West Hertfordshire Teaching Hospitals NHS Trust

Watford General Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at Watford General Hospital

Requires Improvement 

West Hertfordshire Hospitals NHS Trust provides acute hospital services for people living in west Hertfordshire and surrounding areas. The trust serves a population of around 388,493. Acute services are provided from three sites, St Albans city hospital, Hemel Hampstead General Hospital and Watford General hospital. The trust has 643 acute beds across the three sites (June 2021).

The maternity service based at Watford General hospital delivered 4,131 babies from April 2020 to March 2021. The trust provides a choice of three birth settings: homebirth, birthing centre or the consultant led delivery unit. The low-risk birthing unit was temporarily closed in June 2021 to release midwifery staff to support the consultant led delivery unit.

The service is provided by a team of consultant obstetricians who provide consultant presence on the delivery unit, supported by training grade doctors and midwives who work across the inpatient areas. Community maternity services are provided by seven teams of midwives. The maternity service has specialist midwives including a midwife who leads on bereavement and offers ongoing support to women and their partners who have suffered a pregnancy loss.

We carried out an unannounced focused inspection of the maternity service at Watford General Hospital on 13 October 2021, in response to maternity safety incidents. At the time of our inspection the service was operating under the COVID-19 infection prevention and control measures. During the inspection we followed the focused inspection methodology for maternity services.

Our rating of the maternity service went down. We rated it as requires improvement. See the Maternity section below for details.

Maternity

Requires Improvement  

Our rating of this service went down. We rated it as requires improvement because:

- Our rating for the safe key question stayed as requires improvement and our ratings for the effective and well-led key questions went down to requires improvement. Although many aspects of the service were good, where we find a breach of a regulation and we issue a Requirement Notice the rating linked to the area of the breach will normally be limited to 'requires improvement' at best. When we rate two or more key questions as requires improvement the overall rating for the service is normally limited to requires improvement.
- The service did not have enough staff to care for women and keep them safe and offer a full range of choice to women in the delivery environment.
- The service did not always control infection risk well, cleaning audits provided inconsistent levels of assurance of cleanliness and we found a build-up of grime on the windows in the delivery unit.
- Policy and guideline documents were not always reviewed in line with their review date.
- The average time from women requesting epidural pain relief in labour, to anaesthetist review was longer than 30 minutes.
- Managers did not always provide feedback about performance and support development during a timely annual appraisal process.
- The service did not have an established leadership team, with key managers acting in an interim capacity.
- Leaders did not always operate effective governance processes, throughout the service**.**
- Leaders did not always identify relevant risks and issues.

However:

- Staff had training in key skills, understood how to protect women from abuse, and managed safety well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. Staff worked as a team to deliver care to women despite the challenges they faced with the aged estate and staff vacancies.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women. Key services were available seven days a week. Staff provided good care and treatment and gave them pain relief when they needed it.
- Staff understood the service's vision and values. Staff felt respected, supported and valued. Staff worked as a team to maintain the safety of patients during staffing challenges. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.

Is the service safe?

Requires Improvement  

Our rating of safe stayed the same. We rated it as requires improvement.

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Medical and midwifery staff received and kept up to date with their mandatory training. Mandatory training data provided by the trust showed a completion rate of 93% against the trust's target of 90%. Staff had access to virtual teaching sessions online which were completed through two booked training sessions. Life support training was completed face to face in small groups to ensure staff were socially distanced.

The mandatory training was comprehensive and met the needs of women and staff. The service held monthly maternity educational days; trust board minutes demonstrate that 91% of staff had attended these training days which was above the target of 90%. The service also required staff to complete skills and drills training to plan for complex urgent deliveries. The overall compliance for staff completion of this training for all staff groups was 90% which had met the trusts target completion rate.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. The service had a guideline to follow for referrals to mental health services. Women living with learning disabilities or autism were referred to a specialist midwifery team during the appointment booking to ensure that those women had continuity of care.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training compliance was monitored well by managers, staff were prompted to book training to remain compliant with the trust target. Managers we spoke with confirmed they had booked the face-to-face training for all staff members, they told us that the training groups were smaller due to the need for social distancing of staff which meant there were delays in training completion.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Training data demonstrated that staff completed safeguarding training for adults and for children levels one, two and three.

The service had 100% completion rate for safeguarding children at level one and level three training. This was in line with the training matrix for maternity staff.

Medical staff received training specific for their role on how to recognise and report abuse. Training data demonstrated that staff completed safeguarding children level two and three to trust target. The completion rate for medical staff was 100% for both modules.

