater bench which were not secured to the floor or wall) and the two doors were not alarmed. One door opened into the Emergency Decisions Unit and the other opened into a corridor where patients could leave unseen.

1.4 The trust provided information, received on 26 October 2016 that acknowledged the current risks and plans for further work to be completed in the week ending 4 November 2016. This included the provision of immovable furniture, changes to the door hinges and viewing panels to be added. A revised mental health risk assessment tool for adults and children was being introduced.

1.5 In the meeting on 28 October 2016, we requested further information as the mental health risk assessment tool did not include where such patients were to be cared for whilst the dedicated assessment room was being refurbished. We also requested information as to how the trust was assuring itself that patients would not be at risk of avoidable harm as the risk assessment provided did not address this.

1.6 In the trust response on 31 October 2016, an updated mental health risk assessment tool was provided that included an environmental hazard risk assessment (developed November 2016, version 1) to be used at all times including when the dedicated mental health room has been appropriately updated (which was still being planned for the week ending 4 November 2016). A flow chart was set out for staff, describing the areas in which patients presenting with mental health illnesses could be cared for and included the observation level required by staff. You told us that this flow chart had been developed jointly by the clinical team and was in the process of being implemented. This tool was to be reviewed daily and included in the two hourly safety rounds in the emergency department as part of an introduction process over the next month with a formal review and audit in December 2016.

1.7 You provided us with an update on 4 November 2016 that the mental health risk assessment tool had been implemented in the emergency department supported by the mental health liaison team who would not accept any patient without a completed assessment. The departmental lead nurse was undertaking spot checks on compliance with completion.

The clinical business unit risk register that was in place at the time of the inspection did not accurately reflect the risks that the lack of an appropriate mental health assessment room represented to patients.

1.8 Your email on 27 October 2016 stated that the trust is redeveloping the corporate risk register and the CBU level risk registers are all going through the process of approval. You stated this was still work in progress and was due to be shared at the trust risk management steering group in a 'couple of weeks' time' and at the trust board in November . However, the new, updated CBU risk register dated 27 October 2016, as provided to us on the same day, does not identify the lack of an appropriate mental health assessment room in emergency department when patients present with this need as a risk. The trust was not aware of the level of risk regarding this issue until we raised this as an urgent concern.

1.9 We are not assured that the risk management processes currently in place are sufficient to recognise, assess, monitor, and review and therefore reduce risks.

2. Initial time to clinical assessment for ambulance handovers in the emergency department

2.1 For the period from June 2015 to May 2016, we found that the initial time to clinical assessment for ambulance handovers was reported as worse than the England average and between ten and 13 minutes. The trust informed us as part of the pre-inspection data gathering request that they had had 'nil' 'black breaches' for ambulance handovers from August 2015 to July 2016. The NHS England definition of a 'black breach' is where handovers from ambulance arrival to the patient being offloaded to the emergency department takes longer than 60 minutes. From speaking with staff in the department, we established that there were daily 'black breaches' but staff were not able to provide detailed information regarding this.

2.2 On our unannounced inspection on 24 October 2016, we found that the process for recording ambulance handovers was not clearly defined. We spoke with ambulance staff after our arrival on site (at approximately 6.40pm) and they stated that they had already waited 20 minutes to hand patients over and were still waiting in the departmental corridor.

2.3 In our letter to the trust on 25 October 2016 from Fiona Allinson, Head of Hospital inspections, we detailed that the average ambulance handover/offload time was around 1.5 hours in the early evening of the 24 October 2016. Staff had explained that due to nurse staffing difficulties, the emergency department's escalation area was not opened to accommodate patients until later in the evening. We also saw that from 7.30pm, the clinical site supervisors arranged for a hospital liaison officer (HALO) from the local ambulance trust to attend to support paramedic crews whilst they were

waiting to hand over the patients in their care. The associate specialist in charge of the emergency department was not able to clearly articulate the trust's escalation plans or how the department maintained a current clinical oversight of the needs of all patients given the capacity and demand pressures.

2.4 Further information received from the trust on 26 October 2016 showed that from April 2016 to September 2016, there were 15,604 ambulance handovers of over 15 minutes and 323 'black breaches' in that time frame. For example, in August 2016, the emergency department had 7,365 attendances recorded as type 1 (Majors) (source: NHSE statistics) and of those attendances, 2,519 were over 15 minutes for handover, 394 over 30 minutes and 77 were black breaches (including six instances of over two hours). The data sent by the trust also contained errors, for example, the August 2016 total number of cases was stated as 2,519; however when the figures are added up it totals 2,629.

