West Hertfordshire Hospitals NHS Trust

Watford General Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

West Hertfordshire Hospitals NHS Trust provides acute healthcare services to a core catchment population of approximately half a million people living in west Hertfordshire and the surrounding area. The trust also provides a range of more specialist services to a wider population, serving residents of North London, Bedfordshire, Buckinghamshire and East Hertfordshire.

This was the second comprehensive inspection of the trust the first taking place in April and May 2015. It was rated as inadequate overall and went into special measures in September 2015.

Part of the inspection was announced taking place between 6 and 9 September 2016 during which time the hospitals that make up the trust, Watford General Hospital, St Albans Hospital and Hemel Hempstead Hospital were all inspected. Unannounced inspections were undertaken of Watford Hospital and Hemel Hempstead on the 19 September 2016.

We have rated Watford General Hospital as requires improvement overall. Medicine, emergency services, critical care, maternity and gynaecology and end of life care were all rated inadequate in September 2015. Emergency services remain inadequate, however, all, except critical care, maternity and gynaecology services and end of life care, which have now been rated good, have been rated as requires improvement. This means all these services, except emergency services and services for children and young people, have improved and provide a better service to their patients. There was one outstanding rating, caring within children and young people's services.

Our key findings were as follows:

- Most staff were aware of their roles and responsibilities in the management and reporting of incidents, however this was not consistent in all areas of the hospital. The hospital had a lower rate of incidents compared to the national average. This can be an indicator that not all incidents are being reported. In addition, feedback from incidents and evidence of learning from them was inconsistent throughout the hospital.
- Duty of candour was poorly known amongst most trust staff and there was limited evidence that it had been applied routinely.
- There had been one never event which occurred in the maternity service. A root cause analysis had been undertaken and there was evidence of learning from this event and actions taken to mitigate future risk.
- There were effective safeguarding procedures in place for both adults and children. Staff had received appropriate training, in most departments. However, not all who dealt with children and young people were trained to level three, which is the expected standard.
- Patients did not have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. There was no trust database relating to the total number of patients, the expiry of initial authorisation or the date of external assessment. This meant that patients were potentially being deprived of their liberty without appropriate authorisation made. Locally, some wards had understanding of those patients who were being cared for under a deprivation of liberty safeguard (DoLS). In addition, the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form did not prompt staff to complete a capacity assessment as part of the decision making process.
- Provision for patients who had a mental health problem was poor in the emergency department.
- The trust was making improvements to the organisation of outpatient clinics. However, clinics still frequently over-ran and some patients told us they had experienced long delays. The length of time patients waited to be seen was not monitored. The trust's patient administration system had no facility for recording when patients were seen and the information was not collected manually.
- There was a notable culture of acceptance regarding the waiting time breaches in the emergency department with many relating to time to see a clinical decision maker or receive treatment from a doctor. This had improved at the unannounced inspection.

Summary of findings

- The percentage of patients discharged, admitted or transferred within four hours was consistently around 83%, against a target if 95%.
- The number of ambulance handover delays over 30 minutes totalled 2,535, putting the trust in the top quartile of all trusts in England. Between November 2015 and August 2016, the trust has had 2107 black breaches.
- The percentage of patients leaving the department before being seen was higher, at 6.5%, than the England average of 3%.
- The percentage of emergency admissions via A&E waiting from four to 12 hours from the decision to be admitted ranged from 12% to 44% against the England average of 8%.
- Referral to treatment performance had been improving since the last inspection, and exceeding the target for some clinics. However, due to poor performance in certain clinics only 86% of patients met this target from May 2016 to September 2016.
- Data for September 2016 showed that the trust had fallen below the national 93% target that all suspected cancers should be referred to a consultant and seen within two weeks; only 89.4% of patients were seen within this time period. For breast cancer, for the year to date only 76% patients had been seen within two weeks.
- The Five Steps to Safer Surgery checklist were not consistently used; there was a mixture of five and three step processes in operation.
- The management and storage of medications was not always safe. There was varied practice regarding the safe management and storage of patients own controlled drugs. Treatment room temperatures consistently exceeded recommended temperatures.
- Staffing levels were below the trust targets. Mandatory training compliance did not meet the trust target of 90% in all subjects, including basic life support. Not all staff had received an annual performance appraisal. This was a concern we raised in our previous report.
- Although we saw that all departments appeared to be clean, Patient-led assessments of the care environment (PLACE) audits for cleanliness and privacy and dignity were below the England average. We found that there was some poor practice around privacy and dignity in outpatients.
- The Intensive Care National Audit and Research Centre (ICNARC) results 2016 showed the critical care unit had a higher than national average for delayed discharges of 14% compared to the national average of 5%. The trust was in the worst 5% of units for this element. On occasions the unit was unable to admit or discharge patients due to the unavailability of beds. This resulted in single sex breaches. Patients could be nursed in theatre recovery for over 10 hours whilst waiting for a bed either in the critical care unit (CCU) or on the ward. We found that patients experienced multiple moves within admission areas, and were frequently transferred between areas overnight.
- Patients told us that the care they received was good and that they felt safe and in most departments. We saw patients were treated with dignity, respect. During our inspection the weather was hot; we saw that in most departments there was no provision for ensuring patients received extra fluids during this time.
- Staff had undergone sepsis training and were able to recognise and treat sepsis according to national guidelines.
- The numbers of MRSA, Methicillin Sensitive Staphylococcus Aureus (MSSA), and Clostridium difficile, reported between June 2015 and May 2016 were lower than the England average. Between June 2015 and June 2016 there were low numbers and prevalence rates of pressure ulcers, falls with harm and catheter acquired urinary tract infections reported.
- The children's emergency department was outstanding in terms of environment. Children and young people had a dedicated resuscitation area away from the adult department, which was set up with equipment and medicines for children. The medicines storage and management of medicines in the children's emergency department was exemplary.
- Relationships between staff, patients and relatives were strong, caring and supportive. Staff regularly went above and beyond for the children and young people who used their services and valued their emotional wellbeing
- Staff treated all patients with kindness, dignity and respect. All patients and their carers that we spoke with told us that staff were kind, caring and included them in the planning of care and treatment.

Summary of findings

- Patients moving from children's services to adult services were prepared in advance for the transition by individual specialist consultants and nurses.
- Nursing staff completed local induction training when they joined the outpatient department. We saw the training programme which included training on the use of equipment within the department and a medicines competency assessment. Induction programmes were developed to meet the needs of different staff groups for example for trained nurses and healthcare assistants.

We saw an area of outstanding practice in the children's emergency department where children were seen promptly.

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

Importantly, the trust MUST:

- Ensure that care for patients with mental health issues in the emergency department is safe by ensuring that they are cared for in a safe environment, that their safety is risk assessed, and that staff are suitably trained to meet their needs, as well as keep staff safe from harm.
- Ensure governance quality systems, including the reporting of incidents, duty of candour, completion of local audits, learning from incidents and complaints and ensuring the risk register is up to date.
- Ensure that observations of patients who could be acutely unwell are undertaken in a timely way and escalated as required.
- Ensure the timely completion of patient records.
- Ensure that patients who have been in the emergency department for more than six hours are reviewed by a senior clinician and are risk assessed.
- Ensure that there is a provision for the offering of regular drinks to patients during their time in the emergency department.
- Ensure that there are appropriate systems in place to track the patients and the expiry of those being treated under a deprivation of liberty safeguards.
- Ensure that staff completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms where a person lacks capacity to make an informed decision or give consent act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that all staff caring for patients less than 18 years of age has completed safeguarding level 3 training.
- Ensure the safe management of medicines at the hospital complies with Home Office 2016 guidelines on the security of controlled medicines. This includes patients' own medication.
- Ensure that there are procedures in place for the safe management of temperatures within treatment rooms and areas where temperature sensitive medications are stored.
- Prescriptions for syringe pumps must comply with the trust's prescribing standards.
- Ensure that mandatory training compliance meets trust targets of 90%, including blood transfusion training.
- Devise an action plan to address the shortfall between appraisal rates and the trust target and make sure that the trust target is reached.
- Ensure staff in outpatients comply with the trust's hand hygiene policies.
- Ensure treatment rooms where invasive procedures take place are clean.
- To improve the percentage of patients to be seen within 18 weeks of referral from a GP for an outpatient appointment.
- To improve the percentage of patients waiting to see a consultant with a suspected cancer to meet the national target of 93%.

Action the hospital SHOULD take to improve

- Review the arrangements for the collection of blood samples from the emergency department.
- Provide training to staff in dementia awareness, learning disabilities and complex needs.

Summary of findings

- Review the escalation plan for the emergency department and make this effective in practice.
- Review staff training and knowledge on the Mental Capacity Act and DoLS.
- Review ambulance offload and handover times in the emergency department.
- Limited numbers of staff in the emergency department had been trained in safe breakaway. No staff members had received training in ethical control and restraint. Consider increasing the number of staff in the emergency department who have been trained in safe breakaway, and in ethical control and restraint.
- Consider learning and outcomes from complaints.
- Consider developing a vision and strategy for the future of the emergency department.
- Consider lack of staff engagement across the emergency department and work towards improving this.
- Reduce the number of patient moves out of hours within admissions and ward areas.
- Consider undertaking a risk assessment in relation to the lack of a dirty utility area in the emergency surgical admissions unit.
- Review processes and practice so that venous thromboembolism risk assessments are consistently completed and repeated according to trust policy and that the proforma used to complete assessments is fit for purpose.
- Consider further training for staff around Deprivation of Liberty safeguards to ensure that all staff are aware of when it is appropriate to consider an application to meet patients' needs and protect their rights when necessary.
- Review processes so that patients are discharged from the critical care unit (CCU) within four hours of the decision to discharge to improve the access and flow of patients within CCU.
- Consider how to meet the needs of patient requiring admission to CCU at all times.
- Review the microbiologist input to the ward rounds on CCU to review patients care daily, in line with the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- Take actions to reduce the incidence of single sex breaches in CCU.
- Review procedures and practice so that all medicines are administered and documented in accordance with trust policy and national standards.
- Review the process for obtaining tablets for patients to take home to reduce high volumes being received in pharmacy during the afternoon which they are unable to action in a timely manner.
- Review procedures and practice so that modified obstetric early warning score observation charts are completed and acted on in accordance with trust policy.
- Take the required actions to meet the 62 day referral to treatment time for patients with suspected gynaecological cancers.
- Review the consultant cover in palliative care staffing levels. The consultant cover in palliative care staffing levels were below the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.
- Within end of life care, the service should collect effective information on the percentage of patients who were discharged to their preferred place within 24 hours.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	• Duty of candour was not evidenced by the service. Blood samples were not being routinely collected and taken to the laboratory for testing. We found that records were not always thoroughly completed. • The mental health room was located in the main area of the department. The room had been risk assessed in June 2016 for the risk of ligatures and patient self-harm. • Training records provided showed that 0% of doctors had received conflict resolution training. Limited numbers of staff in the department had been trained in safe breakaway. • The deployment of medical staff throughout the medical department did not ensure that the skill mix was safe in all areas of the department. • There was a clear protocol for staff to follow with regards to the management of sepsis. • Fluid rounds and drinks provision for patients had not increased despite the warm temperatures in the department. Pain levels were not routinely scored or monitored. There was a lack of local audit activity in the service. Not all medical staff could articulate Mental Capacity Act or Deprivation of Liberty Safeguard requirements. No training was provided in dementia awareness. Staff had not received training in understanding learning disabilities and complex needs • The percentage of patients leaving the department before being seen was higher, at 6.5%, than the England average of 3%. The percentage of emergency admissions via A&E waiting four to 12 hours from the decision to admit ranged from 12% to 44%, against the England average of 8%.. Learning and outcomes from complaints were not widely known throughout the department. • There was a lack of vision, robust strategy or direction for the emergency department. There was a poor culture noted amongst some of the medical staff which was impacting on the safe

Summary of findings

running, and communication within the department. This culture and behaviours witnessed, disempowered the nursing staff and lowered staff morale. However during the unannounced visit we observed that the culture of nursing staff had improved and nurses were being empowered to make positive changes.

However we also found that:

- During our unannounced inspection, we noted that improvements had been made to the assessment 'pit stop' process and there were no longer delays in assessment.
- There was a notable culture of acceptance regarding the breaches in waiting times. However, during our unannounced inspection we noted that there had been a change in levels of acceptance of breaches, and the number of breaches had reduced. The four hour performance for the department had also improved.
- The time patients waited to see a doctor was too long consistently during the inspection, despite a full rota of medical staff. However, we found that this had improved significantly during our unannounced inspection.
- The escalation plan did not work during our inspection because staff did not accelerate the situation within the department in a timely way. However, during our unannounced inspection we observed that a formal process had been put in place for escalating department risks and we observed this being used effectively by nursing staff.
- We were concerned that the resuscitation department was frequently left without sufficient senior clinical oversight during times when the department was busy. During the unannounced inspection, we found that one consultant or senior clinician was based in this area.
- The children's emergency department was outstanding in terms of environment. Children and young people had a dedicated resuscitation area away from the adult department, which was set up with equipment and medicines for children and young people up to the age of 16

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years. The medicines storage and management of medicines in the children's emergency department was exemplary. Staffing levels within the adult and children's department were at a safe establishment level. Policies and pathways were written in line with the National Institute for Health and Care Excellence (Nice) and Royal College of Emergency Medicine (RCEM) guidelines. The service took part in all national audits. Excellent MDT working was observed.

- We received feedback on site where the majority of service users shared positive experiences of using the service. The friends and family test results were consistently above the England average. The children's department had a range of distraction methods and sensory items to support the individual needs of children whilst they had treatment. Children could watch films, play with toys or play on a games system to support them during their time in the department.

Medical care (including older people's care)

Requires improvement

- The service did not have an overview of the number of patients who were cared for under a deprivation of liberty safeguards authorisation. This included no trust database relating to the total number of patients, or the expiry of initial authorisation or the date of external assessment. This meant that patients were potentially being deprived of their liberty without appropriate authorisation.
- The management and storage of medications was not always safe. There was varied practice regarding the safe management and storage of patients own controlled drugs, and treatment room temperatures consistently exceeded recommended temperatures. There was limited evidence to support actions taken to address elevated temperatures.
- Mandatory training compliance did not meet the trust target of 90% in all subjects including basic life support, which meant that patients might be at risk when appropriately trained staff were not on duty.

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- When there were insufficient side rooms available, patients with confirmed MRSA were nursed in shared bays, in line with trust policy. However, systems were in place to reduce the risk of cross infection.
- The service had variable performance in national audits, and did not have action plans in place to address service results in the National Diabetes Inpatient Audit (NaDIA), Sentinel Stroke National Audit Programme, Heart Failure Audit or the National Lung Cancer Audit.
- Patients experienced multiple moves within admission areas, and were frequently transferred between areas overnight.

However we also found:

- There had been a number of positive changes to improve the safe delivery care and treatment within medical services since our last inspection.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) figures were better than expected.
- The service had an established seven-day working across the service which included dietitians, pharmacy and therapy staff.
- Staff were aware of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty safeguards (DoLS). Staff demonstrated awareness of their roles and responsibilities in escalating concerns and preventing harm and accurately recorded assessments and rationales for decisions made. Locally, wards had understanding of those patients who were being cared for under a deprivation of liberty safeguard (DoLS).
- Patients were treated with dignity, respect and kindness during interactions with all staff.
- Nursing staff utilised support networks for patients with emotional or mental health issues and completed joint ward rounds to ensure that all aspects of the patient's physical and mental health were addressed during reviews.
- Data collected through patient satisfaction audits was generally positive and regularly shared within teams.

Summary of findings

- Non-medical wards used to care for medical patients at times of high activity used admission criteria to ensure patients' needs could be met. The exception of this was the gynaecology and surgical wards, where patients admitted were identified as clinically stable by medical staff prior to transfer.
- The service worked collaboratively with local authorities and agencies to assist with patient pathways through hospital and discharge.
- Staff had assisted with the development of the trust vision. This was also reflected within the service aims and objectives.
- There were robust systems in place to identify and manage risk and risk registers were reviewed and updated regularly. There was clear escalation processes with reporting between ward, service and trust board. All staff demonstrated good knowledge of local risks.
- The service had a robust audit calendar in place and regularly monitored and benchmarked performance to ensure practice was safe and within trust and national targets.
- Nursing and medical staff were positive about the teams they worked in and the services they provided. Staff felt supported and encouraged to develop themselves and services.

Surgery

Requires improvement

- Not all staff received feedback after reporting incidents
- There was no separate recovery area in theatres for children and young people.
- Not all staff involved in the assessment, treatment, and care of children and young people had received the appropriate level of safeguarding children training.
- Theatre five had a scrub area that was not compliant with Department of Health, Health Building note guidance HBN 26 (2004).
- The emergency surgical admissions unit (ESAU) did not have a dirty utility area.
- Venous thromboembolism (VTE) assessments were being completed on admission, but not consistently repeated in line with best practice.

Summary of findings

- Junior nursing staff we spoke with were not able to explain when a Deprivation of Liberty Safeguard (DoLS) application was appropriate.
- Staff were unaware of the trust vision and strategic objectives.
- The Five Steps to Safer Surgery checklist were not consistently used; there was a mixture of five and three step processes in operation.

However we also found that :

- All policies were current and followed the appropriate guidelines, such as National Institute for Health and Care Excellence (NICE).
- Staff understood the importance of reporting incidents and had awareness of the duty of candour process. The team meeting minutes reviewed shared learning from incidents.
- The environment was visibly clean and staff followed infection control policies.
- Patient notes had documented risk assessments undertaken.
- There were competency frameworks for staff who worked in all surgical areas.
- Patients told us staff requested their consent to procedures and records seen demonstrated clear evidence of informed consent.
- The hospital had a nurse led pre-assessment clinic, which provided choice to patients regarding their appointments.
- There was a sense of pride amongst staff working in the hospital.
- The service recognised the views of patients and carers.
- Staff working within the service felt supported by their managers
- Ward sisters had access to leadership programmes.
- Patients told us that the care they received was good and that they felt safe.

Critical care

Good

- Staff were encouraged to report incidents and were confident in reporting incidents and were aware of the importance of duty of candour.
- There was access to appropriate equipment to provide safe care and treatment.

Summary of findings

- The environment was visibly clean and staff followed the trust policy on infection control practices.
- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls and actions were taken. Staff were aware of safeguarding procedures to keep patients safe.
- Medical staffing was appropriate and there was good emergency cover. Care was consultant led.
- Nursing and medical handovers were well structured.
- Safe staffing levels were being achieved by the use of bank and agency staff.
- Staff had completed their mandatory training.
- Policies and procedures were accessible, and staff were aware of the relevant information. Care was delivered in line with best practice guidelines.
- Patients' pain, nutrition and hydration was appropriately managed.
- Care bundles (evidence-based procedures) were in place for the use of ventilators and central lines.
- Patients in the unit were screened for delirium using a recognised screening tool.
- A practice development nurse was in post.
- Staff had awareness of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).
- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect. Patients spoke highly of the care they had received.
- Between June 2015 and May 2016, the trusts Friends and Family Test, were consistently above 95% for each month.
- Patients were kept up-to-date with their condition and how they were progressing and people were aware of how to make complaints.
- The unit offered a monthly coffee, cake and chat session for relatives past and present to meet medical, nursing and allied professionals.
- There were appropriate arrangements for meeting the needs of people who may not have English as their first language.

Summary of findings

- Staff were aware of the ICNARC data and some information was displayed on staff noticeboards.
- Strong leadership, commitment and support were evident.
- A strong supportive teamwork and culture was evident within the unit with improved communication between divisions.

However, we also found that:

- Staff caring for young people aged 16 to 18 years of age were not always trained to level 3 in safeguarding children. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014).
- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database and indicators were generally similar to other units apart from delayed discharged which was higher than the average.
- The ICNARC results 2016 showed the unit had a higher than national average for delayed discharges of 14% compared to the national average of 5%. The trust was in the worst 5% of units for this element. On occasions the unit was unable to admit or discharge patients due to the unavailability of beds within the trust, which resulted in single sex breaches. Patients could be nursed in theatre recovery for over 10 hours whilst waiting for a bed either in the critical care unit (CCU) or on the ward
- Although this was highlighted on the CCU and trust risk register, there was no evidence that an effective plan was in place to address this.
- A microbiologist did not visit the unit during the inspection period.
- The safety of medication management was not always maintained.
- The trust's clinical strategy 2016-2020 did not include any specific reference to critical care.

Maternity and gynaecology

Good

Overall, we rated the maternity and gynaecology service as good for effective, caring, responsive and well-led and requires improvement for safe. The service was judged to be good overall because:

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- Staff were confident to report incidents and there was a robust governance and risk management framework in place to ensure incidents were investigated and reviewed in a timely way. Learning from incidents was cascaded to staff and actions were taken to minimise risks and prevent incidents from reoccurring. This was an improvement from our previous inspection in April 2015.
- Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff understood their responsibilities and were confident to raise concerns. A dedicated team of midwives had been established to provide support, care and treatment to vulnerable women.
- Medical, nurse and midwifery staffing levels and skill mix were planned, implemented and reviewed regularly. Despite high levels of midwifery staff vacancies, staffing levels were sufficient to protect people's safety. Bank and agency staff were used to ensure staffing needs were met. However, staffing levels was the most cited reason for stress and low morale amongst staff and remained the service's biggest risk. The trust were taking action to address staffing vacancies.
- Consultant cover was in line with national guidance. Access to medical support was available seven days a week throughout the service.
- The service regularly monitored and reviewed performance against locally agreed standards, which were in line with national recommendations. Actions were taken to investigate and address issues related to performance.
- We saw effective multidisciplinary working across the service.
- Feedback about the service was largely positive. Patients were treated with dignity, respect and kindness. Staff cared about the services they provided and spoke positively about improvements that had been made since our previous inspection.

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- The service had introduced a gynaecology ambulatory care unit, which reduced the demand for beds on the gynaecology ward.
- Perinatal mental health services had been developed to ensure women with complex mental health needs received sensitive and appropriate care. Combined obstetric and psychiatric run clinics were available and a public event was held to publicise the importance of mental health care and raise awareness in the wider local community.
- Governance arrangements were effective and there was a clearly defined strategy and governance structure in place.
- Leadership was knowledgeable about quality issues and priorities, understood the challenges and were taking action to address them. The service was well represented at board level and leadership within the service was strong, supportive and visible.