Both midwifery and medical staff were expected to complete safeguarding adults training level one, two and three. The training data from the trust showed that the combined completion rates were, 97%, 95% and 85% respectively. This meant that the completion rate for safeguarding adults level three was just below the trust target of 90%.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with understood how to identify any concerns about harassment and discrimination and named the safeguarding midwife, with whom they could discuss any concerns.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff completed training in safeguarding and knew how to apply this in practice. Staff could access support from the safeguarding midwife if they had concerns. The service had a continuity of care team that specialised in complex pregnancies, for example where there were known safeguarding and mental health concerns. The team also had a specialist mental health midwife.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had safeguarding policies in place for both adults and children. The service followed the local authority safeguarding processes to escalate any concerns. The policies and the local protocols were available through the trust intranet system.

Maternity services had additional policies in place for female genital mutilation (FGM), although the policy was outside the review date. Managers told us the policy had been updated, however, there were some required changes before board sign off.

Staff followed the baby abduction policy. The policy set out staff roles and responsibilities in the lockdown of the maternity department. The policy was within the review date of September 2023.The service had relocated the reception of the delivery unit and had airlock style doors. A receptionist was present at the unit entrance, 24 hours a day, seven days a week to prevent a baby abduction.

The trust had not undertaken a baby abduction drill since 2018. The trust had a multiagency drill booked for July 2021, however, this was cancelled due to service pressures. Another drill was scheduled to take place early in 2022.

Cleanliness, infection control and hygiene

The service did not always control infection risk well and the premises were not always visibly clean.

Ward areas were not always clean and well-maintained. The maternity service was clean and well maintained on the antenatal ward, the postnatal ward and within the antenatal clinic. However, we found a build-up of grime and mould around the windowsills of the delivery rooms on the delivery unit. Following the inspection, the trust advised that enhanced cleaning was taking place to clean the window casings.

The trust had detected legionella in the water system within the maternity block through their routine water testing programme. The trust had taken measures to treat and eradicate the waterborne bacteria. The maternity service had no detected cases of legionella in birthing pools from October 2020 to September 2021.

Staff completed additional cleaning of frequently touched surfaces, for example door handles, to reduce the spread of infections. We observed staff completing this cleaning and records we reviewed had been completed at the specified times without gaps.

The service prevented healthcare-associated infections well. The maternity service had no cases of C-Diff and one woman who developed MRSA within 28 days following care, from October 2020 to September 2021.

All women and their partners attending the antenatal and ultrasound clinics were required to undertake a COVID-19 lateral flow test at the entrance. These tests were conducted by hospital staff. All patients admitted to inpatients also took a test for COVID-19, if a positive test result was returned women were isolated in a room with ensuite toilet facilities to protect other women from exposure.

Cleaning records and cleaning audit results were inconsistent. Records we reviewed during the inspection demonstrated that staff had signed off the cleaning they had completed. However, cleanliness audits results were inconsistent from July to September 2021. The results ranged from 77% compliance to 100%. The service had an action plan in place to improve their compliance against the trusts board assurance framework for infection prevention and control.

The service generally performed well for cleanliness. The trust scored 8.8 out of 10 for cleanliness of rooms in the latest Care Quality Commission maternity survey in 2019.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff in all clinical areas we visited wore PPE appropriately while delivering care to women and disposed of the PPE correctly after use.

We observed staff decontaminated their hands before and after patient care. All staff wore uniforms with short sleeves to remain bare below the elbows for effective hand hygiene. All clinical areas had hand washing sinks and hand gel dispensers in staff and patient areas.

Clinical areas did not consistently monitor hand hygiene practices. We reviewed the hand hygiene audits for maternity inpatient audits from July to September 2021, which showed these were not conducted consistently every month in all clinical areas. Katherine ward was the only clinical area with a monthly hand hygiene audit return and they consistently score 100%. This meant that the service potentially missed opportunities to identify issues with hand hygiene and improve hand hygiene practices.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff clean clinical equipment and staff labelled equipment that was not in regular use.

Environment and equipment

The maternity building did not always meet the needs of the service.

The design of the environment did not always meet the needs of the service. The maternity service was challenged by the design and layout of the building infrastructure. Delivery rooms within the delivery unit were small with limited space for all the required equipment for deliveries. We raised concerns with the leadership team as the service had no monitoring in place for exhaled Entonox gas within the small rooms which had limited ventilation. At the end of the inspection managers had agreements from the estates team for the installation of an Entonox monitoring system in delivery rooms.

The maternity inpatient wards had limited toilets and showers. The water pressure on the delivery unit was poor which meant showers did not work effectively. This was impacted further by additional tap and shower attachments required for legionella prevention. The service had plans and funding in place to refurbish the bathroom facilities.

The delivery unit had one private room with en-suite toilet facilities which was allocated as the bereavement room prior to the COVID-19 pandemic. This room was used for women identified as COVID-19 positive. This meant that the bereaved women were placed in another side room with adjacent toilet facilities which limited their privacy.

The trust had plans for a new maternity building. Senior managers told us that the new maternity building was the priority once funding had been secured.