2.5 In the meeting on 28 October 2016, we informed you that the data provided showed that from April 2016 to September 2016, 323 'black breaches' had occurred. Senior staff in the emergency department on inspection had said that no black breaches had occurred.

2.6 In the trust response on 31 October 2016, you provided us with clarification that the original omission of 'black breach' information was due to confusion surrounding your use of 'black breach' terminology to identify patients who were cared for in the emergency department for 12 hours or more of which you have had 'nil' in the past 12 months. You stated that you have updated your 'ambulance streaming' policy to include a clear escalation process for patients 'queuing in' and awaiting ambulance handover and stated that the trust is still in communications with the local ambulance NHS trust to establish an agreed process for handover time.

2.7 In the meeting on 2 November 2016, you referred to 'back breaches' and that internally, the trust was using the term to refer to over 12 hour trolley waits for patients as opposed to delayed ambulance handovers, which is why none had been reported in the data provided us.

2.8 The clinical business unit risk register that was in place at the time of the inspection did not accurately reflect the risks that failure to monitor, assess and mitigate the risks to patients due to delayed ambulance handovers.

2.9 Your email on 27 October 2016 notes that the trust is redeveloping the corporate risk register and the CBU level risk registers are all going through the process of approval. You stated this was still work in progress and was due to be shared at the trust risk management steering group in a 'couple of weeks' time' and at the trust board in November . However, the new, updated CBU risk register dated 27 October 2016, as provided to us on the same day

does not accurately reflect the risks that failure to monitor, assess and mitigate the risks to patients due to delayed ambulance handovers,

2.10 The trust was not aware of the level of risk regarding the 'black breaches' and the governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.

2.11 We are not assured that the risk management processes currently in place are sufficient to recognise, assess, monitor, and review and therefore reduce risks.

3. Initial time to clinical assessment for self-presenting patients in the emergency department

3.1 On our inspection on 12 to 14 October 2016, we found that the streaming process at the front door of reception had been implemented in 2015; the policy which highlighted the streaming competency framework had been undated but had not been ratified. The initial time to clinical assessment for patients who walked into the main emergency department reception was reported as one to two minutes. Between 10am and 10pm, patients who arrived at the department by their own means were initially seen by a receptionist who took personal details, the patient then moved along the receptionist desk to a 'streaming' position (this normally took less than a minute). Patients were seen by a healthcare professional (funded by the GP external provider service from 10am to 10pm) who could be a registered nurse, advanced clinical practitioner (ACP) or pharmacist (the pharmacist has had no specific training for this role); this booking in time was recorded as 'initial clinical assessment'. The streaming process used 'red flag' indicators in line with RCEM, 2011 guidelines and there was no other triage process in place at the front door and patients were directed to a waiting area until they were called by a clinician. Between 10pm and 10am the streaming was conducted by a registered nurse.

3.2 On the unannounced visit to the emergency department on 24 October 2016, we were concerned that the process for taking patients' observations following the booking in process at the reception desk was not carried out on four occasions during our visit. We observed that the waiting time to see a doctor was two to three hours at 7.22pm. The main concern was that there was no robust process to manage category 2 patients to ensure that they had an initial clinical assessment (including full observations) within 15 minutes. On this visit, we documented two patients that presented with chest pains and shortness of breath, their initial clinical assessment and triage time was recorded (as per the streaming described above) as one to two minutes. However, one patient waited more than 20 minutes to be called to have observations completed and one patient had been waiting for ten minutes when we left.

3.3 In our letter dated 25 October 2016, we requested information as to how the trust recorded, audited and monitored the time to initial clinical assessment for all patients arriving at the emergency department, including via ambulance and self-presenting, to assure itself that all patients receive this initial clinical assessment within 15 minutes of arrival to the department. In your response dated 26 October 2016, reference was made to the fact there is no national requirement for a specified timeframe in minors areas, but the data supplied by the trust did not include any times to treatment or initial clinical assessment for walk-in patients.