However, we also found:

- Medicines were not always managed and stored safely. Medicines in the anaesthetic room were not always stored securely, which meant there was a risk they could be removed by unauthorised persons and staff would be unaware. Patients own controlled drugs were not handled in a way to ensure they were safe and secure and there were inadequate controls in place to prevent misuse. Furthermore, the treatment rooms where medicines were stored consistently exceeded recommended temperatures. The trust was taking action to address this.
- Mandatory and midwifery specific training compliance did not meet the trust target of 95% in all topics covered, including adult basic life support and only 7% of midwifery staff were compliant with blood transfusion training. This meant there was a risk that staff did not have up-to-date knowledge in order to protect patients, visitors and staff from potential harm.

Summary of findings

- Not all staff had received an annual performance appraisal. This was a concern we raised in our previous report.
- We were unable to determine how effective the service was in delivering care and treatment in line with national guidance because the majority of planned audits were outstanding at the time of our inspection. However, an effective framework had been established to ensure policies and guidelines were reviewed to reflect current national guidance.
- The normal (non-assisted) delivery rate was 54%, which is lower than the England average of 60%. However, the elective caesarean section rate was 11%, which is in line with the England average.
- The service did not meet the 85% standard for patients with suspected gynaecological cancer who commenced treatment within 62 days following urgent GP referral. However, the service did meet the target for patients on an incomplete pathway who waited less than 18 weeks to start treatment.

Services for children and young people

Requires improvement

Overall we rated the services for children and young people as requires improvement because:

- Incidents were reported inconsistently. The service did not ensure that staff complied with the policy and procedure for reporting incidents.
- Not all staff were involved in debriefing session outcomes.
- Information flows were not always robust.
- Feedback was mixed from staff as to whether incident reporting was encouraged. Whilst some doctors and nurses saw the value of raising concerns, some were afraid or discouraged from raising concerns and felt they may be blamed when reporting incidents.
- The service cancelled some governance meetings. Staff who could not attend did not always receive minutes from these meetings.
- There was a significant division of staff concerning opinion and practice within the

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neonatal unit. Some staff felt this might have had an impact on patient care. An external thematic review of this had been commissioned by the service.

- There were gaps in management and support arrangements for staff, such as appraisal and professional development. Not all nursing staff were up to date with their appraisals.
- Not all nursing and medical staff were up to date with mandatory training.
- Patients who showed signs of deterioration were not always escalated to a senior nurse or doctor as recommended in the trust guidelines.
- There was not a paediatric safety thermometer in use.
- There were high numbers of cancellations of outpatient appointments for children especially in epilepsy and cardiology.
- The neonatal unit lacked sufficient space to operate in accordance with current guidelines.

However, we also found:

- Staff provided skilled and competent patient centred care.
- Staff treated all patients with kindness, dignity and respect. All patients and their carers that we spoke with told us that staff were kind, caring and included them in the planning of care and treatment.
- A carer support team was in place that supported carers and patients' families. Regular activities were arranged for patients. Play therapists were an important part of the ward team ensuring that nervous patients or those with additional needs received the support required.
- Staff regularly went 'above and beyond' to provide individualised care for patients. In feedback from patients and carers, we saw that consultants: "Always listen well, explain difficult information clearly and care very professionally".
- Nurse leaders and matrons were highly visible, approachable and fully engaged with providing patient centred, excellent care.

Summary of findings

- Staff knew how to report safeguarding concerns.
- Nursing staff knew how to report incidents and understood their responsibilities in reporting incidents and near misses.
- Nursing staff shared lessons learned in a variety of ways. Individual nurses were sensitively supported with their learning, skills and development where required, following incidents.
- Staff understood about risk and risk assessments, which were generally thorough and updated frequently. Discussions about risk at multi-disciplinary team meetings were detailed and individualised.
- Patients had their care assessed, planned and delivered in a clear and consistent way. Patient records we checked were accurate and up to date. Nursing staff had completed care plans and assessments. There was regular and well documented monitoring of symptoms and pain in patients.
- Information technology was used to access results and x-rays. Safeguarding information was available to the specialist safeguarding nurses via a community based electronic records system.
- The environment and equipment were visibly clean, well maintained and serviced. Environmental checks were done regularly. Beds and side rooms were thoroughly checked, cleaned and stocked between every patient.
- Doctors and nurses were all compliant with “arms bare below the elbow” policy and hand hygiene. There were adequate places to wash hands and apply hand gel.
- Starfish and Safari wards shared a playroom and adolescents’ room, which were attractively designed and well equipped.
- Staffing levels were safe for the number and acuity of patients. There were effective measures in place to ensure that when there was increased activity staff numbers increased. Medical staff had the relevant experience, skills

and qualifications to care for and treat patients. There were practice development nurses in post to identify and deliver individual and service wide training needs.
- Medicines and drugs were stored, prescribed and administered safely. There was a paediatric pharmacist in post.
- Staff received specialist and mandatory training to enable them to fulfil their roles effectively.
- There was effective multidisciplinary team (MDT) working. This included pharmacists, mental health services, dietitians, safeguarding services, physiotherapists and occupational therapists. MDT working was effective both internally and with partners in other trusts and organisations.
- Patients moving from children's services to adult services were prepared in advance for the transition by individual specialist consultants and nurses.
- The service was planning development of specialist services including diabetes, epilepsy, oncology and gynaecology.
- There was a clear governance structure in place; detailed responsibilities were documented in the governance policies that covered both the trust and the service.
- There was participation in both local and national audit. Audit was routinely used to monitor, inform and develop practice.

End of life care

Good

We rated end of life care services as good for safe, caring, responsive and well led and requires improvement for effective. We found that:

- Staff within the end of life care service understood their responsibilities for ensuring patients were protected from the risk of harm. The service had systems in place to recognise and minimise patient risk. There was evidence that learning from incidents had been implemented within the service.

Summary of findings

- The trust had safety precautions and systems in place to prevent and protect patients and staff from a healthcare-associated infection. Trust infection control guidelines were up to date and reflected national guidance.
- There were sufficient SPCT CNS at Watford hospital. The staffing levels were above National Institute of Clinical Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.
- The service carried out an audit on preferred place of death for patients known to SPCT. The service used the audit to evaluate the quality of the information collated in the care plan and tailored training needs.
- The trust had a replacement for the Liverpool care pathway called individualised care plans for the dying person (ICPDP). The ICPDP was embedded on all wards across the trust.
- The SPCT provided seven-day face-to-face access to specialist palliative care.
- Patients were supported and treated with dignity and respect.
- Feedback from patients and those close to them was positive about the way staff treated people.
- The service was collecting information on the percentage of patients who died in their preferred location. 82% of patients had died in their preferred place of death.
- There was joint working between the SPCT and the medical teams at the hospital to support non-cancer patients.
- The hospital had leaflets available for example coping with dying and procedures to be undertaken after the death of a patient for relatives or friends.The leaflets were available in a number of different languages and formats.

Summary of findings

- A chaplaincy team provided spiritual and pastoral care and religious support for patients, relatives and staff across the trust.
- There had been no complaints about end of life care from July 2015 to July 2016.
- The trust had executive and non-executive board representatives for end of life care that provided representation and accountability for end of life care at board level.
- The trust had a three-year end of life care strategy; the strategy was presented to the trust board in July 2016. The strategy was realistic to achieve the priorities and delivering good quality care.

However:

- Patients did not have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. There was no formal mental capacity assessment of the patient's ability to understand this decision. The DNACPR form did not prompt staff to complete a capacity assessment as part of the decision making process.
- The temperatures of treatment rooms where medicines were stored were consistently above the recommended storage temperature of 25°C and the trust were not following their own policy of reducing the expiry dates of medicines in line with the increased temperatures.
- When medicines were prescribed to patients, who required them to be administered via a syringe pump the prescription did not always include an infusion solution (diluent) either on the prescription or on the administration records.
- There was sufficient consultant in palliative care provision at the trust. The consultant in palliative care staffing levels met the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in

Summary of findings

Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.

- Bereaved relatives' views and experiences were gathered through the trust's bereavement questionnaire. The service used these views to shape and improve the end of life care service. However, the response rate was low at 10%.

Outpatients and diagnostic imaging

Requires improvement

- At our previous inspection in 2015 we found that patients' records were not securely stored in the cardiology and ophthalmology outpatient departments which meant there was a risk of unauthorised access to personal, clinical information or of clinical information being lost. At this inspection we found patient records were securely stored in lockable cupboards in cardiology and lockable trolleys in the ophthalmology clinic areas.
- Outpatient services had responded to many of the environmental issues identified at our previous inspection. Work was underway to provide new accommodation for cardiac patients and a new reception area had been built in the ophthalmology reception and waiting area.
- Two treatment rooms in the dermatology department were not clean and the air conditioning in both rooms had not been working for some time. Staff were unable to evidence any progress on resolving this.
- Nursing staff in outpatients were not auditing staff compliance with good hand hygiene practice and we did not see staff routinely using hand sanitisation gels in the ophthalmology outpatient department.
- Endoscopes were cleaned before each use in the outpatient department. However, the equipment was not returned to the endoscopy department for checking and cleaning at the end of the clinic in line with best practice, as described in Health Technical memorandum 01-06 (HTM 01-06) Guidance on the Management and Decontamination of Flexible Endoscopes.

Summary of findings

- Treatment rooms in the ophthalmology outpatient department were fitted with locks during our inspection. However, we observed one door which led to a room where intraocular injections were being administered, was propped open, and there were no signs on the door to indicate when a patient was receiving treatment.
- The system in place for maintaining medical equipment was not effective. Staff described frustration about equipment being not being adequately maintained.
- Patients' records were not always available for clinics. The trust was monitoring the situation and there had been an improvement since our last inspection. Information provided by the trust indicated that 94% of notes were available for clinics; however staff told us notes were often not available or arrived late.
- There was a 25% vacancy rate for nursing staff in the main outpatient department and the turnover rate was 17% which was considerably higher than the other sites in the trust. The trust's target for staff turnover was 12%.
- Guidance had been developed for radiology staff to administer a medicine (Hyoscine Butylbromide) prior to treatment without a prescription. A patient group direction was in place (PGD). This meant that radiographers were aware of the risks and contraindications, when patients should not be given the medication as it could cause them harm.
- PGDs were in place for nurses in the ophthalmology department who were able to administer medicines without a doctor's prescription.
- There was evidence that staff were following national clinical guidelines and participating in national audits.
- Nursing staff completed local induction training when they joined the outpatient department. We saw the training programme which included training on the use of equipment within the department and a medicines competency

assessment. Induction programmes were developed to meet the needs of different staff groups for example for trained nurses and healthcare assistants.

- Clinic letters provided patients with very little information about the clinics or what to expect. Patients told us they would have appreciated more information about the clinic and about the difficulty parking, which many patients found frustrating.
- Nursing staff told us there were good working relationships amongst the nurses but working relationships between medical and nursing staff was not always effective. They described how the poor communication culture meant they could not pass information on to patients if, for example, the clinic was running late.

However, we also found that:

- Some services, for example, the diabetic service, had developed joint clinics with partners in primary care to support women who had developed diabetes in pregnancy. There were other examples of combined working in renal clinics and links with podiatry services. The service used videoconferencing to provide virtual clinics with community partners.
- The trust was making improvements to the organisation of outpatient clinics. However, clinics still frequently over-ran and some patients told us they had experienced long delays. The length of time patients waited to be seen was not monitored. The trust's patient administration system had no facility for recording when patients were seen and the information was not collected manually.
- During our previous inspection in March 2015, we found that clinics were being cancelled at short notice. This was still happening, although staff told us that the clinical divisions were getting better at providing medical cover. The trust's overall target for cancelled clinics was 8% and was 5% for clinics cancelled with less than six weeks' notice. The overall cancellation rate for clinics had peaked in April 2016 at 14% which was a 3% increase on the mean of 11% over the

Summary of findings

previous 12 months. This improved in June 2016 reducing to 11%. The number of clinics cancelled at short notice had also improved to 3.9% in June 2016.

- Staff told us communication between the clinics, consultants and their secretaries was poor and described examples of patients arriving for clinics that staff knew nothing about. In addition, clinics were cancelled at the last minute because there was no medical cover in place.
- Data for September 2016 showed that the trust had fallen below the national 93% target that all suspected cancers should be referred to a consultant and seen within two weeks; only 89.4% of patients were seen within this time period. For breast cancer, for the year to date only 76% patients had been seen within two weeks.
- Diagnostic imaging waiting times were good. The standard set by the trust was that 99% of patients referred for 15 diagnostic tests for example, ultrasound or a CT scan should wait no longer than six weeks. This standard, which was better than the national position of 98.2%, had been reached since April 2015.
- A comprehensive information dashboard which included a range of performance indicators was under development but had not been rolled out for clinical and managerial use. Operational managers within the outpatient department were aware the information dashboard was being developed but were not aware of what this meant for the service.
- There was a management structure in place. Responsibility for outpatients was shared between the clinical divisions and the outpatient department. Staff were not clear who they reported to.
- In radiology, staff told us medical staff and radiography staff worked well together. Staff spoke highly of their managers.
- The trust recognised the need to make improvements to outpatient services and had set up an improvement programme which had achieved some positive changes.

Watford General Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people;End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Watford General Hospital

Watford General Hospital is at the heart of the trust's acute emergency services - the core location for inpatient emergency care, and for all patients who need the specialist emergency facilities (such as intensive care) of a major district general hospital. It also provides elective care for higher risk patients together with a full range of outpatient and diagnostic services. There are approximately 600 beds and nine theatres (including one minor operations theatre).

Watford is also the focus of the trust's women's and children's services, including neonatal care.

The Trust's maternity service is amongst the largest in south-east England, with almost 6000 deliveries per annum. A £750k investment in maternity services has delivered an increase in capacity, with a new six bedded transitional care unit (step up and down from the Special Care Baby Unit) for mothers and babies; three extra delivery beds; two antenatal beds; and four additional triage beds.

Watford General Hospital is about a 15 minute walk from Watford's town centre.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Specialist adviser

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included 15 CQC inspectors, two CQC pharmacy inspectors and a variety of specialists: safeguarding lead, consultants and nurses from accident and emergency departments, medicine and surgical services, senior managers, an anaesthetist, senior paediatric nurses and a neonatal consultant, a consultant obstetrician, midwife, allied health professionals and a palliative care consultant.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

Before visiting, we reviewed a range of information we held about West Hertfordshire Hospitals NHS Trust and asked other organisations to share what they knew about the trust. These included the clinical commissioning group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Health Watch.

We set up a display near the restaurant at Watford Hospital and at St Albans Hospital to encourage and ask people to share their views and experiences of services provided by West Hertfordshire NHS Trust. Some people also shared their experience by email, telephone or completing comment cards.

We carried out this inspection as part of our comprehensive programme of re-visiting trusts which are in special measures. We undertook an announced inspection from 6 to 9 September 2016 2016 and unannounced inspection on 19 September 2016.

We talked with patients and staff from all the ward areas and outpatients departments.

Facts and data about Watford General Hospital

Watford General Hospital is part of West Hertfordshire Hospitals NHS Trust. It has 608 beds.

Watford has a population of about 120,000. It is ranked 220 out of 326 in the English Indices of Deprivation Rankings. However it is worse than the English average for statutory homelessness, acute sexually transmitted infections and winter deaths.

Overall in 2015/16 the trust had 94,530 inpatient admissions, 454,558 outpatient attendances and 88,673 attendances at emergency department at Watford General Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	☆ Outstanding	Good	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

West Hertfordshire Hospitals NHS Trust serves the population of West Hertfordshire. The trust also provides wider specialist services to North London, East Hertfordshire, Buckinghamshire and Bedfordshire. The population served is mainly affluent, though there is some notable poverty and homelessness.

The adult emergency department saw 88,673 patients in 2015/16. The paediatric emergency department was responsible for seeing and treating approximately 25% of these patients. The emergency department (ED) was originally built for 30,000 attendances but is currently seeing in excess of 88,000 attenders per year. At 22.2%, the trust admits more patients than the England average of 21.6%. Bed occupancy is consistently around 90% making admissions within four hours challenging.

During our inspection, we spoke with nine patients and five relatives in the adult department. We also spoke with three parents and one child in the children's department. We examined the records of 30 patients. We spoke with 18 members of staff including doctors, nurses, support staff and administration staff. We spoke with four paramedics and two hospital ambulance liaison officers (HALOs) from the local ambulance trust. We also spoke with the clinical and operational leaders of the service.

Summary of findings

We have rated the urgent and emergency services at Watford General Hospital as inadequate overall. Safe, responsive and well led have been rated as inadequate. Effective has been rated as requires improvement and caring has been rated as good.

We found:

- Duty of candour was not evidenced by the service. There was no information that duty of candour had been applied and no information was kept with the electronic incident reporting system.
- In the main resuscitation area, we found that blood samples were not being routinely collected and taken to the laboratory for testing. The longest a sample had been waiting was over 14 hours.
- Records were not always completed thoroughly.
- The mental health room was located in the main area of the department. The room had been risk assessed in June 2016 for the risk of ligatures and patient self-harm.
- There was no formal assessment for patients to determine where in the department they would be physically safest until the mental health team arrived to provide them with support, or treatment for their conditions.
- Training records provided showed that 0% of doctors had received conflict resolution (CRT) training. Limited numbers of staff in the department had been trained in safe breakaway. No staff members had received training in ethical control and restraint.

Urgent and emergency services

- Advanced life support for adults training rates were low with 5% of nurses and 71% of doctors trained.
- The deployment of medical staff throughout the medical department did not ensure that the skill mix deployed was safe in all areas of the department.
- There was a clear protocol for staff to follow with regards to the management of sepsis. The department had introduced the 'Sepsis Six,' interventions to treat patients, however we were informed that this was still work in progress because the service was not yet following all six steps.
- Fluid rounds and drinks provision for patients had not increased despite the warm temperatures in the department.
- Pain levels were not routinely scored or monitored.
- There was a lack of local audit activity in the service, which meant that opportunities for learning were missed.
- Not all medical staff could explain the Mental Capacity Act or Deprivation of Liberty Safeguard requirements.
- The percentage of patients leaving the department before being seen was higher, at 6.5%, than the England average of 3%.
- The percentage of emergency admissions via A&E waiting four to 12 hours from the decision to admit ranged from 12% to 44% against the England average of 8%.
- Staff had not received training in understanding learning disabilities and complex needs. No training was provided in dementia awareness, and there were no plans or consideration for dementia needs in the department or in the clinical decision unit.
- Learning and outcomes from complaints were not widely known throughout the department.
- There was a lack of vision, robust strategy or direction for the emergency department. Staff we spoke with across the adult department were not aware of any strategy or vision for the service.
- There was a poor culture noted amongst some of the medical staff, which was impacting on the safe running, and communication within the department. This culture and behaviours witnessed disempowered the nursing staff and lowered staff morale. However during the unannounced visit we observed that the culture of nursing staff had improved and nurses were being empowered to make positive changes.

However:

- We observed the trust system for triaging ambulance arrivals. This was known a 'pit stop'. When the service was busy, the system resulted in delays for patients' first assessment or treatment by a clinician. However, during our unannounced inspection we noted that improvements had been made and there were no longer delays in assessment.
- There was a notable culture of acceptance regarding the breaches in waiting times. Opportunities for immediate improvements in performance against this standard had been missed. However, during our unannounced inspection we noted that there had been a change in accepting long waits for treatment. The number of breaches had reduced and four hour performance for the department had improved.
- Time to see a doctor was consistently too long, despite a full rota of medical staff during the inspection. However, we found that this had improved significantly during our unannounced inspection.
- The escalation plan did not work during our inspection because staff did not accelerate the situation within the department in a timely way. However, during our unannounced inspection we observed that there was a formal process for escalating department risks and we observed this being used effectively by nursing staff.
- We were concerned that the resuscitation department was frequently left without sufficient senior clinical oversight during times when the department was busy. However, during the unannounced inspection we found that one consultant or senior clinician was now based in this area.
- The children's emergency department was outstanding in terms of environment. Children and young people had a dedicated resuscitation area away from the adult department, which was set up with equipment and medicines for children and young people up to the age of 16 years.

Urgent and emergency services

- The medicines storage and management of medicines in the children's emergency department was exemplary.
- The children's observation bay was dedicated only for children requiring clinical interventions and some overnight stays. The area was separate to the adult department and well suited to children.
- Staffing levels within the adult and children's department were at a safe establishment level.
- We noted that the use of the major incident store had improved since our last inspection.
- All nurses working in the children's emergency department were registered nurses (child branch).
- The service took part in all national audits.
- There was a gynaecology pathway for the trust, which meant that women who miscarry or suffer an ectopic pregnancy received organised care and treatment.
- Pain was assessed on arrival and levels of pain for children were checked at stages throughout the child's time in the children's emergency department.
- Excellent multidisciplinary working was observed with acute medical services, stroke services, intensive care, children's services and the elderly frail unit.
- Policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.
- The feedback received from patients was positive. We received feedback on site where the majority shared positive experiences of using the service.
- The friends and family test results were consistently above the England average.
- Staff in the children's department were trained to support children with learning disabilities and complex needs.
- The children's department had a range of distraction methods and sensory items to support the individual needs for children whilst they had treatment. Children could watch films, play with toys or play on a games system to support them during their time in the department.

The department routinely screened for dementia, in patients over the age of 75 years.

Are urgent and emergency services safe?

Inadequate

We have rated the safety of urgent and emergency services at Watford General Hospital as Inadequate because:

- Duty of candour was not evidenced by the service. There was no information that duty of candour had taken place and no information was kept within the electronic incident reporting system with regards to this.
- There were bays in the main adult area, which could not be observed and in Bay 2A, there was no emergency bell, or call bell for the patient. A patient was in this bay on several occasions during our inspection, which meant that they could not call for help if required.
- In the main resuscitation area, we found that blood samples were not being routinely collected and taken to the laboratory for testing. The longest a sample had been there was over 14 hours. This could have compromised the integrity of the blood samples or potentially delayed care to the patient.
- Records were not always completed thoroughly. We reviewed the records of 12 patients who were admitted and awaiting beds on wards. Of those 12, we found gaps in the records of nine of these patients.
- Waiting time to see a doctor was too long consistently, during the inspection, despite a full rota of medical staff. On the Wednesday during our inspection, 42 of 69 breaches were related to patients not seeing a doctor in a timely way (seen within two hours and a decision within three hours according to the trust system). Delays in care presented a risk of harm to the patients. However, we found that this had improved significantly during our unannounced inspection.
- Between November 2015 and August 2016, the trust has had 2107 black breaches.
- The number of ambulance handover delays over 30 minutes totalled 2,535 putting the trust in the top quartile of all trusts in England.
- The number of ambulances who had to wait to hand their patient over to the department for over 60 minutes

had increased since October 2015, rising to 977 at its highest in March 2016. An average of 75% of all ambulances that attended the department were on site for more than 30 minutes.