Maternity

The service did not always have suitable facilities to meet the needs of women's families. The rooms within the delivery unit had plastic chairs for birthing partners. The chairs were not comfortable where birth partners were seated for long periods of time. We raised this with senior managers who reported that they would source more comfortable chairs.

Women could reach call bells and staff responded quickly when called. Women we spoke with told us that staff responded promptly if they called for assistance. One woman we spoke with told us “Every time I’ve called them, they’ve been very quick to come.”

Staff did not always carry out daily safety checks of specialist equipment. We observed that staff completed daily safety checks of equipment on the delivery unit immediately after the morning handover at 8am. The birthing unit had been closed in June 2021 due to staffing shortages. Victoria Ward (antenatal) shared a resuscitation trolley with the birthing unit which had not been checked since the closure. We raised this with senior staff members as a concern. Records we reviewed showed that resuscitation trolleys in all other areas of the service had the required daily and weekly check completed without any gaps.

The service had enough suitable equipment to help them to safely care for women and babies. The service had a range of equipment to monitor women and their babies. Equipment we checked such as blood pressure machines and cardiotocography (CTG) machines were up to date with servicing and safety testing.

The delivery unit where women were admitted for consultant led deliveries had a centralised CTG monitoring system. This enabled midwives and medical teams to monitor fetal heart rates while providing privacy to labouring women.

Staff disposed of clinical waste safely. We observed that staff disposed of clinical waste including needles and domestic waste correctly. Staff ensured that all waste receptacles including sharps bins were not overfilled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Midwives completed risk assessments at the pregnancy booking appointment and streamed women to consultant led care if risks were identified. Clinicians reviewed the risk assessments during each appointment or care episode.

Maternity services had a day assessment unit in the antenatal outpatient department. The day unit completed fetal monitoring, routine pregnancy vaccinations and the administration of Anti-D injections. The day unit liaised with the delivery unit if there were any concerns about women at risk of deterioration. Outside of the day unit opening hours women contacted the delivery unit if they had concerns about reduced fetal movements.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The trust used Maternity Early Obstetric Warning System (MEOWS) to detect the deterioration during pregnancy, delivery and postnatal.

The service had implemented individual growth charts and the International Federation of Gynaecology and Obstetrics (FIGO) cardiotocography (CTG) assessment model for intrapartum fetal monitoring following external reviews into intrauterine deaths. Women’s records we reviewed demonstrated that staff completed growth charts at every antenatal appointment and staff completed the FIGO assessments for CTG monitoring when this was undertaken. The service had fresh eyes and ear initiative in place for peer review of CTG monitoring with stickers for staff to complete and attach to women’s records. We observed staff correctly completing this process in the antenatal day unit.

Maternity

Staff were required to complete additional training for their roles for fetal monitoring and gap and grow. The trust board papers for September 2021 demonstrate that 94% of midwives and medical staff had completed fetal monitoring training in August 2021 and 98% of staff had completed the gap and grow training.

Midwifery and medical staff had training to complete neonatal screening. The postnatal ward completed this screening six hours after the birth.

Staff completed risk assessments for each woman on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service had a triage assessment tool in place when women arrived on the delivery unit. This assessment denoted how long women waited for a full assessment from midwifery and medical staff.

Staff completed individual risk assessments on admission to the delivery unit. These included Venous Thromboembolism (VTE), which we saw staff had completed correctly in the medical records. Although, information about VTE risk was not always completed in the prescription records. Of the four prescription records we reviewed only one had completed VTE information.

Staff knew about and dealt with any specific risk issues. Staff completed regular clinical observations and risk assessments for women in pregnancy and in labour. This enabled staff to detect anomalies, sepsis and individual risks early.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The service had a specialist continuity of care midwifery team, this team was responsible for the care of complex pregnancies where due to mental health or safeguarding concerns. Staff had access to support

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff followed the local guideline in place for mental health referrals if staff were concerned that a woman had deteriorating mental health concerns.

Staff shared key information to keep women safe when handing over their care to others. Staff shared learning and key messages about safety critical incidents or issues within the environment during the handover process and again within safety huddles.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed midwifery and medical handovers, staff provided a comprehensive account of the care provided using the Situation, Background, Assessment and Recommendation (SBAR) model.

Maternity services had an escalation guideline in place for staff to follow in the event of a major incident or staffing shortages. The guideline was under review in line with the specified review date of September 2021.

Maternity theatres completed the World Health Organisation five steps to safer surgery checklists for all surgeries. Patient records we reviewed for women who had caesarean section deliveries demonstrated that staff had completed the checklist. The service completed monthly compliance audit of the completion of the five steps. We reviewed the audit results from December 2020 to September 2021 which demonstrated that the maternity theatres had met the trust's compliance target of 90% consistently.