3.4 Our concern was that the streaming time was recorded as the 'initial clinical assessment' for all walk-in patients: this is not in line with RCEM guidelines which indicates that an initial clinical assessment should include vital signs, pain management assessment and an immediate plan of care. The actual 'initial clinical assessment' occurred when the patient saw the ENP. This was prioritised for patients with 'red flag' symptoms; however, as the initial streaming was being recorded as the 'initial clinical assessment', this did not give a true picture of when patients self-presenting with 'red flag' symptoms received an 'initial clinical assessment'. Intercollegiate guidance (Standards for children and young people in Emergency Care settings, RCPCH, 2012) also recommends that as well as children being visually assessed by an appropriate practitioner they should receive an 'initial clinical assessment' within 15 minutes of arrival. Paediatric patients who were self-presented had their 'initial clinical assessment' time recorded as the time they were at 'streaming'.

3.5 In the meeting on 28 October 2016, we informed you that RCEM guidelines state that initial clinical assessments should include vital signs, pain management and observations and an initial plan of care. The trust used the Manchester triage tool but this did not give the true picture as the trust's streaming time was recorded as 'initial clinical assessment' for all walk-in patients. As the initial streaming was recorded as 'initial clinical assessment' this did not give a true picture of when patients self-presenting with 'red flag' symptoms received an 'initial clinical assessment'. The trust was recording the initial clinical assessments as one to two minutes but this was before the Emergency Nurse Practitioner (ENP) had seen the patients, some of whom were asked to sit in the waiting room before being called to see the ENP. Some patients were waiting considerably longer than one to two minutes. There was a discrepancy between what the inspection team had been told and from what they observed.

3.6 In the trust response on 31 October 2016, you informed us that immediate action had been taken and the trust had changed the streaming process to aim to ensure that all patients have their vital signs, and if required an ECG, taken within 15 minutes of presentation and then streamed and directed to the appropriate clinical area. This has been introduced by one of the emergency department consultants who had completed an audit over the

weekend of 29 and 30 October 2016 which demonstrated an immediate positive impact. Staff had been involved and informed of the new procedure and the ongoing implementation was to be monitored daily through audit to ensure it is embedded. You stated that the results of the audit will be presented at the clinical business unit meetings and reported to the trust quality governance steering group. In addition, whilst the changes are being introduced, the trust's chief operating officer and director of nursing and quality will hold a weekly assurance meeting to monitor compliance with the teams until they are confident the procedures are sustained. This will then lead to ongoing audit and monitoring through the routine audit and evaluation programme. The streaming policy has been developed (October 2016 version one) and includes an exclusion criteria. The trust provided us with an update on 4 November 2016 that the standard operating procedure for the 'Streaming of Patients in the Emergency Department' was introduced on the weekend of 29 and 30 October 2016 and was being monitored by spot checks of compliance to the pathway.

3.7 The clinical business unit risk register that was in place at the time of the inspection did not accurately reflect the risks that failure to monitor, assess and mitigate the risks to patients due to delayed time to initial clinical assessment.

3.8 We note that from your email on 27 October 2016 that the trust is redeveloping the corporate risk register and the CBU level risk registers are all going through the process of approval. You stated this was still work in progress and was due to be shared at the trust risk management steering group in a 'couple of weeks' time' and at the trust board in November . However, the new, updated CBU risk register dated 27 October 2016, as provided to us on the same day, does not accurately reflect the risks that failure to monitor, assess and mitigate the risks to patients due to delayed time to initial clinical assessment.

3.9 The trust was not aware of the level of risk regarding this issue until we raised this as an urgent concern, despite a review and update of the CBU risk register on 27 October 2016. The trust was not aware of the level of risk regarding the delayed time to initial clinical assessments and was not aware that the systems in place were incorrectly recording the time for these assessments. The governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.

3.10 We are not assured that the risk management processes currently in place are sufficient to recognise, assess, monitor, and review and therefore reduce risks.

4 Lack of oversight of risk for children and young people

4.1 Safeguarding

4.1.1 During our inspection on 12 to 14 October 2016, we found that safeguarding level 3 training had not been completed by over 80% nursing staff in the emergency department in line with guidance. We looked at seven paediatric records and found that the safeguarding field had not been completed in two incidences when it may have been appropriate to show that safeguarding had been considered.