- The mental health room was located in the main area of the department. The room had been risk assessed in June 2016 for ligature points and potential for patients to self-harm. We identified two ligature points, a live three point electrical socket, and a fluorescent light that could be used by a patient to self-harm.
- The emergency alarm in the mental health room was not working. We were informed by the service leads that staff were required to take the alarm into the room with them. At no time when we observed staff members entering the room did we see them take a personal alarm in with them. This placed staff at risk of harm.
- There was no formal procedure for asking people or checking their property where a person presented following self-harming. There was no formal assessment for patients to determine where in the department they would be physically safest until the mental health team arrived to provide them with support, or treatment for their conditions.
- Staff within the department had not received any specific or detailed training in dealing, identifying or managing patients with mental health conditions or mental health anxiety. Training records provided showed that 0% of doctors had received conflict resolution (CRT) training. Limited numbers of staff in the department had been trained in safe breakaway. No staff members had received training in ethical control and restraint.
- Advanced life support for adults training rates were low with 5% of nurses and 71% of doctors trained.
- The skill mix of medical staff throughout the department was unsatisfactory and did not ensure safe staffing levels of the appropriate seniority in all areas.

However:

- We observed the trust system for triaging ambulance arrivals. This was known a 'pit stop'. When the service was busy, the system resulted in delays for patients' first assessment or treatment by a clinician. However, during our unannounced inspection we noted that improvements had been made and there were no longer delays in assessment.
- The escalation plan did not work during our inspection because staff did not accelerate any situation within the department in a timely way. However, during our unannounced inspection we observed that a formal process had been put in place for escalating department risks and we observed this being used effectively by nursing staff.
- We were concerned that the resuscitation department was frequently left without sufficient senior clinical oversight during times when the department was busy. However, during the unannounced visit we found that one consultant or senior clinician was based in this area.
- The children's emergency department was outstanding in terms of environment. Children and young people had a dedicated resuscitation area away from the adult department, which was set up with equipment and medicines for children and young people up to the age of 16 years.
- The medicines storage and management of medicines in the children's emergency department was exemplary.
- The children's observation bay was dedicated only for children requiring clinical interventions and some overnight stays. The area was separate to the adult department and well suited to children. The set up and design of the children's emergency department as an environment to children was outstanding.
- Five consultants covered the rota for the children's emergency department, which was positive, as these doctors were dedicated to emergency medical care for children.
- Staffing levels within the adult and children's department were at a safe establishment level. We noted that the use of the major incident store had improved since our last inspection.
- The store was clean, organised and regularly checked by staff.

All nurses working in the children's emergency department were registered nurses (child branch).

Incidents

- The unscheduled care directorate reported 2820 incidents between 1 April 2016 and 31 May 2016. However, this was not broken down by service type. The directorate comprised of emergency care, the urgent care centre, minor injuries unit, ambulatory care, elderly frail unit, and acute medical unit.

- No never events had been reported. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Six serious incidents had been reported between July 2015 and June 2016. Three were related to diagnosis, one related to medicines management, and one related to a pressure ulcer.
- Information about incidents and learning from incidents was displayed on the notice board within the main adult department. We spoke with four nurses and three doctors about incidents reported, and any learning from incidents they could share with us. None of the staff we spoke with could recall an incident that had been reported or share any learning from a reported incident. No staff, except the managers, we spoke with were aware of any serious incidents that had been reported or learning that had resulted from them.
- Mortality and morbidity meetings took place every month; however minutes of these were not routinely recorded. We asked to see the minutes for the last six months and we were informed that only three months had been recorded in minutes. Of the minutes we examined, each case had been appropriately discussed and reviewed.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was no information that duty of candour had taken place and no information was kept with the trust's electronic reporting system to collect and report such information.
- Duty of candour was not evidenced by the service. Although they had developed a process to monitor this. We were not assured the requirements of duty of candour were being adhered to by the service. Two of the seven staff we spoke with about incidents, aside from the managers, were able to explain what duty of candour was and when it would be needed.
- We were not assured that the service was reporting all incidents when they occurred. During our inspection, we identified three clinical incidents, which had not been reported. For example, a patient had sustained a fall in the clinical decision unit (CDU). The incident had not been reported for 12 hours after the event, and no changes had been implemented or risk assessment undertaken to try to minimise the risk of falls for this patient again. We escalated this to the matron who made sure that an incident report and risk assessment was completed for this patient.
- There was no record of the incident in this patient's notes, and no evidence that the family had been informed about the fall, or that duty of candour had been applied.

Cleanliness, infection control and hygiene

- Equipment was visibly clean and had been labelled with 'I am clean' labels, which were dated with when the equipment was cleaned.
- We observed the majority of staff use hand gels between patients and there were gel dispensers in every bedspace to allow the staff to sanitise their hands at the point of care. However, we noted that there were a limited number of hand gel dispensers, outide of the cubicles, particularly in the main corridors and thoroughfare areas of the department.
- We observed that staff frequently used the hand gels between patients as an alternative to handwashing and therefore, did not wash their hands as frequently as required. This was particularly noted in the minor injury area of the department.
- The trust provided us with local audits on hand hygiene. The service had a variable performance in hand hygiene but had not achieved 100% compliance in any month of 2016 to date. In August 2016, the service achieved 85% compliance in hand hygiene. The target the trust aims for each month was 95%.
- There were cubicles in both the main adult department and in the children's department where patients could be isolated to if they were identified as having a potential infection.
- In the dirty utility room within the main area of the department, the macerator was broken. (A macerator is a machine, which breaks down and disposes of human waste products and containers.) The macerator had been out of use since 30 August 2016, and staff had to dispose of waste by using clinical waste bags. We observed that there was a red waste bag attached to the side of the macerator which was open, for disposal of faeces and vomit bowls. This presented an infection

control risk because the bag was open and exposed to the air and therefore there was a risk of spreading infection. We escalated this to the matron who took immediate action to resolve this.

Environment and equipment

- The environment design and layout within the major injuries area meant that it was not possible to observe all patients closely. There were bays in the main adult area, which were not visible and meant that patients could not be easily observed and in Bay 2A, there was no emergency bell or call bell for the patient. A patient was in this bay on several occasions during our inspection, which meant that they could not call for help if required.
- The waiting area could not be observed due to limited visibility from pillars in the middle of the room. There was no emergency bell in the reception area or in the waiting room. We spoke with two reception staff about what would happen in the event that a patient collapsed in the waiting room. There was no formal process in place and due to no alarm being near the reception area, they would have to leave the area and go in to the main department to summon help. This meant that there could be a delay in the event of a patient requiring assistance in the waiting room.
- The minor injury and triage area was located off the main waiting area. This area did not have a dirty utility room and staff were required to share the dirty utility room in the main department. However to get to this, staff were required to walk through the public waiting room and into the main area with the waste they needed to dispose of. We observed staff walking through the waiting area with bowls of bodily fluids and waste.
- We inspected the resuscitation equipment in the department and found that most had been checked daily and were stocked in line with resuscitation council guidelines. However, the resuscitation trolley in the clinical decisions unit (CDU) had not been checked for four days in August 2016 and one day in September 2016.
- We checked the blood glucose boxes and anaphylaxis boxes in the department, we found them to be secure, checked regularly and all items were in date.
- We examined a range of equipment including infusion pumps, syringe drivers, ECG machines, and monitors and found them to have all been serviced and in date.
- We found six out of date vacuum ports plugged into the wall of the main department, resuscitation area, and children's department. We tested the items and found them to be working, however the attached stickers showed them to be out of testing date.
- We found 13 bags of patient property that had been lost, found or unclaimed under the sink in the dirty utility room. There was no patient property policy in place for staff to follow. There were no plans provided to us to deal with this property or what would happen to it.
- The dirty utility room in the main area of the department (majors) was unlocked. In the room, we found unlocked and open cupboards containing chlorine based bleach tablets and specimen preservatives containing formaldehyde. This presented a risk of harm to patients who were could be at risk from ingesting these items including people with mental health concerns, people living with dementia or children.
- The department was fully compliant with standards for 'Children and young People in Emergency Care Settings 2012'. We saw that the children's area was dedicated only to children and young people. The environment was well designed, large and had separate areas for minor treatments, observation and resuscitation. The children's area had a large waiting area, which could be observed from the nurses station at all times, and the bay areas could also be observed.
- The children's observation bay was dedicated only for children requiring clinical interventions and some overnight stays. The area was separate to the adult department and well suited to children. The set up and design of the children's emergency department as an environment to children was outstanding as it enabled the service to undertake interventions on children quickly. The area was set up specifically for the care of children, with enough room and equipment specific to meet the needs of children of all ages.

Medicines

- We checked a sample of medicines, including emergency medicines, these were in date and stored at the correct temperature. Controlled drugs were also checked and found to be correctly recorded, reconciled and stored appropriately.
- Fridge temperatures for medicines requiring refrigeration were checked daily to ensure these medicines were stored correctly.

- Throughout the adult area, of the five fridges we checked all except one were locked. The one that was not locked was stored behind a locked door. However, the matron informed us that they would ensure that it was locked in the future.
- Intravenous (IV) Paracetamol was not stored securely in the main area of the department. We informed the matron and were assured it would be secured. Intravenous medication is administered directly into a vein.
- We observed two incidents in the department where IV fluids were going to be administered to a patient but were left unattended. This meant that there was a risk of fluids being tampered with.
- In the main resuscitation area, blood samples were not being routinely collected and taken to the laboratory for testing. We found four samples that had been left. One sample had been there for 14 hours. This could have compromised the integrity of the blood samples or potentially delay care to the patient. We escalated this to the consultant on duty and the matron who ensured all patients were checked to ensure that they had received the appropriate and required treatments, and to ensure that this practice did not continue.
- The medicines storage and management of medicines in the children's emergency department was exemplary. The area was very well organised and items were frequently stock rotated. The medicines were locked and fridge temperatures regularly monitored.

Records

- We examined the records of 30 patients during our inspection. We found that records were not always completed thoroughly. We reviewed the records of 12 patients who were admitted and awaiting beds on the wards. Of those 12, we found gaps in the records of nine of these patients.
- Safeguarding checks had not been completed in three cases, sepsis triggers not completed in four cases, observations not fully documented in eight cases, pain not recorded in six cases, pressure ulcer risk assessment not completed in five cases, MRSA screening not complete in two cases. There was no plan of care for four patients, no property check on one patient and no admission checks for two patients.
- The trust procedure for undertaking risk assessment of a patient's pressure areas, required assessments to be completed within six hours. We were concerned that this length of time could place patients at risk of developing pressure ulcers. We reviewed the records of one patient who had not had their pressure areas checked and recorded at five hours and noted that they had a pressure ulcer, grade two, to their heel. The staff we spoke with reported this as an incident, however it is not known if this was a community acquired or hospital acquired ulcer due to checks of skin integrity not being undertaken on arrival.
- We identified that no time was being recorded when an electrocardiograph (ECG) was checked and signed by a doctor. The trust policy was that ECGs should be checked within five minutes of being taken, however this was not monitored. An ECG is a recording of the electrical activity of the heart.
- We identified two patients who had notes on their ECGs to: 'repeat in 30 mins,' however no time was recorded of when this was required. We raised this to the nursing staff who ensured that both patients had their repeat ECGs undertaken.
- We spoke with the consultant about this, and they changed the process to ensure that all ECGs were given a time limit when they were to be checked by. Throughout the rest of the inspection, we observed that ECGs being checked by medical staff were signed and a time recorded of when they were checked.
- Six of the patient records we examined were for patients who had been in department for extended periods of time. Three had been in over 10 hours and two had been in for more than 12 hours. Three of these patients had not had a pressure ulcer risk assessment undertaken. Two of these patients were on hospital trolleys and not on beds. Therefore, these patients were at risk of developing pressure ulcers.

Safeguarding

- We saw a current safeguarding policy for adults and children, which was accessible on the intranet. The policies were version controlled and the policies reflected national guidance.
- Staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse, and how they would escalate such concerns appropriately.
- There was a named nurse for safeguarding children and safeguarding adults. Their names and contact details were displayed on the white boards in both adult and children departments for staff to contact them.

- Medical staff training in safeguarding children level three was recorded at 100%, safeguarding children level two at 100%, and safeguarding adult level two at 97.1%.
- Nursing training in safeguarding children level 3 was 93.8%, safeguarding children level two was 98.5%, and safeguarding adult level two was 95.6%.
- Whilst all staff in the children's emergency department from a nursing and medical staff perspective had been trained to safeguarding children level three we were not assured on the safeguarding level three training rates provided for the adult department. The trust figures reported that 100% of medical staff had received level three training; however, four medical staff we spoke with had not undergone this training. Two of these staff were senior clinicians responsible for being in charge for a shift and for reviewing children in the children's department, out of hours. We were therefore not assured that the training data maintained on safeguarding level three training was accurate.
- We saw positive use of the safeguarding children's alert process by the children's emergency department. The staff had raised concerns for a child with an injury of unknown origin and took appropriate steps to escalate this. Staff kept the child safe in the department until children's social services arrived to review the patient.
- Staff in the children's department were knowledgeable about female genital mutilation (FGM) and information was displayed in the staff areas on the identification of this, and how to report it.
- Leaflets for victims of domestic abuse were available for staff to give to vulnerable patients.

Mandatory training

- Staff received effective mandatory training in the safety systems, processes and practices. Nursing training compliance was provided by the trust. Compliance in patient moving and handling (87%), information governance (84%), health and safety (97%), hand hygiene (86%), fire safety (81%), equality and diversity (97%), conflict resolution (84%), infection control (87%), basic life support (BLS) (83%).
- Medical staff training, patient moving and handling (9%), information governance (83%), health and safety (81%), hand hygiene (83%), fire safety (81%), equality and diversity (81%), conflict resolution (0%), infection control (89%), basic life support (BLS) (80%).
- There are 29 regular paediatric nurses working in children's emergency department. Of those 26 (90%) had been trained in advanced paediatric life support (APLS) emergency paediatric life support (EPLS) or paediatric intensive life support (PILS). Those who have not trained have been booked to attend the required courses for their roles.
- Within the adult department we requested the training data for the medical and nursing staff who had undergone advanced life support. The trust provided a response, which stated that five nurses and 32 doctors had received training. However, this equated to 5% of nurses and 71% of doctors trained which is not sufficient.
- The trust said the staff were 'registered with the Resus Council as opposed to being registered directly with the Trust'. The trust response to training rates was, 'In Summary ED has full cover by Doctors and Nurses with appropriate resuscitation training.' However, we were not assured that there was a sufficient number of staff trained with advanced life support skills in the adult ED.

Assessing and responding to patient risk

- The trust reported to us prior to inspection, a time of zero for the median time from arrival in the department, to initial assessment. When we inspected, we saw that at times when the service was quiet the time to assessment was within 15 minutes. However, at times, where the department was busy, time from arrival to initial assessment was up to 50 minutes.
- The general median time to treatment had been higher than the England average between September 2015 and March 2016. The 60 minute standard was not met for 10 of the 12 months. Average time to see a doctor was over 80 minutes.
- Time to see a doctor was outside recommended guidelines, consistently during the inspection despite a full rota of medical staff. On the second day of our inspection, 42 of 69 breaches were related to patients not seeing a doctor in a timely way (seen within two hours and a decision within three hours according to the trust system). Such delays in care presented a risk of harm to the patients.
- During our announced inspection we identified concerns with how patients were triaged and went through the department due to the systems in place. We observed the trust system for triaging ambulance arrivals. This was known as a 'pit stop'. The pit stop was led by the consultant on shift and we were informed by the clinical leaders that they felt it was important that

they were the first people to see the patient upon arrival. We were informed that the process enabled the team to commence treatments at the earliest opportunity.

- When the service was quiet, we observed that the pit stop process worked well for the arrivals. However, the process required improvement because the system meant that all patients that arrived by ambulance had to go through the pit stop process which could have delayed their care and treatment when medical reviewers were not available. When the service was busy, this system resulted in delays for patients' first assessment by a clinician.
- The process for pit stop was meant to reduce the risk of delays for patients who arrived by ambulance; however, we found that this was not always the case. However during our unannounced inspection, we saw that a second pit stop bay was in use in line with the escalation policy. We saw that there were no patients in the corridor waiting for pit stop and the records we checked showed that there were no delays.
- During the announced inspection we reviewed the records of one patient who arrived by ambulance, with severe sepsis. Despite a prior call by the ambulance service that severe sepsis was suspected, the patient was required to go through the pit stop because this is where the consultant was based. This delayed the patient seeing a doctor for nine minutes as there was a queue at the pit stop. In addition, the consultant was based in the majors area during our inspection and not in the resuscitation area. This patient waited for one hour and 12 minutes from the pit stop, or one hour and 21 minutes from arrival, to start their IV antibiotics despite the potential diagnosis of sepsis. There are national guidelines in place (NICE NG 51 July 2016) that state that patients who are suspected of having sepsis should have IV antibiotics within one hour.
- A second patient who arrived by ambulance, during our inspection with a suspected infection and concerns regarding their diabetes waited 30 minutes for the pit stop. Following this, they waited for intravenous fluids (IV) for one hour and 40 minutes, and one hour and 55 minutes for their IV antibiotics.
- Patients at risk of changes to their clinical condition were not always managed appropriately or safely. For example, a patient with an acute kidney injury experienced delays in receiving clinically required treatment for their condition. They waited 44 minutes to be seen at the pit stop and essential observations of their condition were not commenced or recorded until two hours and 15 minutes after arrival. The first treatment was prescribed six hours and 25 minutes after arrival and administered six hours and 55 minutes after arrival. The second treatment was given seven hours later.
- The service did not have a rapid assessment and triage process. When the cubicles were full, the corridor was used for patients to wait until a cubicle became available. When this happened, a nurse was allocated to care for patients waiting in the corridor.
- Patients arriving on foot were assessed using the Manchester triage system. We saw that this process was mostly followed appropriately. There was one exception where a patient was not categorised correctly, post triage. We alerted nurse with regards to this patient, who then ensured that they were safe. However mostly the system worked well and patients were appropriately triaged.
- We examined 16 observation charts, where patients' temperature, blood pressure, pulse and respirations were recorded. The trust used the national early warning score (NEWS) system. Of the 16 we reviewed 11 were calculated correctly and patients were appropriately monitored. Of the five that were not correct, two were not added up correctly so the patient was being monitored according to the wrong score. The other three patients scored at a level that required additional observations every 30 minutes. However, they one was undertaken hourly and the other had not been checked for two hours and 20 minutes until we raised it with the staff.
- One patient had a warning score of four and six when we checked, however their notes contained no detail on plans for treatment or monitoring if their NEWs score increased. We saw that the patient had also not had any recordings of their vital signs for more three hours, as it was recorded they had declined to have them recorded. However, there was no plan on how their potentially deteriorating condition would be managed without being observed or their vital signs recorded. The plan for this patient was to discharge them home despite no plan or action on their NEWS score. We saw that the patient looked unwell and raised our concerns with the consultant. The consultant attended to the patient and then requested treatment, cancelled their discharge and chose to admit the patient, as they were unwell.

Urgent and emergency services

- A patient admitted with a head injury following a fall was observed being cared for in the resuscitation area. This patient did not have their pupil sizes recorded in their records on their arrival. When someone has sustained a head injury, their pupil size and the reaction of the pupils to light can be a key indicator of severe head injury. Observations recording of the size and reaction of their pupils was not recorded until one hour and 12 minutes after arrival. Following this, the next pupil check took place two hours and 45 minutes after arrival. We also noted that no blood glucose check had been recorded which is recommended for patients with a head injury.
- A local audit undertaken every three months on harm free care looked at the completion of NEWS scores. Between April and June 2016, it was found that 71% of patients had observations recorded, 51% were recorded at the required frequency, and 56% had a NEWS score recorded.
- We reviewed three observation charts in the children's emergency department. The children's department used a paediatric early warning score (PEWS) system. All three charts were completed appropriately.
- The paediatric emergency department had two dedicated resuscitation bays for children. These were based within the children's emergency area, which was an area separate to the adults. In the event of a child that required intensive care, they would be stabilised in the resuscitation room, or in theatre recovery. The Children's Acute Transfer Service (CATS) would then be requested. The CATS team then stayed with the child and safely transferred them to a specialist children's hospital.
- The department had an escalation policy in place, dated May 2016. However, it was not being used effectively by the department. Because of the delays in escalating capacity issues and demand within the department, there were avoidable delays in patient care.
- The trust informed us that they had not had any 12 hour breaches. That is patients who had been waiting for treatment for more than 12 hours. The trust had not had any patients waiting on trolleys for more than 12 hours. However the number of patients observed to be in the department for more than 12 hours, who were admitted by waiting on an inpatient bed was high.
- We saw the allocated nurse working in the corridor, caring for patients who were waiting there and completing hourly observations and hourly rounding. NEWS scores we checked had been completed appropriately. We also observed that a ward round was in place, which was undertaken every four hours.
- The trust saw a rise in black breaches between November 2015 and August 2016. The trust had 2107 black breaches during this time. Black breaches are when there is over one hour from the time the ambulance arrives at a hospital, until the patient has been handed over to the hospital staff.
- The number of handover delays over 30 minutes totalled 2,535, between October 2015 and April 2016 putting the hospital in the top quartile of all trusts in England. This meant they were performing poorly.
- The number of ambulances that had to wait to hand over their patient for more than 60 minutes had increased since October 2015 rising to 977, which was the highest, during March 2016. An average of 75% of all ambulances that attended were on site for more than 30 minutes.
- There had been an improvement in the number of ambulances being released within 60 minutes between 10 July and 21 August 2016. During this time 1.7% to 8.9%, were not released within 60 minutes.
- During the week of the 18 August 2016, the weekly commissioning performance report showed that 596 ambulances arrived at Watford General Hospital. During this time 14% of the patients who arrived by ambulance, were handed over to hospital staff within 15 minutes and 16.3% had to wait more than 60 minutes. The ambulance service lost 190 hours during the week where handovers had not been taken by the trust in a timely way.
- The performance report showed for 'all departments' arrival to clear performance overview' the percentage delayed at Watford General Hospital over 30 minutes was 81% and percentage delayed over 60 minutes was 19%.
- The ambulance service lost 2999 hours in the emergency department at Watford General Hospital from 1 April to 28 August 2016 due to delayed handovers. This was an 85% increase on the same period for 2015/16. Watford General Hospital has been consistently the lowest performing hospital, in this regard, in the East of England out of 17 NHS hospitals.
- Advanced life support for adults training rates were low with 5% of nurses and 71% of doctors trained.