Maternity

Midwife staffing

The service did not always have enough maternity staff to keep women safe from avoidable harm and provide a full choice to women about the delivery environment. Although, managers regularly reviewed and adjusted staffing levels and skill mix. Staff gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The trust had closed the midwife led birthing unit to ensure staffing numbers remained at safe levels on the delivery unit. However, this limited the choice for women with low-risk pregnancies as water births could not be facilitated within the hospital.

The trust had challenges with the recruitment of midwives due to the national shortage in this staff group. Managers had implemented initiatives to incentivise midwives to the trust with salary enhancement.

On the day of our inspection the delivery unit had three staff members fewer than planned. A staff member from Katherine Ward (postnatal) moved to the delivery unit for the shift.

The ward manager of Katherine ward supported staff and there was a calm atmosphere within the ward on the day of our inspection.

Victoria Ward (antenatal) was staffed by two trained midwives on the day of the inspection. Staff reported that they struggled to take breaks away from the ward. Staff we spoke with told us they were concerned as they could not provide optimum care, and something could be missed.

Managers accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift in accordance with national guidance. The service had reviewed staffing and used the BirthRate plus staffing tool. Staffing was also reviewed following the Ockenden report. This meant that the service needs were changed, and the service needed to recruit an additional 42 whole time equivalent midwives.

The ward manager could adjust staffing levels daily according to the needs of women. Managers discussed staffing at 9am every day they reviewed staffing for the day and the week ahead. On the day of our inspection the service was short of five midwifes against the planned numbers for the night shift. Managers were waiting for the agency to confirm the vacant shifts were filled. Staff moved between antenatal and postnatal wards and the delivery unit to meet the needs of the women in each area.

The service had high vacancy rates. The maternity service had a vacancy rate of 17% across all clinical areas in August 2021. The service had 36 whole time equivalent vacancies for midwifery staff. The service had employed 13 newly qualified midwives in September 2021, these new starters were waiting for their confirmation of their registration.

The service had high turnover rates. The turnover rate for midwifery staff was 16.5%. Managers and staff we spoke with told us that newly qualified midwives recruited were attracted by pay and development opportunities offered by the nearby London hospitals. Staff also told us that staff had left due to the impact of the high vacancy rate and that the staffing pressures meant that pace of work was unsustainable.

The service had low short-term sickness rates. The short-term sickness rate for maternity services was 3.3%. However, the long-term sickness rate was 7.2%, some of the staff that were off due to long-term sickness had developed long COVID which was impacting on the sickness rates.

The number of midwives and healthcare assistants did not always match the planned numbers. On the day of inspection, the delivery unit were three midwifes short from the expected number, a midwife was moved from Katherine ward (postnatal) which left a deficit of one midwife.

The service had high rates of bank and agency staff. Agency and bank staff covered 52,703 hours of vacant midwifery staff shifts for the 12 months preceding our inspection. Data provided by the trust for staffing in August 2021 demonstrated bank staff accounted for 15% of staffing costs and agency 2.8%.

Managers used bank and agency staff and requested staff familiar with the service. Managers we spoke with, told us that they requested agency staff that were familiar with the service when shifts were allocated to agencies. The service had regular bank staff who had completed a full orientation to the service.

Managers made sure all bank and agency staff had a full induction and understood the service. The service used regular agency and bank staff and booked shifts in advance. All bank staff completed a full trust and local induction. Agency staff had a local induction to the clinical area which was documented. We spoke with a member of bank staff member, they confirmed that they had completed a full trust induction and a local induction for each clinical area they worked on.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. The service employed 19.6 whole time equivalent obstetric consultants in May 2021. Consultants held ward rounds every day supported by junior medical staff.

The medical staff matched the planned number. The medical rotas we reviewed showed that all medical staff shifts were either covered by the allocated doctor or a locum doctor.

The service had low vacancy rates for medical staff. Medical rotas we reviewed confirmed that the service had one registrar vacancy.

Sickness rates for medical staff were low. The service covered any sickness or annual leave internally or fill vacant shifts with locum or bank staff. Medical rotas we reviewed confirmed this.

The service had low rates of bank and locum staff. Medical rotas we reviewed demonstrated this.

Managers could access locums when they needed additional medical staff. The service used locum and bank doctors to cover vacant shifts. Rotas we reviewed clearly showed that all shifts for medical staff were filled. The consultant team covered on-call and duties for annual leave and sickness. The service did not fill consultant shifts with locums.

Managers made sure locums had a full induction to the service before they started work. The trust required all locum staff to provide a completed and signed local induction form at the end of their first shift in each clinical area.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Consultants completed rounds seven days a week and were supported by a team of speciality registrars and junior doctors. Two registrars worked at night to cover maternity and gynaecology supported by junior doctors.