4.1.2 On the unannounced inspection on 24 October 2016, four out of five safeguarding proformas had not been completed in children's records. Two sets of records were in the children's emergency department and both patients had been in the department since 4.24pm and at 6.50pm, the safeguarding proformas had not been completed at 7.30pm. We asked the off going nurse in charge if these had been completed electronically and we were told that they should be completed by hand and they had not been completed at the time as staff had not had the time, but they would be done. One proforma that had been filled in indicated that there was an 'alert' for the patient and they were a 'regular attender'. There was no indication that a safeguarding referral had been considered or made. The patient had been referred to the fracture clinic with a suspected clavicle/shoulder fracture and had left the department.

4.1.3 Further to our letter dated 25 October 2016, the trust provided information on 26 October 2016 regarding the child with fracture explaining that all such cases were routinely reviewed the next day by designated staff to identify any missed referrals. A belated referral to the local health visitor and GP had now been made and the trust explained that the rationale for the decision to discharge the patient had been recorded in the patient's notes but the safeguarding proformas had not been completed at the time of initial presentation. You stated that an extra field was to be added to safeguarding proformas from 1 November 2016 and that 'spot check' audits of safeguarding proformas were to be conducted as of 1 November 2016. You also told us that the safeguarding lead carried out bespoke level 3 safeguarding children training every other month.

4.1.4 In the meeting on 28 October 2016, we said that for level three safeguarding children training, we had been advised during inspection that 18% of staff had received this for the emergency department however we had not yet received clear data to confirm or refute this. The inspection team had been told on inspection that only 60% of doctors had level three training by the trust's safeguarding children's lead.

4.1.5 In the trust's response on 31 October 2016, you told us that emergency department staffs' compliance to level 3 safeguarding children's was at 37% and that the trust had therefore organised for all staff within the department to undertake level 3 safeguarding training. In addition to the training sessions already booked for staff, daily training sessions would commence on 1

November 2016 and will be provided in the department to enable as many staff as possible to attend. You stated that updated training figures would be provided in the week ending 4 November 2016.

4.1.6 In an update provided on 4 November 2016, you told us that additional training sessions were underway and that the bespoke level 3 safeguarding children training sessions for the emergency department that were scheduled to deliver full compliance by May 2017 would be condensed with four sessions delivered monthly for a quicker uptake by staff. As yet, this detailed compliance information has not been provided.

4.1.7 The clinical business unit risk register that was in place at the time of the inspection did not accurately reflect the risks that the failure to monitor, assess and mitigate the risks to patients due to the lack of compliance with level 3 safeguarding children's training presented.

4.1.8 We note that from your email on 27 October 2016 that the trust is redeveloping the corporate risk register and the CBU level risk registers are all going through the process of approval. You stated this was still work in progress and was due to be shared at the trust risk management steering group in a 'couple of weeks' time' and at the trust board in November . However, the new, updated CBU risk register dated 25 October 2016, as provided to us on 27 October 2016 does not accurately reflect the risks that failure to monitor, assess and mitigate the risks to patients that the lack of compliance with level 3 safeguarding children's training presented.

4.1.9 The trust was not aware of the level of risk regarding this issue until we raised this as an urgent concern. The governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.

4.1.10 We are not assured that the risk management processes currently in place are sufficient to recognise, assess, monitor, and review and therefore reduce risks.

4.2 Safety and Security of children on Skylark ward

4.2.1 During our unannounced inspection on 24 October 2016, access to the balcony outside the entrance to Skylark ward was of concern. A patient who had been cared for on the ward over the weekend of 15 to 16 October 2016 had attempted to climb over the balcony and had to be physically restrained by staff to prevent serious injury. Staff told us that actions were now being taken to arrange for this area to be made safe from further such potential serious incidents. Staff informed us that any future referrals of patients that present with challenging behaviours will be risk assessed and one to one care provided whenever required.

4.2.2 The exit to Skylark ward was of concern as there was not currently a safe method of checking all people leaving the ward. This represented a risk of children going missing. Staff we spoke with on the ward stated that they had had no training regarding managing physical aggression from patients or the equivalent of restraint/safe touch training. Staff we spoke with on the ward were not clear about the policy and protocols to follow to respond immediately when a child was found to be missing. The flowchart on display at the nurses' station was not specific to the ward environment and not reflective of the needs of the patients being cared for on the ward. Staff were not able to explain a clear 'lockdown' procedure to be operated immediately in all cases when a child is found to be missing.