Urgent and emergency services

Mental Health

- The mental health room was located in the main area of the department. The room had been risk assessed in June 2016 for ligature points and patient self-harm. We identified two ligature points, a live three point electrical socket and a fluorescent light, which could harm a patient. At the time of the inspection the trust provided us with a report on how this was going to be dealt with. The electrical socket was made safe during our inspection.
- The furniture in the room was not suitable because a patient could cause themselves harm on it. One chair had a metal frame and another chair was solid wood. Should a patient who was at risk of self-harm be left unattended in the room, we were concerned that they could cause themselves physical harm. However, these ligature points and risks had not been identified. We escalated our concerns to the trust.
- The trust provided us with documents of another external review, which also had not identified these risks. Whilst the trust believed the room was safe, the risks identified required addressing.
- During the inspection, we observed that the mental health room was used on three occasions by patients. At no time when we observed staff members entering the room did we see them take a personal alarm in with them. We were informed by the service leads that staff were required to take the alarm into the room with them as the main alarm in the room was not working. On one occasion, we also observed that the second door had been blocked by a chair, yet staff still entered the room with a distressed patient with mental health concerns. This placed staff at risk of harm.
- There was no formal procedure for asking patients or checking their property when they presented after self-harming. Therefore, people could have items with them, which could place the patient, staff, and others at risk of harm.
- There was no formal assessment for patients to determine where in the department they would physically safest until the mental health team arrived to provide them with support, or treatment for their conditions. This meant that adults or children with mental health concerns may not be placed in the most appropriate environment.
- We reviewed the training records provided by the trust. Training on mental health awareness was provided to staff during their induction session. However, there was no further training on mental health awareness.
- Staff within the department had not received any specific or detailed training in dealing, identifying or managing patients with mental health conditions or mental health anxiety. This is an area that requires significant improvement.
- Training records provided showed that 84% of nursing staff had been trained in conflict resolution. However, 0% of doctors had received conflict resolution (CRT) training.
- Limited numbers of staff in the department had been trained in safe breakaway. Records showed that only one consultant, one senior sister, four staff nurses and one healthcare assistant had been trained. This did not provide sufficient cover on the staff rota for safe breakaway in the event of an incident.
- No staff members had received training in ethical control and restraint. During the inspection, we observed a member of staff restrain a child who was trying to run out of the department. Whilst we acknowledge the decision to protect the child from running out the building was appropriate, the technique used to restrain the child did not follow best practice because it did not avoid the head, neck or chest.
- Staff had systems to request a specialist mental health assessment such as from the local mental health trust and crisis support teams known locally as RAID. We observed staff refer patients into this service during the inspection.
- The department could access a Section 12 registered doctor through the RAID team between 9am and midnight, with an on call service between midnight and 9am. A Section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act.

Nursing staffing

- Across the unscheduled care division there was a vacancy of 17.6%. However, there were only 10 nurse vacancies within the emergency department. Of these vacancies, six posts had been recruited to and staff were

due to commence employment within 12 weeks. Staffing was calculated based on 'Baseline Emergency Staffing Tool (BEST)' from the Royal College of Emergency Medicine.

- We reviewed the nurse and support staff rota with the matron and there was a sufficient number of staff to cover each shift. We reviewed the staff rota for nursing staff between March and July 2016, found that the staffing levels were mostly stable, and support from agency and bank was used where required.
- Agency and bank nurse usage per month in the emergency department ranged from 19.6% at the lowest to 29.3% at the highest. Many of the agency staff used were booked on a long term basis to fill the rota.
- We identified during our inspection that agency nursing staff working in the department had received a local induction.
- We found no record of nurses' competencies signed off in the department. For example, nurses must be assessed as competent to administer IV medicines before being able to administer them to patients. There were no IV competency records available, as these could not be located by the department during the inspection.
- Nursing staff numbers were displayed in each area of the department. For example, the resuscitation area had displayed on the outside of the area that they were staffed with five nurses and five support staff for that shift in that area. Their actual staff numbers on duty versus their establishment was accurate.
- We observed throughout our inspections that there were adequate numbers of staff to keep patients safe. The staff we spoke with also told us that the nurse staffing levels in the department were safe to provide care, and if help was required, they could request this and felt confident that they would be supported.
- The children's emergency department was staffed by nurses from the paediatric department. We reviewed the rota for the children's department and found that there was consistently enough nursing and support staff on duty to support the delivery of the service. All nurses who worked in the department were registered nurses (child branch).
- Outside of the children's emergency department and inside the door of the children's observation bay the numbers of nursing staff in the unit were clearly displayed for the public to see.
- Sickness rates for nursing staff in the emergency department were 3%, which was better than the trust average of 4%.
- Turnover rates for nursing in the department were 11%, which was better than the trust average of 12%.
- We observed the nursing handover between staff on each shift. Handover took place between both the nurses in charge and nurses responsible for patients in bays or cubicles. The information discussed at handover was clinically appropriate and clear on the tasks required for the next shift.

Medical staffing

- Within the department there were 6.5 full time equivalent consultants employed.
- Consultants met the 16 hours of cover recommended by the Royal College of Emergency (RCEM) Medicine.
- Medical staff vacancy rate for the department was 23%. The department was particularly short of staff at consultant and middle grade level. The ratio of consultant staff was 20% against the England average of 26%. The middle grade ratio of the department was 3% against an England average of 13%. The core trainee registrar level staff ratio for the department was 23% against an England average of 39%.
- The junior doctor ratio for the department was significantly better that England average of 23% at 53%.
- Consultant hours daily were between 8am and 12midnight Monday to Friday and then 8am to 4pm and 4pm to midnight on Saturday and Sunday.
- After these hours, consultants were available through an on call rota. The consultants undertook an on call duty one in every eight days.
- The medical rota at consultant level was supported by locum consultants. This was predominantly to cover the weekends.
- Medical staffing levels were one of the top risks identified on the risk register. The register cites: 'High vacancy rates at consultant and middle grade level leading to high use of locum and agency staffing and risk of gaps in senior clinical cover'.
- We spoke with the leads for the directorate who shared with us that they had an ongoing recruitment plan for the recruitment of middle grades and registrar grades; however, they were challenged by a national shortage in this field.
- We were not assured of the completeness of competency checks for locum staff working in the

service. For example, we spoke with one locum doctor who was a shift leader at times, who could not tell us what a Deprivation of Liberty Safeguard (DoLS) was or how they would ensure an application was instigated. We provided feedback on our concerns to the trust for information and action.

- We observed a consultant to consultant handover in the resuscitation department which was well structured, clear and covered each patient in the room. Medical staff of all levels were included in this handover and clinically appropriate information was shared.
- The deployment of medical staff throughout the department did not ensure that the skill mix deployed was safe in all areas of the department. The skill mix deployment meant that there was a large number of medical staff based in the main area of the department. There was limited input into minors from medical staff when demand increased, and this ultimately impacted on department performance. For example on one day during our inspection, 42 of 69 waiting time breaches were related to patients not seeing a doctor in a timely way.
- We were concerned that the resuscitation department was frequently left without sufficient senior clinical oversight during times when the department was busy. The consultant undertook a round of the resuscitation area each shift. However, the most senior emergency department doctors observed there for two days were core trainee level one, and a core trainee level two. The consultants were based in the main majors area. The patients who were admitted to the resuscitation area were the most acutely unwell or unstable. Our specialist advisors were concerned for the safety of patients, as there was not sufficient senior clinical oversight of this area of the department.
- During our unannounced inspection, we found positive and significant improvements. There was a consultant based in the resuscitation area and a bleep holder system in place to summon staff quickly. We saw that junior doctors were discussing patients with a senior decision maker 45 minutes after being allocated a patient. This improved the work allocation and flow of the department.
- Locum medical staff did not have their competencies checked before working in the department. We spoke with two locums during the inspection who could not tell us how up to date their training and competencies were. One could not tell us what training they had undergone for safeguarding children or what a Deprivation of Liberty safeguard (DoLS) was. These locums were often left in charge of shifts overnight and at weekends. Although medical staff often reviewed children with a nurse from the children's department, who was level three safeguarding children trained, out of hours, this may not have been possible.
- Within the children's emergency department, one full time equivalent paediatrician was employed. A second paediatrician had been recruited to support increased demand, which was positive. This meant that there was a paediatric trained consultant in the children's emergency department most days between 8am and 7pm.
- The paediatric department supported the children's emergency department medical staff rota. Both teams worked together to deliver a service, however there were ongoing negotiations with regards to contract arrangements and support for the service between the two divisions (Emergency care and paediatrics). The outcome of these negotiations had not been resolved by the time our inspection had concluded.

Major incident awareness and training

- The trust had a major incident plan that had been updated in 2016.
- The emergency department took part in operation Phoenix, which was a full emergency response exercise based on a scenario. Learning had been identified, which the trust and departmental leaders were aware of and were implementing.
- Following our last inspection, which took place in September 2015, the clinical lead for the service recognised that preparedness for major incidents was an area that they needed to improve upon.
- The service had trained 70% of all staff in chemical, radiological, biological and nuclear (CRBN.) There were 30 staff who still required this training but the dates for this had been arranged for those staff members. CBRN defence or CBRNE defence is protective measures taken in situations in which hazards related to chemical, biological, radiological or nuclear warfare (including terrorism) may be present.
- The mass casualty response had been reviewed in relation to capability and suitability and took into account the adjacent football ground as defined within the major incident plan, dated August 2016 and the mass casualty plan dated September 2016. In addition

testing of the mass casualty plan was carried out with a walk through exercise completed in June 2016 with ED staff and was followed by a lockdown exercise after our inspection. To complete the testing and learning process a further stress test of the mass casualty response was built into an exercise with the introduction of live and virtual casualties at both Watford General Hospital and Hemel Hempstead Hospital.

- The major incident plan had not taken on learning following the publication of the Hillsborough inquest, which recommended some reviews and changes for hospital and ambulance services that serve football stadiums. We raised this with the leaders of the service who said that they would consider the learning from the Hillsborough inquest and apply any learning. Since the inspection the trust had taken on board the recommendations and included these as part of the mass casualty plans, which was updated in September 2016.
- The department had an escalation plan for capacity and demand when it was busy. The activation of this plan was based on the flow in the hospital, number of patients arriving and impact on the service. Depending on the incident, the department would declare levels of seriousness, green, amber, red or black.
- The escalation policy did not refer to the number of patients that could safely be in the department before there was a risk to clinical safety. This meant that there were no clear guidelines for staff with regards to how many people were safe to be in the department at any one time.
- We asked staff to access the escalation policy on the intranet or in a folder so that they could review their action cards for escalation. Two staff could not locate this document and the intranet page was not working. The matron found the document and shared it with the staff.
- The escalation plan did not work during our inspection because staff did not escalate the situation within the department in a timely way. The staff said they went with how the department was "feeling" and then they would escalate.
- On the second day of our inspection, we observed that on the morning shift by 10.21am that there were 46 patients in the department with six ambulances on route. The department was short of three nurses and one healthcare support worker. According to the trusts escalation plan this would be classed as the department status going to 'black alert'. However, no escalation took place until 12.20pm. By this time, there were concerns with flow in the department. Potentially, this could have been avoided.
- The response from the trust to increased demand in the department did not follow the trust escalation plan. For example, the acute medical staff attended the department to support with patient reviews; however, no senior managers, directors or operation staff attended to support the department as specified by the escalation plan.
- The department was able to implement lock down by securing the main doors at either side of the department and at the ambulance bay.
- The major incident store, which contained items used to support staff in the event of a major incident, was located outside of the department. We noted that the use of this facility had improved since our last inspection. The store was clean, organised and regularly checked by staff.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We have rated the effectiveness of urgent and emergency services at Watford General Hospital as requires improvement because:

- There was a clear protocol for staff to follow with regards to the management of sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. However, we were informed that this was still work in progress because the service was yet following all six steps. Two of five patients with sepsis reviewed during the inspection were following sepsis six requirements.
- Fluid rounds and drinks provision for patients had not increased despite the warm temperatures in the department.
- Of the 30 records we examined, pain scores were not documented in 21 after triage and pain was not being routinely monitored, or documented in the patient records.

- Nursing and medical staff were observed to work separately rather than together with regards to the flow through the department. There was limited coordination between both regarding the patient's journey and communication between doctors and nurses could be improved.
- There was a lack of local audit activity in the service, which meant that opportunities for learning were missed.
- Not all medical staff could tell us about Mental Capacity Act or Deprivation of Liberty Safeguard requirements.

However:

- Policies and pathways for the admission of stroke, fractures and chest pain were in place, which reflected National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.
- The fracture neck of femur pathway between the emergency department and the orthopaedic service worked well and there were dedicated 'ring fenced' beds in the hospital to support fast treatment of patients with a fractured neck of femur.
- The service took part in all national audits.
- There was a gynaecology pathway for the trust, which meant that women who miscarried or suffered an ectopic pregnancy received organised care and treatment. There were 'ring fenced' or priority beds for gynaecology patients.
- Pain was assessed on arrival and levels of pain for children were checked at stages throughout their time in the children's emergency department.
- Excellent MDT working was observed with acute medical services, stroke services, intensive care, children's services and the elderly frail unit.
- There was good understanding in the children's department on Gillick competence, and Fraser guidelines.

The department routinely screened for dementia in patients over the age of 75 years.

Evidence-based care and treatment

- There was a clear protocol for staff to follow with regards to the management of sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. However, we were informed that this was still work in progress because the service was yet following all six steps. 'Sepsis Six' is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Bundles were also available for neutropenic sepsis.
- We reviewed the notes of five patients who were admitted with a potential diagnosis of sepsis. Of those, two patients were provided with treatment in line with the sepsis pathway recommendations. Whilst the early triggers had been identified, there were delays in triaging and administration of antibiotics and initial assessment of patients.
- We reviewed the policies and pathways for the admission of patients with stroke, fractures and chest pain. We saw that these were written in line with the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.
- The fracture neck of femur pathway between the emergency department and the orthopaedic service worked well and there were dedicated, ring fenced beds in the hospital, to support fast treatment of patients with a fractured neck of femur.
- We reviewed the notes of one patient admitted with a fractured neck of femur. This patient was on the pathway, which had been followed.
- The trust was not adhering to the NICE or CEM protocols for head injury in all cases. We examined the records of three patients who had sustained head injuries. In two cases, pupil sizes had not been recorded on first assessment, and on the third, pupil size had not been recorded until two hours and 45 minutes after arrival. Pupil size and reaction to light is a key indicator of severe head injury
- We observed a stroke patient who had attended the department. They were immediately referred to the stroke team who attended to provide care. The care provided to this patient, followed the pathway for stroke in emergency care.
- There was a gynaecology pathway for the trust, which meant that women who had miscarried or suffered an ectopic pregnancy received organised care and treatment. There were 'ring fenced' or priority beds for gynaecology patients. We observed the pathway utilised twice during the inspection, which meant that care for these women was effective.
- The department took part in all required national audits.

- There was limited local audit activity in the department. The only audits provided to us and undertaken were hand hygiene and track and trigger relating to early warning scores.
- We asked medical and nursing staff what they understood in terms of learning from audits and no one could tell us of an audit they were aware of, or any learning.

Pain relief

- The College of Emergency Medicine, Pain in Children audit, for 2014-15 was not available for this inspection.
- Pain was assessed on arrival in the department and levels of pain for children were checked at stages throughout the child's time in the children's emergency department. We reviewed the records of three children, which supported that pain was routinely monitored and managed in line with best practice.
- When a patient entered the department, via the minors area route, pain was assessed as part of the triage process. This was recorded and where appropriate pain relief was provided to the patient.
- Patients who arrived by ambulance were asked about pain on arrival during their initial triage. However, we were concerned that pain levels were not managed effectively through the rest of their stay in the department.
- Of the 30 records we examined, pain scores were not scored in 21 patients, after triage and pain was not being routinely monitored, or documented in all the patient records we saw. We observed staff talking to patients but we saw very limited interactions regarding whether or not a person was in pain.

Nutrition and hydration

- Food and drink was available to those who were in the department for any length of time. There were regular time slots for care 'rounding' which included offering patients drinks.
- It was very warm at the time of this inspection, with outside temperatures ranging between 28c and 32c, and we noted that many patients were thirsty. One patient we spoke with had not had a drink for nine hours and 20 minutes. However there had been no increase or changes to the times of care rounds. This we raised to the staff who assured us they would increase rounds for drinks when temperatures increased.
- Food and drink was also available to relatives who were waiting in the department.

Patient outcomes

- The trust's unplanned re-attendance rate to A&E within seven days was 9% between April 2015 and March 2016 and has been higher than the England average of 7%. The trust did not meet the 5% standard during the entire 12 month period.
- The Trauma Audit and Research Network report (TARN) report for May 2016 identified no immediate risks. TARN data showed a median time from request to computerised tomography (CT) of head taking place was 2.25hrs (standard 60min). This is a serious risk according to TARN standards. Concerns were in the report over the overall coordination of trauma patients that were managed by the unit.
- Good practice noted in the TARN report included the model of repatriation used at Watford Hospital was commended and it was notable that the unit consistently had the best time to repatriation within the network. The management of orthopaedic trauma theatre capacity, planning and surge management with excellent engagement of the orthopaedic consultant trauma lead was also highlighted as good practice.
- The consultant sign off audit showed that about 6% of patients were seen by a consultant, which was worse than the England average. Consultants discussed cases with the patients in 15% of cases, which was about the same as the England average.
- Only 26% of patients were seen by a doctor, who was ST4 level, (a more senior doctor) and above, which is worse than expected compared to the England average. This meant that the trust had two indicators about the same as the England average and two worse than the England average with regards to patients being reviewed by a consultant.
- The RCEM sepsis audit had not been released at the time of our inspection; therefore no new national data was available on this measure.
- The RCEM mental health audit showed that of the eight indicators the trust performed similar to expected on four indicators, better than expected on three indicators, and worse on one indicator.

- The national audit on assessing for cognitive impairment in older people 2014/15 showed that of the six indicators, the trust scored about the same as the England average on three, better than average on one, and worse than average on two indicators.
- The national audit on initial management of the fitting child 2014/15 showed that of the five indicators that the trust scored better than average on one indicator, and about the same as the England average on the other four indicators.
- A local audit undertaken every three months on harm free care, considered the completion of NEWs scores. Between April and June 2016 it was found that 71% of patients had observations of their temperature, pulse, respirations and blood pressure, recorded, 51% were recorded at the required frequency, and 56% had a NEWs score recorded.
- The department routinely screened for dementia in patients over the age of 75 years. The audit for April 2016 showed an achievement of screening in 97% of patients.
- The A&E fractured neck of femur outcomes were better than the national average on all seven indicators. The last audit was completed for the period of Mary 2016 to April 2016. The data showed better than average rates for time to surgery with 28.5 hours against the national average of 31.1 hours. Time to admission to an orthopaedic ward was 4.8 hours against the national average of 9.6 hours. Completed specialist falls assessment rates were 99.5% against the national average of 96.2%.

Competent staff

- Appraisal rates for administrative and clerical staff were 92.5%, nursing staff 79%, allied health professional staff (AHP) 58% and medical staff 75%.
- Staff had received training in the Manchester Triage system to support initial nurse triage and streaming patients into appropriate areas of the service for treatment.
- Nurse revalidation had commenced, and there were plans, which included training for staff in supporting revalidation. In the department 13 nurses had been revalidated since April 2016.
- Medical staff revalidation had taken place with seven medical staff completing medical revalidation in 2016. There were scheduled plans for all medical staff to go through the revalidation process.
- There were opportunities to obtain further education and qualifications for role specific qualifications, for example, advanced nurse practitioners and nurse prescribers, but their first key priority was the leadership skills development for nursing staff in the department.

Multidisciplinary working

- Nursing and medical staff were observed to work separately rather than together with regards to ensuring there was an effective flow of patients through the department. We observed an approach of nursing staff undertaking their own work and medical staff working separately. There was limited coordination between both regarding the patient's journey. We noticed that communication between doctors and nurses could have been improved.
- We noted that there had been an improvement in the working relationship with the surgeons and doctors who attended the department to see patients who had been referred to them. There was very good engagement and working with the acute medical team and the emergency department. When the department called for an acute medical staff member, they would attend swiftly.
- We spoke with six members of the ambulance service who reported that there continued to be long waits for them to hand over patients to the department's staff and the need for cohorting patients with paramedic crews. They did however feel their working relationship with the trust was improving.
- There was a good working relationship between the department and the intensive care unit. The service was supported by the intensive care unit with regards to resuscitation and with high dependency patients where required, and we observed good interactions between both departments.
- The department worked well with the paediatric service who were responsible for running the children's emergency department. There were some improvements with regards to communication, particularly around staff rotas, but both sides reported good working relationships across adults and children's services.
- The service worked well with the local mental health trust. The department were supported when referrals

were made and response times, when referrals were made, were kept to a minimum. We observed mental health professional's attendance in the department on several occasions, to support the staff.
- There was an excellent elderly frail unit (EFU) available. This service was run by the medical team and took patients from the acute medical referral and emergency referral pathway. During the inspection, we observed several patients being taken from the department to the EFU for treatment. The aim of this service was to support patients to go home, when safe to do so and avoid admissions where possible.
- The service had links with the ambulatory care service in acute medicine. This link enabled the department to refer patients immediately when they were suitable for ambulatory for treatment. This freed up space and staff within the department, which was positive.

Seven-day services

- The emergency department was open seven days per week, 24 hours per day.
- The children's emergency department was open 24 hours per day and has been since 2003. The service was staffed 24 hours per day with registered nurses (child branch). Medical staff were available from 8am to 10pm daily and cover from the adult emergency department and paediatric service was provided out of those hours.
- Radiology services currently did not operate seven days per week but on call services were provided for emergency cases when needed to support the service. There is an on-call Radiologist available for advice when there is not a Radiologist in the department.

Access to information

- Access to all information systems was undertaken through the use of NHS smart cards. This enabled staff access to online systems, which included pathology and radiology.
- Patients' records were in paper format and were stored in a locked trolley.
- Concerns were raised to us by staff regarding to access to information, associated with the IT systems in the trust. The IT systems were slow and challenging to use when the service was busy. This was a frustration for staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The training records showed that 84% of medical staff and 100% of nursing staff had received training on the Mental Capacity Act 2005.
- Nursing staff within the department had a clear understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). However, medical staff were not as knowledgeable. We spoke with two senior doctors one of whom could not tell us about the Mental Capacity Act, and another, who was not familiar with DoLS. These senior staff were shift leaders out of hours.
- Staff explained their systems for assessing people's mental capacity to give consent regarding treatment.
- Staff in the children's department were asked about assessing children as 'Gillick competent'. The staff we spoke with (two nurses and two doctors) were clear when this framework would be used. Within the children's department there was information available on requirements of the Fraser guidelines.
- All patients who arrived in the department who were over the age of 65 years should have had dementia screening undertaken as part of good practice. The department undertook screening for over 75 years for dementia routinely.
- We observed staff explain what they were going to do, prior to any procedure taking place and asking for the patient's consent before they proceeded.