The service always had a consultant on call during evenings and weekends. The service had recruited additional consultants to ensure that a consultant was on site 24 hours a day Monday to Friday with plans to increase consultant presence onsite at weekends. Consultants worked to an on-call rota at times when a consultant was not onsite.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive and all staff could access them easily. We reviewed eight sets of maternity records, all records were completed fully with a summary for each care episode both in the community and within the hospital. This meant that information about women accessing care was available to staff.

When women transferred to a new team, there were no delays in staff accessing their records. Women had handheld records which they took to all clinical appointments or when accessing care from other services.

Records were stored securely. Women's records were stored securely in staff areas of the clinical areas within keypad protected record trolleys.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service used paper medicine administration records for women in hospital. Prescription records we reviewed were not always completed with all patient information including patient weight correctly. Although staff had administered medicines in line with the prescription.

Staff completed medicine administration records, which showed when medicines had been given. However, staff had not recorded patients' weights or risk of developing a blood clot on all records. Prescribing staff would therefore have to look through other records for this information.

Staff followed current national practice to check women had the correct medicines. The trust had correctly completed Patient Group Directives (PGDs) for the administration of vaccines such as flu and whooping cough. Staff who administered these medicines had completed the training and signed documentation within the PGDs. Vaccinations were documented correctly within women's handheld notes.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff stored medicines correctly, within secure medicines storage rooms and locked cupboards and medicines fridges. Staff monitored room temperatures and fridge temperatures daily, records we review confirmed this. Staff stored prescription records with women's records in secure trolleys.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Managers provided information about safety alerts and incidents within maternity services during handovers and safety huddles. We observed the handover process on the delivery unit where staff highlighted key messages including safety alerts.

Maternity

Decision-making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. A review of women's records and prescription records demonstrated that all medicines prescribed and administered were appropriate to women's needs.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them although, they did always apply the right harm grading. Staff we spoke with knew how and what types of incidents to report through the trust's electronic reporting systems. Although, managers within the service were in the process of re-educating staff in the harm grading of incidents. This meant the trust may have missed opportunities to identify learning in a timely way.

Incident reporting data demonstrated that managers had oversight of staffing challenges and the impact this had on the care provided to women. The service monitored red events in conjunction with staffing within the BirthRate plus acuity tool. In September 2021 the service reported eleven red flag incidents attributed to staffing. Four of these incidents reported were about delays between the presentation of women and the time to triage.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Managers we spoke with told us that staff reported incidents in line with trust policy, a review of incidents reported by staff confirmed this.

The service had one never event on the delivery unit. Managers shared learning about never events with their staff and across the trust. The incident in March 2021 was for retained foreign object post procedure. Managers had investigated the incident and shared learning with staff to prevent similar incidents in the future.

Managers shared learning with their staff about never events that happened elsewhere. The service linked with the local maternity network to share learning. Managers shared learning with staff during handovers and safety huddles.

Staff reported serious incidents clearly and in line with trust policy. From 27 September 2020 to 26 September 2021 the trust reported 15 serious incidents. Four of these were as a result of harm reviews where the incidents had been regraded. One incident primarily occurred at another hospital; the trust was asked to carry out the investigation.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff we spoke with understood their responsibility with the duty of candour. The trust had made changes to the risk and governance team within maternity services. The risk and governance team had reviewed and regraded incidents where harm had occurred and completed the duty of candour process with women. The risk and governance lead told us that the regraded harms were not a result of staff failures but a recognition that harm had occurred with third and fourth-degree tears and post-partum haemorrhage over 1.5 litres.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with confirmed that managers provided feedback about incidents they had reported. Staff could request feedback through the electronic incident reporting system.

Maternity

Staff met to discuss the feedback and look at improvements to patient care. Managers met every two days to review incidents reported by staff. This process also incorporated a harm level review and assessment against the serious incident framework.

There was evidence that changes had been made as a result of feedback. The service had implemented a customised fetal growth chart and a new process for the interpretation of CTG monitoring. Senior managers implemented the changes as a result of external serious incidents investigations. Staff had completed training in these processes and patient records we reviewed evidenced these practices were part of business as usual.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. In October 2021 the service had 14 moderate harm incidents under investigation. One of the incidents occurred in January 2021.

We reviewed investigation reports for twelve serious incidents which occurred from January 2020 to September 2021. Records associated with the investigations demonstrated that staff had involved women and their families in the investigations and held meeting to explain the outcome of the investigation. Each of the investigations had action plans for service improvement and learning.

Safety Thermometer

Managers monitored safety information about the service.

The service monitored the NHS maternity service dashboard in conjunction with perinatal quality surveillance model for safety and outcomes for women using the service.

Managers discussed the NHS maternity service digital dashboard with the trust board champions. The dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement.

The clinical areas within maternity service did not always display safety, quality and performance information visibly for women and their families to review. We observed that wards did not always display this information including the delivery unit.

Is the service effective?

Requires Improvement  

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Policies and guideline were not always reviewed in a timely way.