4.2.3 In our letter dated 25 October 2016, we requested information as to how the safety of all patients being cared for on Skylark ward was being ensured until the environmental concerns regarding the exit door system and adjacent balcony were addressed. In particular, what processes were in place regarding the comprehensive risk assessment and management of risk of any CAMHS patients or children presenting with deliberate self-harm behaviours on Skylark ward, including details of the competences of those staff who were carrying out those assessments and managing those risks.

4.2.4 We requested copies of all of the risk assessments for patients referred to Skylark ward who were CAMHS patients or who presented with deliberate self-harm behaviours and copies of the risk management plans in place for them before admission. We also requested real time details of all admissions, whether a risk assessment had been completed, including an environmental risk assessment. We requested information as to how staff on Skylark ward had the skills and competency to manage difficult and aggressive behaviours exhibited by patients. We also asked what actions the trust was taking to make the balcony area safe (and the timescales for this action) and what actions the trust was taking regarding the identified risk of patients leaving Skylark ward unsupervised and the timescales for this action.

4.2.5 Further evidence was provided by the trust on 26 October 2016. In the meeting on 28 October 2016, we said that the internal crisis plan and policy provided addressed a missing child / baby following an event, including lockdown, but did not address actions in relation to a child who absconded or if staff witnessed an abduction. The flowchart said to alert security and then police, however we understood that security was not provided 24 hours a day seven days a week. When security was provided, CQC were not assured they had had training in the restraint of children and young people. For the new risk assessment tool, there was no evidence of who was doing the risk assessment and if they were competent to undertake such assessments. The risk assessment tool was in draft and required review by CAMHS team. Staff had not had training or competency assessment in relation to caring for patients with mental health needs. The difference between medium and high risk is unclear in terms of whether additional staff are sourced. Whilst the

trust had said there would be close observation at all times, it is not clear how this differed from one to one care and therefore had the same staffing implications as per high risk. In addition, if the staff providing this additional support were to be provided from within the ward area or CBU, then we were not assured they would still have had the relevant training and competency to care for these patients. In terms of the deliberate self-harm pathway (DSH), on inspection, we had concerns about how that had been used. The DSH pathway was seen in use during inspection but it lacked detail and pertinent prompts, e.g. environmental risk assessment, with access to the balcony being a significant risk. The evidence provided was not sufficient to reduce risk in the short term and we were not assured patients would not experience harm. You said that Skylark nurses were acute children's nurses trained and the ward was not a mental health unit. The trust were looking for greater awareness for patients' mental health crises and CAMHS patients' needs and specifically how the trust would safeguard these patients in terms of the environment. Our stated concern was that if a patient was admitted over the weekend, would staff have the competencies to care for their needs and to undertake a risk assessment.

4.2.6 In your response on 31 October 2016, evidence was provided regarding the change to entrance systems and balcony assessment with security present on the ward monitoring the entrance/exit. Longer terms plans were being developed including consideration of a tagging system for high risk patients. There was a lack of information regarding CAMHS and DSH patients that had been admitted to the ward and these risk assessments had not been provided. There was also not assurance of staff competency for dealing with CAMHS and DSH patients.

4.2.7 In the meeting on 2 November 2016, you confirmed the trust had an actual security individual sitting by the door to the ward 24/7 until CCTV and door entrance mechanism installed on Friday 4 November 2016. You confirmed that with regards to training in the restraint of children and young people, security individuals had had a five day programme which was a generalised programme for adults. None of the security personnel would ever be alone with children as there would always be a registered healthcare professional with safeguarding training present.

4.2.8 We requested further information regarding the number of referrals of CAMHS and DSH patients to the ward and the time to assessment by CAMHS teams. We also requested further information to the competency of Skylark ward staff regarding the completion of the mental health risk assessment tool.