Are urgent and emergency services caring?

Good

We have rated urgent and emergency services at Watford General Hospital as good for caring because:

- The feedback received from the majority of patients was positive.
- The friends and family test results were consistently above the England average.
- We observed positive and caring interactions between staff and patients throughout the inspection. Staff were caring and compassionate when they spent time with patients.
- Clinical nurse specialists were available to provide support to patients in the department.

However:

- We received feedback from two patients and two relatives in the adult area that care was good whilst the service was quiet, but they felt that it was not as good when they had visited previously when it had been busy.
- Friends and Family data was not displayed in the department for staff or patients to read.

Compassionate care

- We spoke to nine patients and five relatives during this inspection in the adult department. We also spoke with three parents and one child in the children's department.
- All patients we spoke with provided positive comments about the service including, "They are wonderful", "Very kind, I have no complaints", and "They are doing a great job looking after me".
- The CQC Accident and Emergency survey (2014), showed that of the 24 questions related to caring that the trust scored about the same as other trusts on 20 questions, and better than average on four questions. There were no negative outcomes in this survey.
- Throughout the inspection, we observed examples of care where doctors and nurses were kind and compassionate towards patients and treated them with dignity.
- We observed several examples of staff asking for the patient's consent prior to entering their cubicle area, respecting their dignity.
- Where a patient was unwell, we routinely saw domestic staff ensure that the curtains were pulled to maintain the person's privacy and dignity, which was positive.
- The service scores for the Friends and Family Test were: 92% for April, 89% for May, 89% for June, and 91% for July 2016. August data had not been published at the time of our inspection. These scores were above the England average of 85%.
- The response rate for the Friends and Family test was between 4.3% and 6.6%, which was worse than the England average of 12.9% to 13.5%.
- Friends and Family data was not displayed in the department for staff or patients to read.

Understanding and involvement of patients and those close to them

- We observed positive examples where staff in the children's emergency department spoke with adults and children in appropriate ways. For example when the staff were speaking to an adult, this was done in an adult way. When speaking with a child the staff adapted how they spoke so that the child could understand what they were saying and be involved in their care.
- We spoke with nine patients and five relatives regarding care. All felt that they were being kept informed and updated by staff on what was happening, and what they should expect regarding their or their relatives care.
- However, two relatives and two patients informed us that they felt care it was good on that particular day because the department was quiet. They shared experiences with us of previous attendances where they told us that they were waiting for a while before they were told anything. We asked staff about this, who acknowledged when the department was busy, that giving information to patents and their loved ones would often be delayed.
- The hospital used a 'test your care' survey system for local patient feedback. The matron completed this survey through undertaking quality checks. The questions on the survey included patient's involvement in their care, and asked questions such as: 'Does the patient know the reason for them being in hospital and awareness of their plan for discharge.
- Of the most recent survey results for May 2016, the survey showed that 90% of patients had their care discussed with them, 0% knew who their consultant was, 80% knew who their nurse was, 20% knew their plan for discharge, and 20% knew what was happening with their care. However, 100% of patients reported being treated with dignity and respect, and that staff introduced themselves to patients.

Emotional support

- Clinical nurse specialists were available to provide support to patients in the department and we observed two occasions where the older person's specialist nurse and respiratory nurse were asked to attend the department and speak with patients.
- Counselling services were available through the local mental health trust.
- Patients and staff had access to the chaplaincy service who offered support to patients and staff seven days per week. In addition, there were multi-faith options available and non-religious ministers who also supported the department.

Urgent and emergency services

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Inadequate

We have rated urgent and emergency services at Watford General Hospital as inadequate for being responsive because:

- There was a notable culture of acceptance regarding the waiting time breaches. We reviewed the categories where there had been breaches, for one day during our inspection and found that many related to time to see a clinical decision maker or receive treatment from a doctor. Opportunities for immediate improvements in performance against this standard had been missed. However, during our unannounced inspection we noted that there had been a change in levels of acceptance of breaches, as the number of breaches had reduced and four hour performance for the department had improved.
- The percentage of patients leaving the department before being seen was higher, at 6.5%, than the England average of 3%
- The percentage of emergency admissions via A&E waiting from four to 12 hours from the decision to be admitted ranged from 12% to 44% against the England average of 8%.
- Staff had not received training in understanding learning disabilities and patients with complex needs.
- No training was provided in dementia awareness, and there were no plans or consideration of patients dementia needs in the department or in the clinical decision unit.
- Learning and outcomes from complaints were not widely known throughout the department.

However:

- The service was planned to allow for support from the acute medical services as first call when the department was busy. This was established as a need through a review of the type of patients who attended the department. The patients attending the service were presenting with acute medical conditions in most cases and the service had planned their support arrangements around this.
- Staff in the children's department were trained to support those with learning disabilities and complex needs.
- The children's department had a range of distraction methods and sensory items to support children's individual needs whilst they had treatment. Children could watch films, play with toys or play on a games system during their time in the department.

Service planning and delivery to meet the needs of local people

- It was acknowledged by the leaders of the service that the layout of the department did not support a good flow of patients through it at all times. The department was originally built to deal with 30,000 people per year and now sees in excess of 88,000 per year.
- There were discussions about the future of the department and how the service could be delivered, however nothing had been formalised.
- We saw that the trust had plans to work cohesively with other trusts to ensure responsive care. This included a London trauma trust, and the mental health trust.
- There were ongoing concerns with regards to delivery and the performance of the emergency department. This was monitored though a system wide resilience process and engaged stakeholders including commissioners of care, NHS Improvement and NHS England.
- There was a plan in place to allow for support from the acute medical services as first call in the event the department became busy. This was established as a need, through a review of the type of patients who attended the department. The patients attending the service were presenting with acute medical conditions in most cases and the service had planned their support arrangements around this.

Meeting people's individual needs

- Staff had access to translation services, via a telephone service, when there was a need to communicate with a patient whose first language was not English.
- In the adults department, staff had not received training in understanding patients who had a learning disability and complex needs

- In the children's department there were training sessions for staff to support children with learning disabilities and complex needs.
- The children's department had a range of distraction methods and sensory items to support the individual needs for children whilst they had treatment. Children could watch films, play with toys or play on a games system to support them during their time in the department.
- Dementia was discussed as part of safeguarding level two training. There were no plans or consideration for patients who may have been living with dementia for more specific training in the department or in the clinical decision unit. Staff we spoke with could not really remember attending training. One staff member told us that they used "common sense" to care for these patients.
- Staff had access to mental health services to support people with mental health needs. The response times for mental health teams to see a patient once they were referred, for both adults and children were good, and it was noted during the inspections that these teams responded within an hour of being called.
- The service had a dedicated area for relatives which had three individual relative rooms for speaking with patients and their families and for breaking bad news. Patients had access to leaflets in the waiting area providing information on a variety of health conditions. Further leaflets in other languages were also available.
- Leaflets were available for children and adults in the children's emergency department. Information for children was provided in an easy read format to help them understand their condition.

Access and flow

- The percentage of patients seen within four hours was lower than the England average between June 2015 and May 2016. The trust performance against the standard ranged from 71% to 93%. The trust has not achieved over 90% since August 2015.
- We reviewed the daily performance of the emergency department and attended two bed meetings during the inspection. We observed that there was no challenge towards the level or number of waiting time delays over four or 12 hours by managers or members of the executive team. There was a notable culture of acceptance regarding the breaches.
- We reviewed the breach categories of attendances for one day during our inspection. There had been 243 attendances with 70 breaches, giving them a performance score of 71.6%. Of the breaches we reviewed, 18 related to bed availability and 42 related to time to see a clinical decision maker or receive treatment from a doctor. This number was exceptionally high given the number of medical staff working in the department, versus the number of attendances.
- On another day, the performance was noted to be 70.5% on a day where 241 patients attended the department, and there were 71 breaches. Of these 35 related to the unavailability of beds and 26 were related to time to see a doctor. Opportunity for immediate improvements in performance against this standard had been missed.
- The percentage of patients leaving before being seen was higher, at 6.5%, than the England average, which is 3%, between April 2015 and March 2016.
- The percentage of emergency admissions via A&E waiting four to 12 hours from the decision to admit until actually being admitted had been higher than the England average between June 2015 and May 2016. The trust's performance in this regard, ranged from 12% to 44% against the England average of 8%. February 2016 was particularly high at 44% versus the England average of 8%.
- The trust have stated: 'Since October 2015 period of high number of stranded patients (100 + average) Average 50 DTOC patients per day.' DTOC is a delayed transfer of care. However, when we attended the bed meetings we observed that the bed state was not under such pressure as we had been led to believe. During our inspection, on one day, we observed four patients who waited for more than 12 hours for a bed in the department. However, patients from the emergency department were not prioritised through. With a bed state of minus one and five beds available, there was capacity to move these patients prior to the 12 hour mark.

Learning from complaints and concerns

- Between July 2015 and July 2016, the emergency department received 110 complaints. The top reported complaints for the service were 'all aspects of clinical treatment' (32), 'attitude of staff' (22), and 'admission, discharge and transfer arrangements' (19).

- The trust had a complaints policy and procedure, which followed NHS best practice recommendations.
- We asked four nurses and three doctors if they could tell us about a complaint that had been received, what feedback had been provided and what lessons had been learned. No one could tell us of a recent complaint that they were aware of.
- Complaints information was displayed on the notice board in the main area of the department, and included lessons learned and feedback. However, staff were unaware of this.
- The leaders of the department including the matron, divisional head nurse, and clinical lead were aware of the complaints received. The matron was able to share examples of how they had spoken with staff when concerns had been received about staff attitude.

Are urgent and emergency services well-led?

Inadequate

We have rated urgent and emergency services at Watford General Hospital as inadequate for being well led because:

- There was a lack of vision, strategy or direction for the emergency department. Staff we spoke with across the adult department were not aware of any strategy or vision for the service.
- We were not assured that all incidents within the department were being reported, or were not being reported in a timely way. Staff were unable to demonstrate any sharing or learning from incidents, serious incidents or complaints at a local level.
- There was a lack of quality assurance processes in the department because local audit activity was minimal.
- The role of 'controller' was not functioning well and required review to make the role of the consultant in charge more effective and efficient as a leader.
- The nurses were not treated as equal partners by the behaviour and approach of some consultants. This meant that their views were not always regarded. The culture and behaviours that were witnessed disempowered the nursing staff and lowered staff morale.
- We observed some poor behaviours exhibited by staff during the inspection. This did not demonstrate professional behaviour expected of staff.
- The staff said that they sometimes felt that there was a blame culture from the hospital towards the emergency department because they were not routinely achieving the four hour wait to treatment target.

However:

- Staff were aware of the core values of the organisation and could articulate these to us.
- There was a clear vision and strategy for the children's emergency department. Staff were clear on what the vision was, where the service was going and how they would be involved in the progression of the service.
- The leadership, culture and staff satisfaction within the children's emergency department was very positive. The local leadership team of the children's emergency department demonstrated good leadership for the service.
- Whilst a poor culture was noted in the department during the inspection, we noted that this was being dealt with and some improvements had been noted by the time we had completed our unannounced inspection. However, these needed time to demonstrate embedded change.

Leadership of service

- The emergency department was locally led by a clinical lead consultant and a matron. These leads were also responsible for the urgent care centre and minor injuries unit.
- The senior management team for the service included a divisional director, divisional manager and divisional head nurse. The divisional leads were responsible for unscheduled care, which encompassed a range of areas including acute medical services.
- The structure of the directorate was being reorganised and the clinical lead role had been reviewed and was changing to a clinical director position. Recruitment was underway and the interviews had been scheduled.
- The matron was recognised as the nursing leader within the department; staff spoke highly of the matron and felt supported by them.

- The band six and seven tier of nurses had not received any leadership development and management training in organising shifts at a senior nursing level. This was clear when it came to communicating the requirements of the service with the site team and the medical staff.
- The medical leadership within the emergency department was managed on each shift by a 'controller'. This role was the senior consultant on duty who coordinated the medical staff and worked with the nursing team. We observed during the inspection that this role was not functioning well and required review to make the role of the consultant in charge more effective and efficient as a leader.
- We observed staff routinely approach the controller and ask them for work as they had not been allocated any patients. There were issues identified during the inspection with regards to how medical staff were organised throughout the department to make the best use of resources and reduce waiting times for patients to see a doctor.
- The resuscitation department was frequently left without sufficient senior clinical oversight during times when the department was busy. The consultants were based in the main major injuries area.

Culture within the service

- The General Medical Council (GMC) 2015 trainees survey for the ED reported that of the 14 questions 11 were within the expected range. Three were worse than expected, which were: feedback, access to educational resources and induction.
- The nursing and support staff culture was one that worked to provide the best care possible to the patients and their families. However, the nurses were not treated as equal partners by the behaviour and approach of some consultants. This meant that their views were not always regarded.
- The medical staff in the department at junior level worked well together and with the nursing staff, however we observed there to be some inappropriate behaviours from the consultants at times. Consultants were observed on two occasions to not be listening to the nurse in charge's suggestions regarding patient flow and their ideas were dismissed.
- On multiple occasions during the inspection, the inspectors observed poor attitudes and behaviours towards the CQC inspection process. Inappropriate comments were made in front of patients. For example, a junior doctor who asked a consultant how the inspection was going was heard to say: "They are just here to find problems, they will go soon." Another consultant was heard saying to junior doctors: "We need to be seen to care, so do try".
- We frequently observed faces being made, and eyes being rolled at inspectors on occasions when they walked past. This did not demonstrate professional behaviour.
- A consultant from another service, external to the trust, approached an inspector to speak about concerns that had already been raised. This was done in a very challenging way, and as not considered have been undertaken in a professional manner.
- We observed a consultant ask the doctors to ensure that their computers were locked when not in use, to which a doctor responded: "Why? We have never done that".
- We asked the nursing staff about the approach of doctors, and working with them. Nursing staff were hesitant about speaking about the doctors and their working relationships at the start of our inspection. However, towards the end of the inspection, three nurses spoke with us about how challenging the consultants could be and how their attitude and approach had: "Always been that way" and that they were: "Used to it".
- The nursing staff did not feel able to challenge consultants in the department. We were informed of some consultants that nurses would be comfortable to challenge, but they also shared with us those who they would not challenge and why. This meant that the working culture between doctors and nurses needed to improve to be more open and transparent.
- We spoke with the trust executive team who told us that they were aware of behaviours and leadership concerns within the emergency department. They informed us that there was a plan to address this. However, nothing had been formalised and no timescales for this to be tackled and resolved had been agreed. We raised our concerns about the culture and attitude of the consultant team in the department to the executive team for their immediate action and attention.
- The staff said that they sometimes felt that there was a blame culture from the hospital towards the emergency department because they were not routinely achieving the four hour wait to treatment target.
- There was an accepted culture of waiting time breaches over four hours, eight hours and 12 hours within the

trust. We attended two bed meetings during our inspection where performance was discussed. However, the reasons for poor performance, breaches or 12 hour breaches were not. There was no challenge or input into the departmental performance at the bed meetings from the executive team attendees.

- During our unannounced inspection, we noted that there had been a change to the culture within the department. The nursing staff appeared to feel more empowered and were openly escalating concerns to senior managers in the department.
- There had been a change in the culture where waiting breaches were accepted and there was a more open and professional challenge to practice within the department. This was a positive improvement. However, these changes needed to be embedded and sustained which could not be evidenced through the duration of the unannounced inspection.

Vision and strategy for this service

- The emergency department leadership team had a focused on the building of relationships within the unscheduled care directorate since our last inspection. This was a new directorate and the leaders felt that this worked well between emergency care and medicine. Their focus was to build, continue and strengthen the working relationships for the directorate.
- The current clinical lead was not aware of any formal vision for the department. Their vision for the service was: “to be a better department.”
- The strategy for the department dated 2015, provided a list of items for the department to work on during 2015 and 2016. However there were no measurable outcomes identified, leads identified, or how performance would be measured against the strategy, included in the document.
- There was a clear vision and strategy for the children’s emergency department. This included staff training, service expansion and additional coverage out of hours. The service leaders were clear on their vision, how this would be delivered, and when it would be delivered.
- Staff we spoke with across the adult department were not aware of any strategy or vision for the service. However, in the children’s department staff were clear on what the vision was, where the service was going and how they would be involved in the progression of the service.
- Staff were aware of the core values of the organisation and could tell us about these. They were aware of the vision of the trust and the changes that were likely to take place following a change in the executive team.

Governance, risk management and quality measurement

- The department had a risk register, which was part of the unscheduled care directorate. At the last inspection, the identification of risk was a concern and departmental risks were not reflected on the register. At this inspection, we found that there were 22 items specifically related to the emergency department that had been added since our last inspection.
- We met with the leaders of the service who could tell us what the risks were, how they were being managed and where they were being reported to.
- We asked two members of medical staff and two members of nursing staff about the departmental risk register, and if they could tell us what it contained. None of the people we spoke with could tell us what was on the risk register. It was however, displayed on a notice board in the main area of the department.
- We followed a risk through the service to assess staff knowledge and understanding with the CQC critical care team. The risk related to a ‘lack of equipment to transfer ventilated patients for further investigations to ITU or other NHS hospitals. A&E unable to transfer ventilated patients in a timely manner due to lack of oxylog (ventilator) Harm to patients (e.g. recent incident). Still awaiting business case approval’. We spoke with staff about this risk from both an emergency department and critical care perspective. Of the two critical doctors and two emergency department doctors we spoke with, no one was aware of this risk, or the incident. The staff reported that there were no concerns with the availability of equipment so we were unclear why it was on the risk register.
- Staff were unable to demonstrate any sharing or learning from incidents, serious incidents or complaints at a local level. The senior staff, which included the matron and the consultants, were aware; however, other staff were not.
- We were not assured that all incidents within the department were being reported, or were not being reported in a timely way. We had to escalate incidents to the matron to ensure that they were reported and acted upon.

- There was a lack of quality assurance processes in the department because local audit activity was minimal.
- Quality measurements utilising the Royal College of Emergency Medicine quality indicator standards were not taking place. Should the service have reviewed the standards and assessed themselves against it then there would have been clear evidence of how they could have improved the overall four hour performance.

Public engagement

- The department sought comments from the patients. They were engaged through feedback forms, comment cards, the friends and family test. Posters were displayed throughout the department asking for their comments in an effort to improve the service.

Staff engagement

- The department did not undertake any local surveys of staff within the emergency department. However, there had been an increase in staff meetings and sessions to share information.

Innovation, improvement and sustainability

- Having an entirely separate children's resuscitation department was innovative and unique within the region. This was a positive addition to the service.
- The department was running a wide range of admission avoidance services through the emergency department to support patients. This included ambulatory care and the elderly frail unit.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

West Hertfordshire Hospitals NHS Trust provides inpatient medical services with 408 medical beds. The service had 37,033 admissions from March 2015 to February 2016, which consisted of approximately 30% day case admissions, 5% elective and 65% emergency admissions. Approximately 50% of all admissions required general medical treatment, 5% gastroenterology, 8% haematology services and 23% other specialities. Patients were predominantly adults over 18 years; however, some patients were between 16 and 18 years of age.

Medical services were reconfigured in October 2015. The current structure includes a divisional director, head of nursing and a service manager. This team is supported by associate divisional managers and assistant service managers for each speciality, plus a deputy head of nursing and matrons. Medical services are split into two groups, unscheduled care and scheduled care. Unscheduled care consisted of all admission areas, such as the acute admissions unit, coronary care unit and ambulatory care and scheduled care consists of all speciality inpatient wards.

The service had been previously inspected in April 2015 and had been found inadequate for safe, required improvement in effective, responsive and well-led, and good in caring. The service was required to complete a number of actions to ensure that the compliance with the Health and Social Care Act 2008 and had produced a comprehensive quality improvement plan, which reflected these requirements and additional aims and objectives of the service.

During this inspection, we visited the following areas at Watford General Hospital:

Acute admissions unit (AAU)

Aldenham ward - respiratory medicine

Ambulatory care unit

Bluebell ward- care of patients with dementia / impaired cognitive function unit

Cassio ward - gastroenterology

Castle ward- care of the elderly

Coronary Care Unit

Croxley ward- care of the elderly

Discharge lounge

Elizabeth ward- gynaecology

Endoscopy units at Watford General Hospital and Hemel Hempstead

Gade ward – rheumatology and haematology

Helen Donald Unit - haematology day unit

Heronsgate ward – general medicine

Letchmore ward- surgical

Oxhey ward- care of the elderly

Medical care (including older people's care)

Red suite- short stay acute admissions for general medicine

Sarratt ward - care of the elderly

Stroke Unit

Tudor Ward- care of the elderly

Winyard ward - care of the elderly

We spoke with 120 members of staff including nurses, doctors, pharmacists, therapists, administrators, and housekeepers. We spoke with 27 patients and relatives. We observed interactions between patients and staff, considered the environment and looked at 117 care records. We also reviewed the trust's medical performance data.

Summary of findings

Overall, we rated the service as requires improvement for safe and responsive and good for effective, caring and well led because:

- There was no overview of the number of patients who were cared for under a deprivation of liberty safeguards authorisation. This included no trust database relating to the total number of patients, or the expiry of initial authorisation or the date of external assessment. This meant that patients were potentially being deprived of their liberty without appropriate authorisation.
- The management and storage of medications was not always safe. There was varied practice regarding the safe management and storage of patients own controlled drugs, and treatment room temperatures consistently exceeded recommended temperatures. There was limited evidence to support actions taken to address elevated temperatures.
- Mandatory training compliance did not meet the trust target of 90% in all subjects including basic life support, which meant that patients might be at risk when appropriately trained staff were not on duty.
- When there was insufficient side rooms available, patients with confirmed MRSA were nursed in shared bays, in line with trust policy. However, systems were in place to reduce the risk of cross infection.
- The service had variable performance in national audits, and did not have action plans in place to address service results in the National Diabetes Inpatient Audit (NaDIA), Sentinel Stroke National Audit Programme, Heart Failure Audit or the National Lung Cancer Audit.
- Patients experienced multiple moves within admission areas, and were frequently transferred between areas overnight.

However we also found:

- The service had made a number of positive changes to improve the safe delivery care and treatment within medical services since our last inspection.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) figures were better than expected.