Maternity

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. care was delivered broadly in line with national guidance. Although we found that 26 out of 69 guidelines and policies specific to maternity were outside their review dates. We saw guidance documents which were due for review in 2016, these included the clinical guideline for outpatient induction of labour by midwives and supporting parents guideline.

The service had processes in place to monitor women with reduced fetal movements. Staff in the day assessment unit assessed women referred with concerns about reduced fetal movements. Outside the open hours of the day assessment unit women attended the delivery unit for assessment.

The service had a specialist clinic for women at risk of gestational diabetes. Women attended for glucose tolerance tests to identify gestational diabetes. Women with diabetes during pregnancy were referred to the specialist diabetes midwife.

Staff assessed fetal growth and plotted the growth of fundal height from 24 weeks gestation. This was in line with national guidance.

The service had audits in place to monitor Local Standards for invasive procedures (LocSSIP) for instrumental deliveries, episiotomy and trauma to the genital tract. In April 2021 the departmental governance meeting minutes evidence that the staff compliance rate with the LocSSIP was 90%.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Women with complex mental health and safeguarding concerns received care from a specialist continuity of care teams which had expertise to support these women and linked with other services.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Women received pain relief soon after requesting it.Patients told us they were offered pain relief regularly throughout the day and staff responded quickly when they made requests for pain relief overnight.

Staff prescribed, administered and recorded pain relief accurately. Medicine records we reviewed demonstrated that pain relief except for epidural pain relief, had been prescribed and administered in a timely way on women's request by midwifery staff.

Women were able to request epidural pain relief during their labour. However, the average time for anaesthetist review was over 30 minutes. The time to complete the procedure and for the pain relief to take effect was 40 minutes, this meant that some women waited over an hour for effective pain relief in labour. The trust had recognised that the time for anaesthetist review need to be improved.

Patient outcomes

Staff monitored the effectiveness of care and treatment. Where performance was not at expected levels, they used the findings to make improvements.

The service participated in relevant national clinical audits. Outcomes for women were not always positive, consistent and met expectations, such as national standards. The service participated in national audit programmes such as MBRRACE and the maternity dashboard.

Maternity

Information from the maternity dashboard July 2020 to June 2021, demonstrated that the trust performed better the national average for babies born prematurely, babies with the first feed of breast milk, babies born with an Appearance, Pulse, Grimace, Activity, and Respiration (APGAR) between 0 and 6 and Robson groups 1 that had a caesarean section delivery.

There was a decline in the trust's performance against the vaginal delivery rate following a previous caesarean section measure.

The trust performed worse than the national average for women in Robson group 2 that had a caesarean section delivery, the number of women that sustained third and fourth degree tears during delivery and the number of women that had a post-partum haemorrhage over 1,500mls. The Robson tool is World Health Organisation advised tool for delivery classification.

The trust had started to implement the continuity of carer standards and had two teams in place. Managers had to suspend plans to increase the continuity of carer teams due to staffing challenges. The maternity dashboard indicates that the trust had passed the requirement for women with a continuity of carer by gestation of 28 weeks. However, the trust had failed in the measure for ongoing continuity of carer.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. The service had an action plan in place following the MBRRACE recommendations for saving lives, improving mothers' care. The action plan had deadlines for completed actions and a name staff member responsible for the oversight of the required action.

Managers and staff used the results to improve women's outcomes. The risk and governance team had regraded incidents and were in the process of educating staff of the correct harm grading of incidents following audit outcomes. The service had also increased the number of obstetricians to provide senior clinical input to the care of women with complex deliveries. This was aligned to the service vision and strategy.

The service was in the process of reviewing the programme of internal audit to ensure that audit data provided meaningful trust board assurance against performance and outcomes.

The service demonstrated compliance with NHS resolution maternity safety actions. The trust had submitted a compliance return for the ten requirements.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. An example of this was the completion of risk assessments such as Venous Thromboembolism (VTE) and the actions taken to prevent VTE if risks were identified. With further audits planned to follow the implementation electronic patients records and prescribing.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance in a timely way, to provide support and development.

Managers did not always have opportunities to identify any training needs their staff to develop their skills and knowledge. Midwifery staff did not always receive a timely annual appraisal. The appraisal rate for midwifery staff was

80% which was under the trust target of 90%. We saw those areas with the greatest staffing challenges low rates for appraisals such as the delivery unit (68%). This meant that staff did not always have an opportunity to discuss training needs and performance. One of the ward managers was off work long-term which meant there was limited oversight of staff performance and limited identification of any poor practice.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers made sure staff received any specialist training for their role. Staff that cared for women had a programme of required training in addition to mandatory training requirements. Medical and midwifery staff groups had completed this training as reported in the safe section of the report. This formed part of the core competency framework for all clinical staff employed by maternity services.