4.2.9 In the trust's response on 2 November 2016, you stated that all staff had experience of working with their CAMHS partners in completion of the county wide deliberate self-harm pathways. Since the trust had added the risk assessment pathway, it had agreed with colleagues from CAMHS to use

the expertise of an advanced mental health practitioner who would undertake training and knowledge assessment for Skylark Ward staff on Thursday 3 November and Friday 4 November 2016. As part of the roll out and implementation of the risk assessment, a competency assessment tool would be drafted in partnership with the mental health practitioner. The undertaking of the risk assessment would only be by those staff who coordinated the shifts and held experience on caring for those patients with challenging behaviours; not the whole ward staff. The paediatric lead nurse or matron would review all risk assessments with staff on a daily basis to ensure these had been effectively completed. A draft policy had been produced and you would be happy to share this policy once ratified by the quality governance steering group on 8 November 2016. You stated that a monthly review of completed risk assessments and interventions was to be undertaken by the CAMHS Lead with the paediatric lead nurse.

4.2.10 In an update on 4 November 2016, you informed us that the enhanced observation risk assessment tool and escalation process was in place and being monitored daily. The implementation of this had been supported by the advanced mental health practitioner, from CAMHS with training delivered 3 and 4 November 2016. She was supporting the development of a formalised competency assessment. The lead nurse was undertaking a daily review of the completed forms to identify ongoing learning and to ensure patients received the appropriate level of care. The revised flowchart for the missing/abducted child was displayed in all areas with communication of this undertaken at each handover. The maternity and paediatrics team had initiated a 'live' skills drill related to a missing/abducted child with police engagement today with a debrief planned. Revised policy and flowchart were provided on 31 October 2016. The mental health triage assessment tool had been implemented in the emergency department supported by the mental health liaison team who would not accept referrals without a completed assessment. The lead nurse was undertaking spot checks on compliance with completion.

4.2.11 The clinical business unit risk register that was in place at the time of the inspection did not accurately reflect the risks that the failure to monitor, assess and mitigate the risks to patients that the lack of effective security systems for Skylark ward presented.

4.2.12 We note that from your email on 27 October 2016 that the trust is redeveloping the corporate risk register and the CBU level risk registers are all going through the process of approval. You stated this was still work in progress and was due to be shared at the trust risk management steering group in a 'couple of weeks' time' and at the trust board in November . However, whilst the new, updated CBU risk register, dated 25 October 2016 and provided to us on 27 October 2016, do identify the security issues and environment issues (as a new risk entered on 17 October 2016, following our inspection), the level of risks regarding the appropriate risk assessment of

CAMHS and DSH patients and care provision by competent staff are not reflected.

4.2.13 The trust was not aware of the level of risk regarding this concern until we raised this as an urgent concern.

4.2.14 The trust was not aware of the level of risk regarding the environmental factors for this ward or of the concerns regarding the risk assessment and care provision for CAMHS and DSH patients by competent staff. The governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.

4.2.15 We are not assured that the risk management processes currently in place are sufficient to recognise, assess, monitor, and review and therefore reduce risks.

4.3 Safety and security of paediatric emergency department

4.3.1 On the inspection on 12 to 14 October 2016, we found that there were insufficient registered nurses (children's branch) in post (two out of four WTE were in post, two were due to start) to ensure that the unit had a minimum of one such nurse on duty per shift in line with RCN & RCPCH guidelines for safer staffing for children in emergency departments (2013, 2012). There was no dedicated resus bay/room in the paediatric emergency department and due to the lack of suitably trained adult nurses, the children's' nurse had to leave the area staffed with an health care assistant or untrained adult nurse whilst they attended the paediatric resuscitation patient in the adult department. On the unannounced inspection on 24 October 2016, at the start of the 7pm shift there was a health care assistant rostered to support the nurse in paediatric emergency department; however they were relocated to another area in the hospital due to staff shortages leaving the nurse in department alone. On two occasions the department was left unattended with patients in situ.

4.3.2 In our letter dated 25 October 2016, we requested information as to how the trust assured itself that the paediatric emergency department was constantly staffed and patients were not left unattended.

4.3.3 Further evidence was provided by the trust on 26 October 2016. In the meeting on 28 October 2016, we requested further information as the information provided by the trust did not provide reassurances that the paediatric emergency department would be safely staffed at all times. The data provided by the trust did not explain how they would achieve this, only that business case would be submitted for a 'twilight shift' with no time frame.

4.3.4 In your response dated 31 October 2016, the trust stated that it had taken immediate action with the allocation of a registered children's nurse

working in the paediatric emergency department covering all shifts, including overnight. Should the nurse need to leave the area, they were to be covered by a nurse with paediatric intermediate life support training for the short period. The nursing rota had been reviewed to ensure this was to be sustained. The nurse-in-charge of the shift was to conduct two-hourly safety rounds and ensure that this was maintained throughout the shift.