Medical care (including older people's care)

- The service had an established seven-day working pattern for physiotherapy and occupational therapy staff.
- Staff were aware of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty safeguards (DoLS). Staff demonstrated awareness of their roles and responsibilities in escalating concerns and preventing harm and accurately recorded assessments and rationales for decisions made. Locally, wards had understanding of those patients who were being cared for under a deprivation of liberty safeguard (DoLS).
- Patients were treated with dignity, respect and kindness during interactions with all staff.
- Nursing staff utilised support networks for patients with emotional or mental health issues and completed joint ward rounds to ensure that all aspects of the patient's physical and mental health were addressed during reviews.
- Data collected through patient satisfaction audits was generally positive and regularly shared within teams.
- Non- medical wards used to care for medical patients at times of high activity used admission criteria to ensure patients' needs could be met. The exception of this was the gynaecology and surgical wards, where patients admitted were identified as clinically stable by medical staff prior to transfer.
- The service worked collaboratively with local authorities and agencies to assist with patient pathways through hospital and discharge.
- Staff had assisted with the development of the trust vision. This was also reflected within the service aims and objectives.
- There were robust systems in place to identify and manage risk and risk registers were reviewed and updated regularly. There was clear escalation processes with reporting between ward, service and trust board. All staff demonstrated good knowledge of local risks.
- The service had a robust audit calendar in place and regularly monitored and benchmarked performance to ensure practice was safe and within trust and national targets.
- Nursing and medical staff were positive about the teams they worked in and the services they provided. Staff felt supported and encouraged to develop themselves and services.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Overall, we rated safe as requires improvement because:

- There was no standardised system in place to manage the storage of patients' own controlled drugs or dispose of them following expiry, which meant that there was a risk of misuse.
- There was no system in place for the management of and escalation of treatment room temperatures, which meant that when temperatures exceeded 25 degrees Celsius, some medications were at risk of deterioration.
- Patients with confirmed MRSA were nursed in shared bays when side rooms were not available. However, there were processes in place to monitor patients and reduce risk of cross infection.
- The physical structure of some wards made the storage of equipment difficult, resulting in equipment being stored in ward corridors. These were risk assessed and recorded on the risk register.
- The age of the building limited affected the ability to ensure a sufficient level of oxygen flow to provide all the treatment options for patients with respiratory conditions within the respiratory ward. This meant that alternative treatments were sought.
- Overall, mandatory training figures had improved, however these did not meet the trust target of 90%.
- There was poor compliance in the monitoring of venous thromboembolism (VTE) risks, which placed some patients at risk of blood clots. Compliance was recorded at 90% against a trust target of 95%.
- The World Health Organisation (WHO) 5 Steps to Safer Surgery' checklist to prevent avoidable mistakes was not in use across the endoscopy units in preference to a three step process.

However we also found:

- Staff were aware of their roles and responsibilities in the management of incidents. With systems in place to report, investigate and share learning both locally and across the service.
- Although the service had a high numbers of medical vacancies locum staff were used to ensure the delivery of care and treatment.
- The service held alternate month mortality meetings, which discussed data and trends.
- Quality indicator dashboards and safety thermometer audit results were shared with teams and reviewed by service leads to identify areas of poor compliance or in need of improvement.
- All areas were visibly clean and tidy. Cleanliness was audited regularly and action plans devised to address any areas of concern.
- Patient's records were maintained and stored securely in line with trust policy. Risk assessments and treatment plans were well documented, clear and legible.
- Staff had a good understanding of safeguarding processes and their roles and responsibilities about escalating concerns.

Incidents

- During the previous inspection, we found that staff were not fully aware of their roles and responsibilities concerning the management and reporting of incidents. During this inspection, we found that improvements had been made. All staff spoken with were aware of their roles and responsibilities in the management and reporting of incidents. Staff said they were encouraged to complete incident reports on the trust's electronic reporting system. Nursing staff reported that they used reflective accounts to consolidate learning from incidents and were able to give accounts where this had happened.
- The trust medicine service reported 2657 incidents from April 2015 to May 2016, which included 217 relating to documentation, 141 relating to communication and 114 relating to behaviour. We saw evidence that incidents were investigated locally and findings shared with staff through team meetings and communication books. Staff confirmed that the service shared learning across all staff groups through individual feedback, team meetings or newsletters.
- The trust reported no never events in medical services from July 2015 to June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to

cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

- Strategic Executive Information System (STEIS) data showed that, between July 2015 and June 2016, there had been 12 serious incidents requiring investigation. This was a significant reduction from the previous inspection data, which reported 90 serious incidents between February 2014 and January 2015. Five of the current serious incidents referred to hospital acquired pressure ulcers, above grade 2. Pressure ulcers affect an area of skin and underlying tissue and are categorised according to severity from one to four. For example, category one identifies the discolouration of skin, with category four being full thickness skin loss with underlying damage to muscle, bone or tendons. All pressure ulcers reported by the service as a serious incident were category three which denotes damage to full thickness of skin, but not through to underlying tissue. To help reduce the number of hospital acquired pressure ulcers the trust had implemented an increased awareness programme, which included improved staff alertness of risks and actions that could be taken to reduce harm.
- The trust had established a mortality review process, which electronically recorded mortality reviews and graded statements of care. Mortality review group meetings were held every alternate month and chaired by the medical director. Agenda items included mortality reviews, performance data relating to mortality, which included the Hospital Standardised Mortality Ratio (HSMR) data, clinical coding as well as patient safety indicators. Consultants reported that the meetings were well attended and discussed at local and service lead meetings. Minutes from these meetings were observed during inspection and confirmed discussion topics and attendance. Minutes also demonstrated open discussions relating to learning and challenge from peers to confirm practice and where things could be improved.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Staff were aware of their roles and responsibilities in relation to duty of candour. Nursing staff openly discussed incidents and learning, and were able to give examples of situations where duty of candour was applied.
- A consultant in the admissions assessment unit (AAU) reported that the team maintained effective duty of candour with both patients and relatives especially where a patient was found to have a hospital acquired infection.
- Staff told us that policies and procedures were changed to reflect learning from incidents and recalled an incident, the learning and the changes to policy to demonstrate the service learning. For example, following an incident where a nasogastric tube (tube placed into the nose and down to the stomach for nutritional support) was placed incorrectly. The policy had changed to state that all nasogastric placements required an x-ray to check position prior to being used. This also reflected National Patient Safety Agency alerts 2011, which stipulated that placement of nasogastric tubes should be checked through either pH (acid) testing or by x-ray prior to use.

Safety thermometer

- Each ward used the NHS Safety Thermometer (which is a national improvement tool for measuring, monitoring and analysing harm to patient's and 'harm-free' care). Monthly data was collected and displayed locally on pressure ulcers, falls and catheter associated urinary tract infections and blood clots (venous thromboembolism or VTE). Staff we spoke with were aware of these audits and how results were used to make improvements.
- NHS Safety Thermometer data showed the service reported 13 pressure ulcers (category two to four) from June 2015 to June 2016. Five of these were reported as serious incidents. Local ward actions taken prior to our previous inspection included raising awareness of staff through teaching and ward meetings and the use of visual reminders of patient's movement regimes. Since May 2016, these actions had resulted in fewer hospital-acquired pressure ulcers.
- Wards carried out monthly audits on pressure ulcer prevention in addition to the safety thermometer audit, which were reviewed by the matrons. Audit results were

reported to the trust board as part of the quality performance review of each service and trends and themes were discussed. Action plans were put in place to address any concerns.

- Twelve falls with harm were reported across medical services from June 2015 to June 2016. One incident resulted in a fracture and was reported as a serious incident, the remaining falls had resulted in minimal or no harm such as bruising. Trust data showed that the number of falls had reduced over this period with 44 falls being reported from December 2013 to December 2014.
- Sixteen catheter-associated infections were reported between June 2015 and June 2016. This was an improvement since the previous inspection when 66 catheter-acquired infections were reported from December 2013 to December 2014.
- NHS Safety Thermometer data showed that the trust had a harm free rating greater than 95% from January to April 2016, which was in line with trust target and as expected for the organisation.
- In addition to the safety thermometer data, wards completed monthly quality dashboards, which identified their performance against quality markers such as the number of complaints, number of incidents and staff sickness and vacancies. These were held electronically and discussed at service governance meetings and at ward meetings to identify areas of poor compliance or in need of improvement. Ward staff were aware of the dashboards, and told us that the wards were commencing a ward accreditation scheme. Minutes were observed relating to this during inspection.
- All wards also used noticeboards to display recent safety and quality information. These were updated regularly during inspection and details included how each ward performed in delivering harm free care to patients.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were generally well maintained. The service had systems in place to reduce the risks of healthcare associated infection.
- Areas visited were visibly clean and current cleaning schedules were displayed. Cleaning schedules were signed in accordance with trust policy to confirm that cleaning had taken place.
- We saw that housekeeping staff usually refrained from entering the ward bays during meal times, however we observed one occasion on Sarratt ward where a patient had been taken off the ward on their bed and the floor was being swept during breakfast. This meant that patients' breakfast could be contaminated from dust being generated by the sweeping of the bed space.
- We also saw that one male patient had a used urinary bottle on their bedside table, whilst eating their breakfast. This was removed when highlighted to the staff concerned.
- All staff reported that they were familiar with the trust's infection control policies and were able access them on the trust website.
- Staff had access to personal protective equipment (PPE) such as gloves and aprons. We observed staff adhering to the trust's 'arms bare below the elbow' policy, applying gloves and aprons as required, and washing their hands and using hand sanitising gel following their time spent with patients.
- "I am clean" stickers were used across all inpatient areas to inform staff and patients that equipment was appropriately clean for use. Equipment seen was labelled and dated for the day of inspection, signifying that all equipment had been cleaned.
- Cleaning materials were stored appropriately and were kept securely in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances, which are hazardous to health.
- Infection control and prevention audits were completed monthly, with an increased frequency of auditing for poor compliance. For example, AAU isolation area was found to be 15% compliant with handwashing in April 2016. As a result, the service increased the auditing to weekly, targeted training and completed a hand hygiene day. The infection control team completed regular visits to this area, and compliance improved. In May 2016, compliance was recorded at 90% in line with trust target.
- Infection control information was displayed across all clinical areas, with details of correct procedures for hand washing, contact details for the trust's infection control and prevention team and details of audit results.
- We saw two patients with confirmed MRSA being nursed in bays of six patients (on Winyard and Sarratt wards). On discussion with the nursing teams, staff confirmed that patients identified as being MRSA positive were usually moved to a side room, however in both cases

highlighted this had not been possible. The process for managing patients in this situation was to continue to treat the patient within the bays. We saw that staff provided appropriate PPE, and separate washing/ toileting facilities for these patients in line with the trust policy for MRSA dated 2015.They also involved the infection control and prevention team to ensure that all risks had been identified and actions taken to reduce the risks of cross infection. We did not see records of discussions with the infection control team recorded in the patient records, but did see that the patients were aware of the diagnosis and treatment plans.

- We were informed that when the patient was discharged, the remaining patients were screened for MRSA, the bay was deep cleaned, and curtains changed. Nursing staff reported that the trust had a small number of side rooms, and patients with loose stools were deemed to require isolation in preference to those with MRSA. The trust policy for MRSA (2015) gives clear instructions for the cleaning of bed space and equipment following patient discharge. The policy also included a comprehensive care plan for patients with MRSA. We saw that the risks associated with the number of side rooms, or risks associated with nursing patients with MRSA in bays was not recorded on the trust or service risk register.
- From December 2015 to June 2016, there were eight cases of hospital acquired C.difficile infections within the service. These were attributed to four separate clinical areas, with no identified trends. The trust target was for less than 23 cases per year.
- Patient records we viewed had discussions with microbiologists regarding the management of infections recorded to minimise risks of infections.
- The trust have had a water hygiene manager in place since October 2015 in response to an increased risk of legionella or other bacteria due to the age and condition of the estate. This individual was responsible for the completion and reviewing of all audit data relating to water sampling across the trust, the development of associated action plans and reporting findings to the infection prevention and control group and trust board. Elevated risks associated with the quality of water were recorded on the trust risk register.
- The endoscopy unit had effective processes in place to ensure the cleanliness of equipment and to prevent contamination. This included separate dirty and clean rooms, and the use of designated staff for equipment cleaning. We saw endoscopes were leak tested, manually cleaned, and washed in washers between 45-50 minutes following a full wash cycle.
- The endoscopy team completed weekly water sampling for contamination. There was evidence of sampling, results and action taken for "rogue" results. Any incident of contamination was managed by resampling and "closing" the unit until confirmed as clear of contaminants. We saw stringent infection control measures were followed in the endoscope washrooms.
- Decontaminated endoscopy equipment was stored for up to 72 hours in ultraviolet cabinets within the department. Endoscopy staff tracked all equipment to ensure effective decontamination.
- There were processes and procedures in place for tracking equipment used for each patients investigation, including sterile equipment used for biopsies and details of staff members operating and decontaminating.
- Patients attending endoscopy appointments identified as having suspected communicable infections were placed at the end of treatment lists to allow additional cleaning times between patients.

Environment and equipment

- During the previous inspection, we identified that not all sterile supplies were stored appropriately, and not disposed of when they had expired. During this inspection, we found that improvements had been made and supplies were managed, stored and disposed of appropriately.
- The medical service was divided into two main groups; admissions and inpatients. Admissions were located in the acute assessment unit (AAU) building that was relatively new and was accessed from behind the main hospital building. Wards within this area consisted of a series of bays and side rooms. We found that signage was poor within the AAU building, with areas being referred to as colours and names, for example, blue suite was also referred to as the coronary care unit. We observed in the reception area for a short period and noted that the majority of people attending asked the receptionist for directions to the area they were looking for.
- AAU was attached to the Granger suite, which consisted of three inpatient areas, Winyard and Bluebell wards and Red suite (short stay general medical ward). These

wards consisted of one male and one female-bedded bay and no side rooms, each bay holding nine patients. These areas were approximately three years old and appropriate to the needs of patients cared for.

- The remaining estate of the hospital varied in age, with most medical wards within the main building named the Princess Michael of Kent (PMOK) building. The estate affected the ability to store equipment and use certain therapies. For example, Aldenham ward had insufficient dirty utility room space, which resulted in clean commodes being positioned in the main ward corridor. In addition, the existing oxygen pipe work did not permit sufficient flow to enable portable continuous positive airway pressure (CPAP) ventilation on wards within the PMOK building. This reduced treatment options available and patients requiring this type of respiratory support were treated with alternative therapies. All staff reported plans to move the respiratory service to the AAU building as part of a trust wide reconfiguration. The storage of clean commodes and reduced oxygen flow were known by the service and were recorded on the risk register.
- The layout of wards within the PMOK building meant that nursing staff were not always visible if they were attending patients in bays. For example, some wards such as Aldenham and Croxley were positioned around the corners of the building, making an "L" shaped ward. This meant that on occasions when visitors attended the wards, they could not see staff. The wards within the acute admissions and Granger suite had been designed to include a nurse's station in each bay, which enabled visibility of both patients and staff.
- All equipment we checked was labelled as being suitable for use. We spoke with the equipment library staff who confirmed that medical devices such as infusion pumps (devices used to administer intravenous medication at a controlled rate) were removed from ward areas following use and returned to the equipment library for cleaning and testing. Once this was completed, the item would be available for staff to collect and reuse when necessary.
- Nursing staff said there was adequate supply of equipment to meet the needs of the patients. This included alternating air mattresses and infusion pumps.
- The medical devices compliance audit conducted in May 2016 reported that the trust's reactive maintenance compliance rate was at 88% against a target of 90%. The clinical engineering team maintained an effective database of equipment in use and servicing details.
- We inspected 12 resuscitation trolleys that were centrally located on wards. They were visibly clean and defibrillators had been serviced in line with trust policy. Staff had documented daily equipment testing for the resuscitation trolleys to ensure equipment was fit-for-purpose.
- We looked at environmental audits completed in five medical wards and the compliance rates ranged between 96% and 100%. Issues identified during the audits were discussed with the ward sister and an action plan devised to target the findings. These included additional training or support to staff about handwashing, cleaning and the replacement of equipment. Audit results were reviewed by the ward matrons and reported to the service and trust board.
- All doors to treatment or storage rooms had keypad locks in-situ. Nursing staff reported that keypad numbers were changed at regular intervals (six to eight weeks) to ensure security.
- Waste management was handled appropriately with separate colour coded waste bags for clinical and domestic waste. Bins were not overfilled. Sharp boxes for the disposal of needles were found to be appropriate to clinical area and detailed the date, time, and person responsible for assembling them. All were assembled correctly. Dirty utility rooms (or sluice rooms) were observed to be clean and tidy with appropriate storage for waste and chemicals.
- We observed that the fire extinguishers on each ward had been checked to ensure they were safe and appropriate to use.
- The endoscopy department had achieved Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation in January 2014, which includes the annual review of policy and guidelines and a number of audits in clinical practice. The audits required reviewed consultant specific completion rates, pain scores, timeliness of procedure list and an annual review by clinical commissioning.
- Both endoscopy units (Watford and Hemel Hempstead sites) were well maintained. We observed that the Watford unit provided separate male and female recovery areas ensure privacy and dignity.

- Equipment used for endoscopy procedures was tracked through the cleaning and sterilisation phases, and stored in locked cupboards in line with best practice.
- Weekly cleaning audits were completed effectively within the endoscopy unit. No anomalies were noted.
- Staff told us that specialist equipment was maintained through manufacturer maintenance contracts. Nursing staff reported that they had access to sufficient equipment for the clinical needs of each department. This included the endoscopy unit, catheter laboratory and wards.
- We observed that blood samples were stored in a designated container on the nursing station of wards visited. All samples we observed were labelled and packaged correctly. We saw that nursing staff told porters that the samples were ready for collection and the porters took samples to the relevant laboratory.

Medicines

- The previous inspection identified that medication was not always appropriately secured, the treatment room on Gade ward was not locked, and drugs were left on top of a drug trolley on Sarratt ward. We had also previously identified that there were gaps in the recording of drug administration in 13 out of 25 patient drug charts. During this inspection, we found some improvements in the recording of omissions, however had concerns regarding the safe storage of controlled drugs (those requiring extra checks and special storage arrangements because of their potential for misuse).
- There was no process in place for the safe storage of patients own controlled drugs. On Sarratt ward, nursing staff used the patients' own drugs, which they brought into hospital. These were checked and recorded when used and daily. However, we saw that Tudor ward sealed patients' own controlled drugs in envelopes and stored in the locked controlled drug cupboard. The envelope was checked daily, however was not opened to check the number of tablets contained. This meant that there was risk that not all controlled drugs were being accurately recorded and were at risk of misuse. The medicines management policy 2016 states that patients own controlled drugs should be sealed in envelopes, which are labelled with the patients' addressograph and double signed across the seal by two nurses. These were to be returned to patients on discharge.
- We raised this inconsistency of storage, administration and recording of patients' controlled drugs, with the senior managers during the inspection. During the unannounced inspection on the 19 September 2016, we saw that all staff had been informed that all patients' own drugs were to be checked and recorded daily in line with stock controlled drugs and not stored in sealed envelopes. This had been requested through a letter to each ward area and observed that envelopes were no longer in use on the wards. The medicines management policy did not reflect this change at the time of inspection.
- We saw that staff on Red suite and Croxley ward had disposed of unused controlled drugs from infusions in sharps bins. This was not in line with Home Office advice and the Department of Health Safer Management of Controlled Drugs: a guide to good practice in secondary care 2007. We spoke with staff in these areas and were told that there were not robust systems in place for the management and disposal of controlled drugs. The medicines management policy 2016 states that unused liquid medication should be poured onto gauze or tissue and disposed of in the sharps bin. Unused or partial tablets are required to be disposed of in the same manner.
- Ward staff told us that the pharmacy team attended the wards to remove unused or expired controlled drugs. However, on the ambulatory care unit, we found two controlled drugs out of date. Ward staff told us that these had been reported to the pharmacist and were waiting for them to be removed.
- All drugs were stored safely behind locked doors and only accessible to appropriate staff.
- The ambient temperature of the treatment rooms were recorded daily to ensure temperature sensitive medication was stored correctly. The temperatures of Tudor, Heronsgate and Croxley wards treatment rooms were found to be consistently above the recommended storage temperature of 25 degrees Celsius. Temperatures were recorded up to 27 degrees Celsius on Oxhey and Tudor wards. This meant that drugs were at risk of being damaged, which could affect their effectiveness if administered. Nursing staff told us that they had reported these incidents to the pharmacy department and recorded them as incidents. However, the expiry dates had not been changed as required by trust policy. Nursing staff had taken steps to reduce room temperatures, which included opening of

restricted opening windows and placing fans within rooms. Nursing staff also confirmed that they had discussed dates of expiry with the pharmacy department. During our unannounced inspection on the 19 September, we observed that incident report numbers were noted on temperature charts and expiry dates had been amended in line with trust policy.

- In addition to ambient temperatures, all wards recorded drug fridge temperatures daily. Records on all wards showed that the drug fridges were maintained within the recommended temperatures. The record sheets detailed actions to be taken if temperatures were outside normal range.
- Intravenous fluids in Red suite were stored securely in a cupboard, however, some had been decanted from their original outer boxes and were being stored on top of boxes containing a different type of fluid, and this included potassium-containing fluids. There was therefore a risk that staff could pick up the incorrect fluid and potentially administer this to a patient. This was raised with the ward sister at the time of inspection and the fluids were rearranged.
- We saw that there was no process or chart in place to assist nursing staff to correctly administer drugs that were applied by patches to the skin. Nursing staff on Heronsgate ward were not familiar with the need to rotate medication patches to avoid side effects, and confirmed there was no process in place. Staff were not aware of any initiatives to introduce a system at the time of inspection. Risks associated with poor rotation of drug patches includes, local irritation and poor absorption,
- Nursing staff were observed administering patients' medication in line with the Nursing and Midwifery Council Standards for medicines management 2007. This included checking the drug, its expiry date, dose and time due. All nursing staff were observed checking patients identity prior to administering drugs.
- We saw that two nurses checked controlled medications and drug registers confirmed this, as two signatures were always present. The pharmacy department completed quarterly checks of the controlled drug stock and administration books in line with the medicines management policy 2016. We saw evidence of these checks within the ward controlled drug stock books.
- We looked at 45 patient drug charts. Arrangements were in place for recording administration of drugs and a coding system was used to explain any reasons why they were not administered. During the previous inspection, there were concerns that some patients had not been given the correct medication with a high number of omissions noted. However, we found that there were no gaps on the drug charts during this inspection. All drug charts had allergies and weights recorded and all medicines were recorded as given as prescribed. Where medicines had been omitted, they were clearly recorded with an appropriate code as to the reason why.
- Nursing staff told us that antibiotic regimes were not always reviewed in line with trust guidance. Drug charts were designed so that the medical team could review courses of antibiotics at set intervals, usually 72 hours. However, compliance with this varied. We saw medication charts across all wards where some antibiotic regimes had been reviewed and drug charts signed and dated to record this and others that had not. The trust had completed an audit of antibiotic prescribing to review compliance against trust policy and national guidance. The audit was completed for 621 patients across the trust, 286 of which were prescribed antibiotics. The largest portion of these patients was within medicine (56%). The results showed that within medicine there was an overall 76% compliance with guidelines, and 70% compliance in the completion of records associated with the prescribing of antibiotics. These results were compared to the same audit from 2012, 2013 and 2014 and showed a reduction in the use of antibiotics with 33% of patients prescribed antibiotics in comparison to 40% of patients in 2014. This was a positive step and in line with national institute for clinical excellence guidance 2014 on reducing the overuse of antibiotics .The actions planned because of this audit included additional training and the completion of joint ward rounds with pharmacy. We saw pharmacists attending ward rounds during our inspection.
- During the week, the ward pharmacist visited the ward daily and monitored the prescribing of drugs, and offered prescribing advice. They also completed drug reconciliation, which was a process of checking drugs prescribed against those previously taken by a patient. All drug charts checked had a completed drug reconciliation record. We saw evidence of reconciliation being completed with comments being recorded in patient notes and on drug charts.

- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- Prescriptions for patients awaiting discharge were completed as part of the hospital discharge letter. The ward pharmacist reviewed the letter containing a list of drugs to take home before being taken to the pharmacy department. While people were waiting for this to be prepared, drug charts were not available, which meant that patients might miss doses or have delays in administration. Nursing staff told us this was particularly a problem in the discharge lounge; however, we did not see any occasions where drugs were not available during inspection.
- We saw that sedation prescribed by consultants in the endoscopy department was prescribed and administered in line with trust policy.
- The service used a competency assessment tool for all new staff. This involved new staff completing a series of drug rounds whilst supervised and assessed by the ward sister or professional development team. This process was repeated as necessary until competence agreed. Nursing staff were given additional support if necessary to complete this. We saw drug rounds being supervised and assessed during inspection.

Records

- The previous inspection identified several concerns relating to the management of patient records, which included unsecure computer terminals, the display of confidential patient information in ward areas and incomplete patient records. The issue of patients' records were detailed in the trust quality improvement plan as requiring improvement following consistently poor audit results. During this inspection, we found that patients' individual care records were written and managed in a way that kept patients safe. Records seen were accurate, complete, legible, and up to date. Patient records were maintained in accordance with trust policy.
- Since the last inspection, the service had introduced new patient records. The documents replaced the previous nursing risk assessments and included a file, which contained guidance on types of assessments used, and how to complete them. The system was introduced one month prior to inspection. We observed 80 patient records across all ward areas and found that all nursing risk assessments were completed and repeated at regular intervals. The repeat risk assessments corresponded to changes in patient's condition; transfer to another ward or after three days of admission. We saw that these charts were completed in accordance with trust policy and that they accurately recorded information pertaining to the patient's condition. For example, we saw that patients unable to mobilise or change position in bed were assisted to move and the records accurately reflected changes made.
- The service had introduced a ward round checklist which was completed during each consultant ward round. The templates included guidance on what to consider during the ward round, such as the completion of venous thromboembolism (VTE) assessments, review of antibiotics, discussions with family and review of treatment plans. These checklists were only in use on Cassio ward, as the service was awaiting the final version to be delivered from the printers following a successful trial across clinical areas. Implementation across the service was planned for October 2016.
- On the last inspection, full patient names were visible on ward boards, however during the inspection we noted that the patients' initial and surnames were displayed only. This meant that patients were still identifiable to visitors and staff attending the unit.
- All wards had locked medical notes trolleys, which were located either at the nurse's station or at the entrance to the medical bays. The keypad numbers were universal across all wards to ensure that staff were able to access information in any clinical area. All computer terminals were secure and locked to prevent non-authorised persons accessing patient information.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- Safeguarding children training was mandatory for all staff. The level of training varied according to the individual's role. For example, staff that were not clinical and had no contact with children required a different level of training to those who worked clinically with children. Trust data showed that Safeguarding children training level 1 training had been completed by 91% of medical staff, Level 2 by 94%.

- Safeguarding vulnerable adults training was also mandatory with a trust target of 90%. Within the service, medical staff did not meet the trust target with 88% compliance with safeguarding adults' level one training and a 90% compliance with level two training.
- Nursing staff had 90% compliance for safeguarding adults' level one and 93% compliance in safeguarding adults' level two 2 training, which met the trust target of 90%.
- Those interviewed were able to provide definitions of different forms of abuse and were aware of safeguarding procedures, how to escalate concerns and relevant contact information. Information on safeguarding was seen on staff noticeboards and in public areas with relevant contact numbers.
- There were clear systems, processes and practices in place to keep patients safe, and staff were able to give examples when they had made referrals to the safeguarding team when required.
- Nursing staff were aware of their responsibilities regarding safeguarding and had access the trust policy on the intranet.
- There was a named safeguarding lead for the service and ward staff knew how to contact them for support.

Mandatory training

- During our last inspection, we identified that staff compliance with mandatory training was 79%, which was below the trust target of 90%.
- The quality improvement plan included improving the compliance of all staff in the service with mandatory training to the target of 90%.
- Mandatory training included ten core topics, which included infection control, manual handling and basic life support. The level of training depended on the individual's roles and responsibilities.
- Overall, mandatory training compliance in the service varied between 44-100% against the target of 90%. Aldenham, Heronsgate, Tudor, Oxhey wards, ambulatory care, the discharge lounge and hospital at night teams had achieved this target in all mandatory training. The remaining wards had varied compliance across all ten mandatory subjects. Sarratt ward had the lowest compliance across all mandatory subjects with 64% in manual handling and information governance, and 76% in the remaining subjects. Nursing staff training compliance for basic life support was reported as 44% on Sarratt ward, 60% on Winyard ward, 70-80% on Tudor and Cassio wards, 80-90% on Croxley, and Bluebell wards and greater than 90% in all other areas.
- Medical staff were reported as being 90% compliant in basic life support, which was in line with the trust target, which would ensure that there was a competent person in attendance at all emergencies.
- Ward sisters reported having worked hard at improving compliance and were planning training in off duty to ensure targets were met. The service had a planned trajectory for full compliance by December 2016. We saw evidence of training sessions displayed on ward notice boards and names planned to attend throughout our inspection.
- Training was not recorded on the risk register but was being tracked through the trust quality improvement plan. In response to the training deficit, the service had developed online training and a review of roles to ensure that training was specific to the needs of the role.
- We did not see any evidence of sepsis training for nursing or medical staff during inspection.

Assessing and responding to patient risk

- During our last inspection, we found that there were inconsistent consultant-led ward rounds, arrangements for the care and treatment of patients with respiratory problems was not being managed safely, the trust policy for non-invasive ventilation (NIV) was out of date, and there was not a facility to care for deteriorating patients with high dependency needs. During this inspection, we found that improvements had been made in accordance with the service's quality improvements plans. Appropriate systems and process were now in place to identify, assess and respond to deteriorating patients' needs.
- We reviewed the medical notes of 80 patients across all ward areas and found that there was a robust system in place for clerking new admissions. When appropriate, clinical treatment pathways were in use, and the templates included relevant assessment templates. We found that these were completed and patient treatment plans were in place within 24 hours of admission.
- All patients were assessed on admission to hospital and medical consultant reviews were completed within 12 hours of admission. These were usually completed within the acute admission unit or clinical decision unit.

Any patient identified as being acutely unwell and a high risk were escalated to the consultant for an urgent review. During inspection, we saw that the consultant reviewed patients according to their stability, prioritising high-risk patients above those who were more stable. This practice was in line with the London Quality Standards 2013.

- We saw that the endoscopy teams did not consistently use the World Health Organisation (WHO) 5 Steps to Safer Surgery' checklist to prevent avoidable mistakes. A mixture of three step process and five step process checklists were being used across the teams.
- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. The service used the National Early Warning Score (NEWS) system for identifying and escalating deteriorating patients. We reviewed 30 NEWS charts and found these were completed appropriately with evidence of escalation when required.
- We saw that sepsis bundles were included in the clerking templates within all clinical pathways. During the review of medical notes, we found that the sepsis bundle was well used and included details of patient condition and symptoms, possible diagnosis and treatment plan. In all cases where sepsis was suspected, treatment such as oxygen therapy and antibiotics was provided within appropriate timescales.
- Wards did not have sepsis boxes but held frequently used antibiotics within the treatment rooms, which could be used if patients were admitted with a suspected sepsis. We did not see the sepsis pathway in use on the wards during inspection.
- Helen Donald Unit staff provided patients with alert cards with drug specific information, side effects and signs and symptoms to observe post chemotherapy. There was a 24-hour acute oncology telephone triage service. Patients who had received chemotherapy within one to seven days and had suspected neutropenic sepsis were advised to go to the emergency department for assessment and treatment. Trust data showed that 13 neutropenic patients were admitted through the ED from April 2016 to September 2016. Seven patients received intravenous antibiotic treatment within the recommended one hour from admission, a further four patients received treatment in less than two hours. The last patient received treatment after three and a half hours, but was already noted as being on oral antibiotics. NICE guidance July 2016 states that patients with suspected sepsis should receive antibiotics within one hour of being identified which meant that 53% (7 out of 13) of patients were treated within the recommended timescale. Although this is a relatively small sample size, the results show poor compliance to national guidance.
- The service used a venous thromboembolism (VTE) and risk of bleeding assessment tool, which should be completed on admission and repeated after 24 hours. We saw that this did not always follow the National Institute for Health and Care Excellence (NICE) reducing venous thromboembolism risk in hospital patients' guidelines on all wards. Initial assessments were completed, however, not always repeated within 24 hours of admission. The service recognised this as an area for improvement and had implemented a number of actions to address the concerns. This included monthly auditing of VTE assessment completion, the implementation of additional nursing and medical staff training, the use of a ward round checklist to trigger a review during the ward round and the inclusion of VTE assessments within the matrons ward quality check. Trust data showed that there was 91% compliance in July 2016 against the trust target of 95%.
- We saw that patients' skin integrity was reviewed on admission using a national skin integrity assessment tool, the Surface, Skin inspection, Keep moving, Incontinence and Nutrition (SSKIN) care bundle. The care bundle provided guidance to use five interventions to promote effective skin care. We saw this assessment was completed upon arrival to the admissions wards and repeated after each transfer to another clinical area. This process enabled staff to identify a baseline condition and any pre-existing tissue damage.
- Patients at risk of skin damage due to underlying or admitting clinical conditions were nursed using pressure relieving mattresses and seat cushions.
- Intentional rounding charts were used across the service and included staff signatures for all care provided. These included ensuring call bells were in reach, oral fluids were offered, and details of patients being assisted to change position.
- All patients admitted to the service were assessed for falls risks using a national falls risk assessment tool. We saw evidence of this being repeated when patients' conditions changed or when transferred to another

clinical area. Nursing staff informed us that patients identified as being at risk of falls were placed close to bathrooms where possible. This prevented patients from walking long distances.

- Consultant ward rounds were reported by nursing staff as being completed a minimum of twice daily within the acute admission unit. The department had an electronic system for recording patient arrival and treatment times, which enabled auditing to ensure compliance against national guidance. Data reviewed during inspection confirmed that a consultant saw patients within the recommended 12 hours (London Quality Standards, 2013). We saw that all patients' records detailed reviews and treatment plans completed as part of a consultant ward round.
- Consultants completed daily ward rounds on the stroke unit, cardiology wards and respiratory wards. All other clinical areas completed consultant ward rounds on Mondays, Wednesdays and Fridays with specialist registrars completing ward rounds on Tuesdays and Thursdays. All patients were reviewed during the ward rounds, which ensured that patients' progress was monitored. All staff reported that the consultants would prioritise new admissions or those patients whose clinical condition had deteriorated since the last review. We saw evidence of weekday reviews in all patients' medical notes. At weekends, patients were reviewed by the out of hour's medical team following a referral for ongoing assessment or following deterioration.
- Respiratory medicine offered a seven-day service, which enabled high-risk patients requiring non-invasive ventilation (NIV) to be reviewed by a specialist consultant daily. Patients on NIV are at high risk of deteriorating if their ventilation is not managed appropriately. All non-invasive ventilation patients were cared for on the respiratory ward (Aldenham). The service did not provide a high dependency area but by grouping patients together was able to ensure that skilled nursing staff were available to care for higher risk patients in one area. We saw that ward staffing reflected this with senior experienced staff working in the bays with patients receiving NIV. During inspection, we saw evidence of daily consultant reviews recorded in medical notes and one male and one female bay, each with a variety of patients, including non-invasive ventilation.
- Patients who became unwell during outpatient procedures such as endoscopy or during outpatient clinic appointments were admitted to the service through the admissions assessment unit following a discussion with the GP liaison nurse.
- The critical care outreach team were available to all staff from 8am to 9pm seven days per week. Between 9pm and 8am, the critical care outreach team calls were triaged by the hospital at night team, who made direct contact with the service through a dedicated number. All members of the hospital at night team were aware of the direct contact numbers out of hours. Patients requiring high dependency care were transferred to the intensive care unit following a referral to the medical team and a clinical review.
- The service had introduced a "hospital at night" team, which consisted of a specialist nurse, two assistant practitioners, a foundation year one doctor, a foundation year two doctor and a registrar. This team were responsible for the medical care of patients overnight within the main hospital (excluding admissions). The service triaged all calls for assistance by wards and allocated tasks to the most appropriate person, for example, placement of intravenous devices or blood samples by the assistant practitioners. This meant that the nursing staff were able to support the medical team on call and complete clinical tasks. This enabled the doctors on call to prioritise and review acutely ill patients or referrals in a timely manner.
- Patients identified as at risk of harm if left unattended were nursed in all inpatient areas using a one nurse to one patient ratio. The nurse would assist the patient to complete task and offer support when necessary to prevent harm, this would include assistance with mobility and when attending other departments for investigations. Any patients identified as requiring specialist support were referred to Bluebell ward. This ward provided additional services and support for high-risk patients with cognitive impairment such as dementia or delirium. This included joint assessment by a frailty specialist and mental health consultant, diversional therapy, activities and input from the mental health team.

Nursing staffing

- During our previous inspection, we identified that there were significant shortages within the nursing staff establishments, which directly affected the risks

associated with the management of patients. Agency nursing staff consisted of up to 21% of ward establishments, and there were regular reports of unfilled shifts. Agency staff were poorly orientated to clinical areas, and did not receive training in equipment or security. During this inspection, we saw that improvements had been made in line with the service's quality improvement plan.

- We saw that staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. On most wards one registered nurse and one healthcare assistant were responsible for one bay of patients, which usually had six to eight patients. Staff measured patient acuity and flexed rotas to match patient dependency. The service used the Safer Nursing Care Tool Establishment, a recognised patient acuity tool, to determine levels of nursing staffing on the wards.
- Actual staffing levels were comparable to the planned levels for most of the wards we visited. Wards displayed their planned and actual staffing numbers at the entrance to each ward. These were changed regularly to reflect the actual number of staff on duty. We observed previous duty rosters, which confirmed staffing levels were appropriate to clinical need.
- There were arrangements in place to escalate concerns regarding staffing levels. We saw that the matrons and on-call clinical leads were responsible for ensuring safe staffing across all clinical areas. This was completed using professional judgement and no formal checklist or risk assessment was in use. Ward sisters were required to complete a daily report detailing staffing levels. This was graded as red, short staffed with high activity and requiring assistance, amber, short staffed but manageable workload, and green, normal staffing and no issues. Clinical leads used this information to move staff from areas identified as green to those which were identified as red (staffing shortages). Out of hours, staff recorded all decision making on a daily report, which was cascaded across the senior nursing and management team. This process and copies of the daily report were observed as part of the inspection.
- The service reported on the number of shifts per month that were identified as being "red" (at risk) and trust data showed that there was one shift reported as red rated on Heronsgate and Gade wards in July 2016. The trust reported no harm to patients because of this, and a root cause analysis was in progress to identify any learning or actions. This was an improvement in at risk shifts, as 56 were reported in May 2016 and 169 in April 2016. There were no red rated shifts in June 2016.
- The ward sisters who managed two ward areas flexed staffing levels across their wards to meet the demands of the activity. For example, the ward sisters for Gade and Heronsgate wards, and Tudor and Castle wards, and cardiology were observed flexing staff during inspection, based on an initial assessment of the activity in each ward area.
- The service had a staffing escalation policy and process in place whereby any unfilled shifts were escalated to a matron or the clinical site supervisor at night. We observed the ward matrons attending each clinical area to review the staffing levels, ward activity and offering support to the ward teams. Management staff flexed permanent staff from ward to ward to cover vacancies.
- The service had recruited 60 nurses since July 2015. To ensure that staff were fully inducted to the hospital and competent, all staff worked a supernumerary period within the clinical areas. The duration of this period could be flexed depending on the individual's development needs. Throughout this period, a named mentor and ward sister supported the staff member. We observed this in practice on Sarratt ward where supernumerary staff were allocated a number of patients and managed their care under the supervision and guidance of another registered nurse. Staff reported that this system worked well and enabled them to develop at their own pace.
- Ward sisters reported working from 7am to 3.30pm with junior ward sisters taking responsibility for the wards in their absence. Ward sisters completed clinical activity on the wards during their shifts and often prioritised clinical needs over management tasks.
- Student nurses were supervised during their placement on wards, and depending on their level of training would take their own caseload of patients (under supervision) to develop their skills.
- Arrangements for using bank, agency and locum staff were robust. The service reported that they had filled 10% of registered nursing shifts with agency staff on average, from June 2016 to August 2016. This was a reduction from the figure identified during our last inspection, when the trust reported 15% use of agency staff in May 2015.

- The service reported that all wards were in the process of completing an establishment review and move to "safer nursing care" model, which is a tool used to identify safe staffing in acute clinical areas. This process included the senior nursing team, including ward sister discussing activity and patient dependency and agreeing on the number of staff required to provide the care. This process was reported as being completed every six months.
- During our previous inspection, we identified that Sarratt ward had 14.9 whole time equivalent (WTE) nursing vacancies, which was equivalent to half of the ward's registered nurses. During this inspection, Sarratt ward nursing staff reported that they were still recruiting and had a current vacancy of five WTE nurses. The lead nurse for medicine said the team had agreed to stagger the recruitment of staff, as this process would enable smaller numbers of new staff to be fully orientated to the ward setting. The risks associated with the vacancies in this ward were on the service's risk register.
- Vacancies across the service varied, with a high proportion within the discharge planning team (five staff members 28%), Winyard ward (six staff members 25%), Bluebell ward eight staff members 19%) and Aldenham ward (seven staff members 16%). Areas with reduced vacancies were Croxley ward (three staff members 6%), Cardiology (two staff members 6%) and acute admissions purple (three staff members 7%). The hospital at night team, Heronsgate ward, ambulatory care, acute admissions yellow and endoscopy teams reported no vacancies. The overall vacancy was 14% in June 2016.
- Our previous inspection raised concerns that agency staff made the largest component of workforce on Tudor ward, and that agency staff were not always completing the tasks required or expected. During this inspection, we saw that although agency staff were in use, they made up a lower proportion of workforce. The service reported that there was a vacancy of 11% for nursing staff on Tudor ward, with agency and bank staff covering the vacancies where possible. Nursing staff reported that agency staff completed tasks that were allocated and expected.
- Oxhey care of the elderly ward staffing consisted of one permanent ward sister and agency staff. During our inspection, staff said that the agency staff worked regularly on the ward, and were all orientated by the ward sister. Patients reported that they saw the same staff and were treated compassionately, documentation was completed and all staff were aware of their roles and responsibilities. The ward sister reported that a large proportion of the agency staff had applied for the posts, which had been advertised.
- We saw evidence throughout clinical areas that agency staff were appropriately inducted to the wards, to ensure they were aware of layout, call bell systems and team working. The service used induction checklists to complete this task and these were observed in use during our inspection. We saw completed induction booklets in place for bank and agency staff within the wards.
- Nurse revalidation was in progress, and staff reported that there were systems in place to assist and support them through this process.

Medical staffing

- Medical staffing was appropriate with effective out of hours and weekend medical cover provided. Medical staffing within AAU was in line with the national guidance from the Society for Acute Medicine and West Midlands Quality Review Service in the publication "Quality Standards in the AMU" dated June 2012.
- Out of hours, there was one registrar and two foundation year two doctors for all inpatient medicine beds. There was a separate team for the admission areas (AAU) which consisted of one registrar, two foundation year two doctors and one foundation year one doctor. On-call consultants who were available for telephone advice between 10pm and 7am supported the teams.
- Medical staff told us that there were a high number of vacancies across most specialities and grades, which were filled with locum staff. Where possible, the same locum staff were employed to cover periods on short-term contracts. This promoted continuity of service. Trust records from May 2015 to April 2016 showed between 6% and 24% use of locum medical staff across the service. Locum usage had remained the same in general medicine (7%) and gastroenterology (12%) since July 2015. Other areas showed a reduction in use, for example, care of the elderly 34% to 16% since February 2016. Some clinical areas showed an increase in locum usage, for example, acute medicine (15% in October 2015 to 24% April 2016) and cardiology (0% March 2016 to 7% April 2016). Chest medicines and Tudor ward had the highest percentages of locum use

with 42% and 100% respectively. Locum staff were inducted to the hospital and given access to online policies, patient records and identification badges and passes. Where possible locum staff worked for several weeks or months, which enabled the continuity of patient care.