Managers gave all new staff a full induction tailored to their role before they started work. All newly qualified midwives completed a preceptorship programme to gain skills and experience within their role. All bank staff had to complete a full trust induction programme and a local induction for each clinical area they worked in.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical trainees had a programme of supervised practice dependent on their experience. Junior doctors on rotation within maternity services had an allocated consultant supervisor to support and competency sign off. The appraisal rate for medical staff was 100% which exceeded the trust's target of 90%.

The clinical educators supported the learning and development needs of staff. The service had a practice development midwife who worked with staff who required additional supported to complete core competencies. The service also had access to clinical educators to ensure staff remained up to date with basic life support and neonatal life support skills.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service had suspended team meetings due to the COVID-19 pandemic, however, ward managers had plans in place to reinstate these meetings.

All student and newly qualified midwives had an allocated mentor for the sign off of their required competencies.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Midwifery staff had the opportunity to complete training to conduct new-born checks before discharge from hospital. Data provided by the trust demonstrated that 53 midwives had completed this training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service had specialist clinics held in conjunction with maternity. The service held weekly anaesthetic clinics follow recommendations made by the Ockendon report, alongside established working between specialities such as diabetes, partner mental health organisations and safeguarding teams.

Midwifery and medical staff worked well together and supported each other in the care of women and their babies. The service had established mortality and morbidity meetings for staff to discuss complex pregnancies and deliveries

Maternity

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked with partner organisations within the local maternity network, including safeguarding teams and mental health services.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women are reviewed by consultants depending on the care pathway. Consultants held daily ward rounds within all clinical inpatient areas of the service. The service had increased the number of obstetrics and gynaecology consultants to provide 24-hour consultant presence on site Monday to Friday. The service was in the process of reviewing consultant rota for the weekend. Although there was always access to a consultant on-call.

Maternity services had a 24-hour a day, 7 days a week maternity triage for women to contact if they experienced changes in fetal movements or vaginal bleeding. Information about the triage service was easily accessible through the trust's website.

Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week. The service had access to diagnostic imaging, pharmacists and pathology services 24-hours a day, 7 days a week to provide timely diagnosis and treatment.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, some key leaders worked in an interim capacity.

Managers understood the challenges of the service. All of the managers we spoke with stated that staffing was their biggest challenge. The service was supported by the trust's chief nurse to implement changes which were required.

The service had representation on the trust board. The divisional director for the service represented maternity within the trust board. They championed innovations and issues affecting care and the staff team.

The service had a wealth of specialist midwives and matrons, a high proportion of the vacancies were ward-based midwives. The senior managers for the service had implemented strategies to recruit more midwives. The staff numbers were impacted with the publication of the Ockendon report, with additional staff required for the service.

Managers we spoke with were proud of their staff, how they had supported each other through the COVID-19 Pandemic and the on-going staffing challenges.

Maternity

Staff we spoke with felt the service leaders and managers were supportive and they felt able to approach the leadership team about service delivery issues or personal concerns.

However, the service did not have an established leadership team, with key roles such as the director of midwifery and the head of midwifery acting in an interim capacity. There was a substantive deputy director of midwifery to support the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision to provide high quality safe maternity care to women and their families. The current strategy had a focus on the infrastructure and environment where maternity was delivered.

The long-term plan was for a new building for maternity services. The trust had gained approval for the new building, but they were waiting for the funding to be allocated. In the interim the service had a business case approved for the upgrade of bathroom facilities in the maternity building.

The service had recruited five additional consultants to improve consultant presence on-site. The delivery unit also had a centralised system to monitor cardiotocography (CTG), which demonstrated progress against the strategy in place. However, the service still had challenges with the recruitment and retention of midwifery staff.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with confirmed that they felt encouraged and supported to raise concerns and action was taken when they raised concerns.

All staff we spoke with told us that maternity was a close-knit team, staff supported each other at difficult times for example through the height of the COVID-19 pandemic. Staff worked as a team to deliver care to women despite the challenges they faced with the aged estate and staff vacancies.

The morale of midwifery staff was low due to the staffing pressures. Some of the midwives we spoke with were unhappy that the salary incentives offered to attract midwives was not offered to existing staff. They reported that some of the newly qualified midwives had a higher salary than experienced staff.

The trust had a freedom to speak up guardian, information provided by the trust showed that five concerns were raised by staff. None of the concerns raised with the freedom to speak up guardian related to safety.

Governance

Leaders did not always operate effective governance processes, throughout the service.

Maternity

The service did not have a permanent director of midwifery or head of midwifery. These posts were held by staff acting in an interim capacity. This had impacted on the leadership of midwifery and the oversight of governance such as policy and guidance documents, a third of which were beyond the review date. We also found gaps in the governance oversight for equipment checking following the closure of the midwife led birthing unit, which managers had not identified prior the inspection.