4.3.5 In your update on 4 November 2016, you stated that every shift in the paediatric emergency department was covered by a paediatric nurse with a system in place to ensure cover of this individual should they need to step out of the unit by an adult nurse with paediatric life support skills training. The emergency department operating procedure was provided to us on 1 November 2016.

4.3.6 The concern remains that there is a consistent failure to continually monitor the staffing levels and security of patients in the paediatric emergency department as these concerns were found on the unannounced inspection of the department on 10 February 2016. We raised immediate concerns during the inspection regarding the lack of security and that the paediatric emergency department had been left unstaffed when patients were present. The trust at that point took immediate actions to address this concern at that time, however, as our recent inspection findings have shown, these actions have not been sustained and embedded in practice.

4.3.7 The clinical business unit risk register that was in place at the time of the inspection did not accurately reflect the risks that the failure to monitor, assess and mitigate the risks to patients that the lack of effective staffing levels for patients in the paediatric emergency department.

4.3.8 We note that from your email on 27 October 2016 that the trust is redeveloping the corporate risk register and the CBU level risk registers are all going through the process of approval. You stated this was still work in progress and was due to be shared at the trust risk management steering group in a ‘couple of weeks’ time’ and at the trust board in November . However, the new, updated CBU risk register, dated 27 October 2016 and provided to us on 27 October 2016,does not identify lack of nurses in the paediatric emergency department when patients are present as a risk.

4.3.9 The trust was not aware of the level of risk regarding this risk until we raised this as an urgent concern. The governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.

4.3.10 We are not assured that the risk management processes currently in place are sufficient to recognise, assess, monitor, and review and therefore reduce risks.

5. Fit and Proper Persons employed

5.1 A further concern which was detailed in our feedback letter of 18 October 2016 was regarding significant concerns that were found regarding the trust's understanding of the requirements of the fit and proper persons' regulation (Health and Social Care Act 2008 (Regulated activities) Regulations 2014: Regulation 19: Fit and proper persons employed). There was not a policy in place giving clear guidance for all appointments to the board, executive team and which staff the trust may consider as associate directors of boards who are members of the board, irrespective of their voting rights. No audit programme was in place to review the evidence within staff personnel files on a cyclical basis. On a review of these staff files, we found gaps in essential documents, including written references and Disclosure and Barring Service checks having been carried out, which demonstrated that a robust recruitment and selection process had not always been followed.

5.2 We note that from your email on 27 October 2016 that the trust is redeveloping the corporate risk register and the CBU level risk registers are all going through the process of approval. You stated this was still work in progress and was due to be shared at the trust risk management steering group in a 'couple of weeks' time' and at the trust board in November. However, the new, updated corporate risk register dated 25 October and provided to us on 27 October 2016, does not accurately reflect the risks that failure to monitor, assess and mitigate the risks to patients that the lack of effective governance systems regarding the carrying on of regulated activities presents.

5.3 The trust was not aware of the level of risk regarding this issue until we raised this as an urgent concern.

5.4 The lack of awareness of the fundamental standards governing the appointment of staff within the trust, and the trust's failure to implement the requirements of the changes in regulations, demonstrates a significant failure to ensure effective governance systems are in place regarding the carrying on of the trust's regulated activities.

You are required to make the significant improvements identified above by 31 December 2016.

Please note: If you fail to comply with the above requirement and thereby make a 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 requiring Monitor, now known as NHS Improvement, to make an order under Section 65D(2) of the National Health Service Act 2006 (appointment of trust special administrator).

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

If you think that the notice has been wrongly served on you, you may make representations to us. This could be because you think the notice contains an error, is based on facts you consider to be inaccurate, that it should not have been served, or is an unreasonable response to the situation it describes. You may also make representations if you consider that for these or any other reason, the notice should not be more widely published.

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 MRR1-3000184665.

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 do get in touch, please make sure you quote our reference number MRR1-3000184665 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, Executive Regional Managing Director NHSI
Paul Watson, Regional Director, NHS England
Carole Dehghani, Chief Executive, Corby CCG
John Wardell, Accountable Officer, Nene CCG