The service had a governance structure in place which set out managers' roles and responsibilities. However, we found one example where staff we spoke with were not always clear about where to raise concerns. The ward manager for Victoria ward had been away from work due to long-term sickness and staff were unsure who was responsible for oversight of the ward in their absence.

The service held a range of meetings to share learning and monitor performance with senior and middle managers. However, most of the ward meetings had been suspended due to the COVID-19 pandemic due difficulty of maintaining social distancing and staffing challenges. Although staff received key messages during handovers and safety huddles.

Maternity service was part of the division for women and children, service performance, safety and quality fed into the divisional board and to the trust board. The clinical lead for maternity had trust board membership and actively championed issues and improvements for maternity.

Management of risk, issues and performance

Leaders did not always identify relevant risks and issues.

The divisional leadership team had not identified the risks associated with small delivery rooms with limited or no ventilation and the use of Entonox gas for prolonged periods of time. Although the service risk register had a high risk for the building infrastructure, there were no entries related to the use of Entonox gases or any actions to mitigate the risks.

The service had a high risk for the building infrastructure, this included the limited ability for staff to isolate COVID-19 positive women due to the lack of side rooms. The risk also related to the number of bathrooms and issues with the water pressure. The trust had immediate plans to improve bathroom facilities and a longer-term plan for a new building for maternity services.

We found a third of the policy and guideline documents specific to maternity were outside their review date. Managers had identified the backlog in policy and guidance document reviews and the service had an action plan in place to update documents outside of their review date. The departmental meeting minutes from September 2021 reported that 45 documents had been published, 13 documents were awaiting senior review and eight were in the process of review.

The maternity service had 21 risks on the risk register. All of this risk entries had a risk owner and a review date. Managers stated that staffing and the building infrastructure were the highest risks for the service. The service was severely challenged due to staffing shortfalls, although managers monitored safety and had taken actions to mitigate risks with the closure of the midwife led birthing unit, this had limited delivery choices for women with low risk pregnancies. The midwifery leadership was in an interim capacity which had an impact on the proactive recruitment strategy for midwifery staff.

The divisional governance meeting minutes from May 2021 to September 2021 demonstrate that managers discussed safety, risk and performance against internal and external compliance measures. Managers completed reports for the trust board following the divisional governance meetings.

Managers had rolling agendas for divisional and service level meetings which included performance against national audits and guidance as well as safety and quality measures set locally. Departmental governance meeting minutes from April 2021 attribute the staffing position to the reduction in breast feeding rates and home birth rates.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers demonstrated that they understood the performance of the maternity service which included women's and staff views, safety and risks. Managers had a framework to oversee the quality and safety of patient care, which included the maternity dashboard.

The service used paper records and managed these records securely while women were in hospital. The trust was due to move to electronic patient records at the end of 2021. However, managers within maternity services had identified that the electronic records did not meet the needs of the service and were exploring suitable alternative electronic records to ensure that the data quality met the needs for reporting internally and externally.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers communicated important messages to staff through safety huddles, handovers and through the monthly risky business newsletter.

The service had mechanisms to received feedback from women. Managers had reinstated the friends and family test in August 2021, maternity services scored over 90% for all measures.

The service lower staff satisfaction results for the 2020 NHS staff survey, when compared to comparator trusts. Managers had implemented changes to service following externally facilitated staff mediation.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had safety champions in all clinical areas of maternity services. Safety champions had regular meetings and discussed topics related incidents and assurance measures.

The service had implemented a centralised fetal monitoring system on the delivery unit. The system enabled the delivery unit co-ordinator and medical teams' oversight of all fetal monitoring on the unit and the technology allowed staff to review the monitoring history and identify anomalies.

The service had increased the number of obstetric consultants to provide additional consultant presence on site. This meant that the trust had exceeded the RCOG recommendations for consultant hours.

Maternity

Areas for improvement

MUSTS

Watford General Hospital – Maternity service

- The trust must ensure that the maternity wards are clean, and the delivery rooms have monitoring in place for Entonox levels. (Regulation 12(1)(2)).
- The trust must ensure that there are enough midwives to provide a safe service for women and does not limit their choice of the delivery environment. (Regulation 12(1)(2); 18(2)).
- The trust must ensure that policy and guidance documents are reviewed in line with the review date. (Regulation 17(1)(2)).

SHOULDS

Watford General Hospital – Maternity service

- The trust should consider how they display safety, quality and performance data to inform women and their families about the service.
- The trust should consider manager oversight where ward managers are absent, to monitor equipment checking and staff wellbeing.
- The trust should ensure that women are reviewed by an anesthetist within 30 minutes of requesting epidural pain relief.
- The trust should ensure that all staff participate in the annual appraisal process.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, CQC team inspector and a specialist advisor who was a senior midwife. The inspection team was overseen by Philippa Styles, Interim Head of Hospital Inspection.