- The number of medical consultants was slightly below the England average with 36% in comparison to 37% of medical staffing. Middle career doctors were in line with England average at 6%. The registrar group was approximately one third lower than the England average with 24% in post in comparison to 36%. The proportion of junior medical staff was higher than England average with 35% in comparison to 21%.
- We saw evidence of medical induction training which included topics such as infection control, hospital at night, values and behaviours and clinical informatics. Signing sheets showed that these sessions were well attended.
- Medical locum staff reported that they had excellent support from substantive staff members including 24-hour support from consultants.
- Nursing teams reported that they were informed when locum doctors were working which enabled them to introduce themselves and allow additional time for orientation to wards and teams.
- Medical staff reported that there was a lack of registrar cover at night and weekends. One medical doctor said that there had been three occasions recently where a registrar had not been available for out of hour's shifts. This meant that some junior staff felt unsupported, and that there was an increased risk to patient safety. When registrars were not available, junior doctors could seek support from the other medical team or consultant on call. Medical staff we spoke with stated that teams were supportive of needs. We reviewed the medical rosters for April 2016 to September 2016 and noted no gaps in the planning of cover.
- During our inspection, one foundation year one doctor, who had been responsible for the out of hours provision of cover between 5pm and 9pm said that the second doctor who should have been on call did not attend, which meant that they were responsible for the medical wards within the Princess Michael of Kent building on their own. The on call doctor for admissions had given support, however this had meant that there was a delay in reviewing some patients due to the large amount of calls received. This incident was reported through the electronic incident-reporting tool. We discussed this incident with the trust and assurance given that adequate staff coverage was in place for subsequent shifts.
- The hospital at night team also included other speciality doctors and nurses including the surgical team on call, and the critical care outreach service. All clinicians needed to attend the hospital at night handover meeting to obtain their on call bleep and a handover. We observed the handover between the day medical team and hospital at night team and found that the process was methodical and well organised. Each member of the team was required to sign in and out, and bleep numbers were exchanged. The team then received a verbal handover from the day team, which included a list of sick patients, any requiring medical review and any outstanding jobs. The trust reported that e-handovers were available for staff, however we did not see these in use during inspection.
- During inspection, the surgical staff member briefly attended the meeting to obtain the bleep but was unable to stay for the medical patient handover as was required to attend the surgical wards. This was not in accordance with hospital at night operational policy.
- Doctors within the acute admissions unit used an electronic handover system. This was observed during inspection and identified as enabling a thorough review of all patients within the department. The medical team were able to identify sick patients and handover care or treatments that were outstanding between shifts. Medical staff told us that this had improved communication between medical teams as doctors all used a single record.
- Cardiology consultants provided a week on call service, where they would be responsible for the cardiology unit from 8am to 6pm daily for the full week. After 6pm, the on-call medical team provided cover and they provided a telephone advice service. Nursing staff reported that the cardiologists would attend the unit in an emergency.
- Respiratory consultants provided dedicated respiratory consultant cover in the admissions areas (Emergency department and AAU). Consultants provided an on call service for advice from 5pm to 9am. The remaining respiratory consultants within the team managed patients on the respiratory ward (Aldenham).

- The endoscopy team had an effective process in place to manage patients requiring an urgent endoscopy with on call provision out of normal working hours.

Major incident awareness and training

- Staff could describe the trust's major incident policy and there was a link to the policy on the trusts internal website (intranet) home page. Staff we spoke with did not report completing major incident training.
- The trust had appropriate plans in place to respond to emergencies, business continuity (for adverse weather) and major incidents.
- Staff we spoke with were aware of the trust's fire safety policy and their individual responsibilities. We observed fire alarm tests being carried out during inspection.
- The service had an on call bed utilisation sequence for escalation. There was a policy in place dated April 2016, that detailed actions for staff to undertake when activity increased. These included details of at what point additional clinical areas were opened and what was required to ensure patient safety and whose responsibility the decision-making was. All staff were able to identify their roles and responsibilities when the policy was activated.

Are medical care services effective?

Good

Overall, we rated effective as good because:

- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- The service reported better than expected in the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) audits.
- Pain control was effectively managed with referrals to specialists for additional support and treatment plans.
- Patient's nutritional needs were regularly assessed and monitored.
- Staff were qualified and had the skills they needed to carry out their roles effectively and were supported to maintain and further develop their professional skills and experience.
- There was evidence of effective multidisciplinary team meetings.
- There was a seven-day service in place, with the exception of the Helen Donald day case unit.
- Staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards processes, referring patients appropriately.

However we also found that:

- There was a variable performance in a number of national audits relating to patient care and treatment. Actions plans were not consistently developed in response to areas for improvement. We saw that action plans were not in place to address the service results in the National Diabetes Inpatient Audit (NaDIA), Sentinel Stroke National Audit Programme, Heart Failure Audit or the National Lung Cancer Audit.
- There was no system in place to monitor patients held under Deprivation of Liberty Safeguards (DoLS) and no system to track expiry of the conditions.

Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health needs (clinical, mental health, physical health, and nutrition and hydration needs) and social care needs. Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- New nursing documentation had been implemented in August 2016 and was based on national guidance; this included national falls risk assessment tools, nutritional assessments and skin assessments.
- The service had an audit calendar in place, which monitored compliance against policy, procedures and National Institute for Health and Care Excellence (NICE) guidance. Data captured was discussed locally amongst teams and at service and hospital wide quality meetings.
- There were a series of care bundles in place, which were based on national guidelines from NICE and Royal College's. This included guidance for the assessment and treatment of medical conditions such as dementia care, chronic obstructive pulmonary disease, hyperglycaemia (high blood sugar), sepsis (blood infection) and acute kidney injury.
- All staff demonstrated awareness of trust policies and guidelines, which were available on the intranet. Nursing staff on Aldenham ward demonstrated locating updated guidelines and policies on respiratory conditions within the trust intranet.

- The respiratory team had reviewed and updated policies relating to the management of non-invasive ventilation and respiratory treatments since our last inspection. We saw that these were easily accessible through the hospital intranet and nursing staff demonstrated this during the inspection.
- We saw effective treatment planning recorded in nursing and medical notes for the implementation of care and treatments in line with national guidance. For example, we reviewed four patients admitted with a suspected stroke and found that the information captured and treatment implemented was in line with national guidelines.
- The hospital followed the trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. The care pathway for suspected sepsis would usually be commenced in the emergency department. Wards did not have "sepsis boxes" available but did have access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.
- The service's clinical leads informed us that additional evidence based patient pathways were currently being developed. This included a delirium/dementia pathway, which was being trialled across the trust. The paperwork was currently in use as separate templates; however, the team felt that this would be better suited to be one pathway document. This was to be colour coded for easy identification.
- The service had introduced a cognitive assessment into every clerking pathway, to enable staff to capture details of any underlying clinical condition. The assessment template was designed in line with national guidance.
- The service was using a clinical frailty scale for assessing patients admitted into the hospital with dementia. This is a national evidence based tool, which identifies frailty according to physical ability and dependence.
- The service had introduced a behaviour-monitoring template, which was used to track patient's behaviour. This template was used by all wards for patients with cognitive impairment or a history of mental health illness. Nursing staff were encouraged to use the template to identify any triggers for behavioural changes and any actions that calmed patients or situations. We saw that the templates were used to identify actions that could be taken prior to patients becoming agitated or aggressive and inform the treatments required. The template was based on a national tool used within mental health for recording behaviour triggers and treatment.
- We saw that all procedures within the endoscopy unit were completed in line with national guidance.
- Joint Advisory Group on Gastrointestinal Endoscopy (JAG) found that the endoscopy services met the accreditation standards framework such as policies, practices and procedures. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale (GRS) Standards. Endoscopy services in Watford General Hospital were JAG accredited in June 2016.

Pain relief

- We observed nursing staff monitoring pain levels of patients, recording the information, and taking appropriate action to control patient's pain. Pain levels were discussed during the completion of patient observations and recorded on the patient's National Early Warning Score (NEWS) charts. We observed nursing staff ask patients if they were in pain, and to identify the intensity and the location of the pain. When pain had been identified, nursing staff reviewed medication charts and administered pain relief.
- The dementia implementation group were in the process of introducing the abbey pain scale for patients with dementia. This was not fully established at the time of inspection and the date for completion was not shared by the service.
- Nursing staff told us that patients could be referred to the pain control specialist team, if pain was difficult to control. This service was provided Monday to Friday 8am to 5pm, with medical teams managing pain control at weekends. Palliative care specialists were also used to assist with the management of palliative care patients and symptom control.
- We saw nursing staff interacting with patients and relatives, discussing pain management, and actions that could be taken to assist with patient comfort. This included repositioning, diversional therapy and referrals to specialists.
- We spoke to patients who stated that their pain was under control and they found staff very compassionate

and understanding. One patient on Castle ward stated, "My pain is under control, my personal needs are met, nurses are very busy but always ready to help. I have had a good journey".

- Pain scores were recorded by staff within the endoscopy unit, in line with the requirements set out by the JAG guidelines.

Nutrition and hydration

- We saw that all patients were screened for risk of malnutrition on admission using a recognised assessment tool, the Malnutrition Universal Screening Tool (MUST) risk assessment. Where possible patients were weighed on admission and then at weekly intervals or when their clinical condition changed. We identified four patients on Sarratt ward who had not been weighed on admission. The staff nurse informed us that these patients were unable to sit out to be weighed and an alternative recognised method of monitoring the estimated body mass index was in use. This included the measuring of the mid upper arm circumference. We did not see this system in use during inspection.
- Patients identified at risk of malnutrition were monitored through the completion of oral fluid and nutritional charts and referred to the dietetic team for additional support. We saw that patients identified as at risk were prescribed supplementary/high calorie foods and drinks and were regularly reviewed by the dietetic service.
- We observed that oral fluid and nutritional charts accurately recorded patient's daily oral and nutritional intake, which enabled accurate assessments and the identification of risks of malnutrition or dehydration.
- We observed a mealtime on Sarratt ward and found that staff were attentive to patient's needs. We observed patients being repositioned to enable them to eat or drink without risk of choking, they were offered a selection of items and where necessary assisted to eat their meals.
- We saw that patients who were unable to eat or drink were provided with alternative hydration through intravenous fluids (infusion into a vein). They were also identified by a sign above their bed to prevent staff and visitors accidentally providing oral fluids or diet.

Patient outcomes

- The service had processes in place to monitor patient outcomes and report findings through national and local audits and to the trust board. This information was used by the organisation to benchmark practices against similar organisations.
- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of trust-wide mortality that measures whether the number of in-hospital deaths is higher or lower than would be expected. The trust's HSMR for the 18 month period April 2015 to September 2016 was better than expected, with a value of 84.7. This was reported by the trust as a sustained improvement, and the trust was one of 17 trusts nationally with a lower than expected HSMR.
- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. In August 2016, the trust reported a figure of 93.8, which was better than expected (100).
- In the March 2016 national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) the trust was rated as band C (A being the best and E the worst). The audit looks at several domains, which includes scanning, implementation of treatments, provision of therapy services and discharge planning. The service scored well for scanning of patients and discharge planning, however, scored poorly for the provision of speech and language therapy and multidisciplinary team (MDT) working. The service reported there was no action plan in place to address the results of the audit.
- The most recent Myocardial Ischaemia National Audit for 2013/14 reported that the trust performed in line with England average. For the 2013 to 2014 audit, the number of nSTEMI (non-ST-segment-elevation myocardial infarction, a common type of heart attack) patients seen by a cardiologist or a member of team was 98%, which was better than the England average of 94%. The hospital was better than England average for those patients who were referred for or had angiography (with 97% of patients having angiography compared to the national average of 78%). The number of nSTEMI patients admitted to cardiac unit or ward was 27%, which was worse than the England average of 55%.
- In the Heart Failure Audit 2013/14, Watford General scored better than the England average for in-hospital care in one indicator (input from specialist). The

remaining three indicators scored worse. All seven-discharge indicators scored better than the England average. The service had no action in place to address the audit results.

- National Diabetes Inpatient Audit (NaDIA) 2014/15 data showed that the trust was better than the England average for six out of 17 applicable domains including insulin errors, meal choice and timing and assessment of feet. However, scored worse than England average for the remaining domains, which included staff knowledge, visit by specialist diabetes team and overall satisfaction. The service was not currently participating in the National Diabetes Audit due to issues with the database and the services ability to access the system.
- The trust completed the National Lung Cancer Audit 2015 with details of 229 patients from January to December 2014. The trust achieved a better than peer average in the completion of multidisciplinary meeting (99%) and number of patients seen by a nurse specialist (99%). The trust performance for pathological diagnosis (73%) was lower than peer average (84%). There was no action plan associated with this audit at the time of inspection.
- Endoscopy services were JAG accredited in June 2016. This meant that the service met the accreditation standards framework for aspects such as policies, practices and procedures.

Competent staff

- Staff had the appropriate clinical skills, knowledge and experience for their roles and responsibilities within the clinical area worked. The service had processes in place to identify training needs and compliance, and implemented changes to practice to address any identified issues.
- The quality improvement plan contained sections relating to the development of all staff. This included the improvement of online training programmes, local induction programmes, implementation of coaching and mentoring for new staff.
- All new staff attended a trust induction programme that covered topics such as the trust values, information governance and clinical skills such as basic life support. We saw evidence that the medical induction training included topics such as infection control, hospital at night, values and behaviours and clinical informatics. Staff were required to confirm attendance at induction and sign-in sheets showed that these sessions were well attended. Staff we spoke with confirmed they received adequate inductions.
- New nursing staff worked as supernumerary team members for a short period on commencement to post. We were told that this was a minimum of two weeks, however could be extended according to individual's needs. This was to ensure competence and could be extended by the ward sisters depending on the individuals experience and development needs.
- Due to the large number of newly recruited staff, the service had identified that additional support was required locally on wards to ensure that staff were competent. This had included a non-registered nurse, who assisted with an orientation programme. However, it had been identified that this was not sufficient to ensure that nursing tasks such as the administration of medicines were completed in line with national guidelines. The service had therefore recruited a senior staff nurse who worked with new nursing staff, observed, and assessed competence with nurse specific tasks. This enabled staff to be deemed as competent much sooner than previously as a nurse was available to assess individuals.
- We saw that nursing staff within specialist clinical areas had additional competencies to ensure they were able to manage patients safely. For example, nursing staff within cardiology were expected to become competent in heart rhythm recognition, performance of electrocardiograms (ECG- tracing of the heart) and heart failure recognition and management.
- Specialist training was available through the local university and staff confirmed attendance to courses. For example, the hospital at night nursing team was supported to complete Masters Degrees in Advanced Nurse Practitioner training at the local university.
- Nursing staff reported and demonstrated that the electronic ward rosters also recorded staff training records. The system alerted managers and individuals when training was about to expire, to enable timely booking. Staff were able to access the system from home, which enabled them to keep up to date with off duty and alerts regarding pending training.
- Each ward sister reported that they had "link nurses" identified for topics such as dementia awareness, infection control and falls. Link nurses were staff members who had a particular interest in a topic. They

would attend additional training, meetings or review new guidance and share their learning with the rest of the team. We observed the names of link nurses and their specialist interest displayed on Sarratt ward and in the Cardiology ward.

- The medical team offered training through daily ward rounds and weekly teaching sessions. These sessions were available for all staff including locum medical staff. Junior doctors we spoke with reported that teaching was of a high standard and they were supported to learn.
- The previous inspection highlighted that nursing staff did not have formal clinical supervision in place. During this inspection, we identified that staff were allocated to senior members of the team who were responsible for individuals' clinical supervision, however there was no data relating to the percentage of staff that had completed regular clinical supervision.
- The service had introduced a ward sister development programme, which included training and guidance on staff management, finance and leadership. Ward sisters reported the programme had given them the opportunity to discuss their roles and responsibilities with colleagues and learn from each other's experience. This had also affected the management of the junior ward sisters, as they had been encouraged to complete management tasks, such as appraisals.
- We observed that each ward displayed a chart detailing which staff member was responsible for each staff member's appraisal. We were informed that staff would have appraisals annually and where necessary three months prior to their incremental date. Appraisals included discussion about individual learning and development needs. The electronic rostering system alerted staff to appraisal dates.
- The trust reported 78% compliance in nursing staff appraisal and 98% consultant appraisal rates in June 2016, against the target of 90%. This had improved since September 2015 when 64% nursing staff 33% of general medical doctors had completed an appraisal
- Medical and nursing staff told us that they had sufficient support relating to revalidation.
- The service reported that 97% of all medical staff had an appraisal in place and completed the revalidation process. Revalidation is the process for doctors to positively affirm the general medical council (GMC) that they are up to date and fit to practice.
- We saw evidence throughout clinical areas that agency staff were appropriately inducted to the wards, to ensure they were aware of layout, call bell systems and teams they were working within. This induction was recorded on a checklist, which was held on the ward.
- Wards were allocated student nurses depending on the team's ability to provide mentor support and on the level of training the students had completed. We spoke with two students during the inspection. They reported that the ward staff were supportive to their learning needs and identified learning opportunities. They participated in ward activities, but considered this part of their learning.

Multidisciplinary working

- All necessary staff were involved with assessing, planning and implementation of patient care. Medical records detailed an admission treatment plan and were amended according to clinical findings and patient condition.
- We saw that multidisciplinary team (MDT) working was well established throughout the acute medical wards. In all clinical areas, MDTs meetings were completed daily in conjunction with the daily board rounds. There was daily communication between nursing and medical teams, physiotherapists, occupational therapists and discharge coordinators. The meetings observed were well structured and inclusive. All staff in attendance at ward rounds and meetings contributed to discussions and all team members were open to suggestions from others.
- We observed that the MDT reviewed all patients within 24 hours of admission to the hospital, which enabled baseline conditions to be identified and treatment plans formulated. This included a review from the ward pharmacist and if appropriate the physiotherapist or occupational therapist.
- Medical staff within the acute admissions unit reported excellent working relationships with the emergency department (ED). Stating that they worked collaboratively to manage patient flow through both departments.
- Staff reported good multidisciplinary team working, with effective links to specialist services such as tissue viability, infection control and diabetes specialist nurses. Nursing staff told us that they knew how to contact specialists and felt supported by them.

- We saw evidence of referrals to specialists recorded within patients' records. We were informed that although referrals were made with a written referral letter to the speciality, medical and nursing staff would speak to individuals directly to ensure that they were aware of the referral.
- Medical teams were able to refer to other organisations for the provision of specialist treatments. For example, the trust did not provide a nephrology service, but was able to refer all patients to the regional centre. Referral was completed by a consultant-to-consultant referral by telephone and a follow up letter to the speciality. Medical staff reported that this process worked well.
- We saw that ward rounds on Bluebell ward were completed in conjunction with the mental health team. This enabled a seamless transition between services for patients with end stage dementia and enabled nursing staff to access guidance on management techniques.
- The integrated discharge team attended all clinical areas and assisted with the flow of patients through the service. Integrated discharge team staff would attend wards and liaise with medical and nursing staff to identify intended discharges and assist with planning. The team was reported to work collaboratively with the ward-based staff.
- Discharge coordinators attended the wards daily to assist with the movement of patients across wards and assist with tasks to promote a speedy discharge. This included arranging transport, liaison with relatives and care placements.
- The rapid assessment, interface and discharge team (RAID), provided additional support for staff, patients and relatives of patients with diagnosed or suspected mental health conditions. Nursing staff reported that the team would assess and review patients following referral and offer support on the management of conditions. The team were based on site and easily accessible, responding to calls within 24 hours. We saw evidence of assessments within patient's notes, which offered advice for treatments, medication changes and tracking of patients through their admission for possible follow up on discharge.
- Nursing staff told us that relationships with medical staff and other professionals were inclusive, positive and promoted multidisciplinary working. Ward sisters reported that the working relationship with the speciality consultants was strong.

Seven-day services

- Physiotherapists and occupational therapists provided a seven-day service. With speech and language therapists and dietitians providing a weekday service..
- The endoscopy unit operated a weekday service with two or three sessions per day. In addition to this, there was a gastroenterologist on call to meet any demands for urgent referrals.
- The medical consultants provided weekday cover between 8am and 6pm, with on call facilities overnight and at weekends. All wards reported that at weekends, patients would continue the treatment plans identified by their consultant unless they became acutely unwell. Patients requiring continued assessments or reviews at weekends were seen by on call consultant. Medical notes confirmed that weekend assessments were completed.
- The service had two teams providing medical cover daily, one based in the admissions area and another for the inpatient wards (Princess Michael of Kent building-PMOK). During the day the admissions area team consisted of an on call consultant, two foundation year two doctors overnight and in the mornings, increasing to four in the afternoon and evening, and two foundation year one doctors all day. The PMOK staffing consisted of an on call consultant, two senior doctors and four junior doctors all day, an on call consultant, two senior doctors, and one junior doctor overnight.
- Medical consultants within the admission areas were reported as completing a minimum of three daily ward rounds at weekends, which was in line with London Quality Standards, 2013.
- Local diagnostics services were available daily with out of hour's facilities for emergency procedures, such as x-ray and pathology. Staff reported no issues with accessing diagnostic testing out of hours.
- The pharmacy department was open seven days a week. Opening hours were 8.30am to 5.30 pm Monday to Friday and 10am to 4pm at weekends. There was an out of hour's emergency cupboard, which was accessible by nursing staff for any medications prescribed that were unavailable on the wards.

Access to information

- All staff reported that they had access to all information required to review patients' conditions and plan safe care and treatment. The service had an aging IT

infrastructure, which was in the process of being updated. The service leads reported that until the infrastructure was in place, access to more modern systems or databases was limited.
- Trust policies and guidance was available on the trust intranet, and staff were able to demonstrate accessing information held.
- Patients' records were kept in similar locations in each clinical area with nursing notes such as risk assessments and observation charts at the patient's bedside and medical notes stored in locked notes trolleys at either the nurse's stations or the entrance to bays.
- All clinical staff had access to hospital computers, which were password protected. During inspection, we observed that all computers were locked when not in use and no patient identifiable information was left unattended.
- All admissions to the hospital were tracked using e-handover. This enabled the medical and nursing team within the admissions assessment unit to track patient's progress through the department.
- There was no live tracking system in place for the inpatient wards. The hospital had an electronic admissions and discharge system which displayed patients allocated to wards. However, this system was reliant on staff discharging patients from one area and admitting to another and did not display whether the patients were being discharged or whether they were fit for discharge. This meant that the discharge coordinators tracked bed availability and patient discharges manually.
- Access to diagnostic test results was through an electronic database, which medical staff reported was frequently difficult to access, and slow. This was frustrating for all staff concerned.
- We saw that endoscopy equipment used during clinical procedures was clearly recorded in patient's notes, along with details of staff that completed procedures. This ensured that all information relating to a clinical procedure was accessible. This meant that should there be any reason to review patients treated by an individual or with a particular piece of equipment, patients could be easily identified.
- Patients GPs were provided with copies of discharge letters to ensure awareness of changes to patients' admission and treatment plans. These were planned to be sent within 24 hours of discharge.
- GPs were able to contact the on call consultants, registrars or GP liaison nurse for clinical advice via a telephone or bleep service. This meant that when patients were referred by GPs to the service, clinical information was shared, promoting a seamless transition between GPs and the acute admissions areas. This also meant that the service was able to prepare for planned attendances, allocating admission location and time. This was observed during inspection when the GP liaison nurse spoke with GPs and directed their calls to the registrar during inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our previous inspection, we identified that staff had restrained a patient chemically and physically within the acute admissions unit without completing the relevant mental capacity assessment or associated deprivation of liberty safeguards or best interest assessments. The trust was asked to address any shortfall in knowledge and understanding of the Mental Capacity Act 2005 (MCA). We also identified that consent was not always recorded within nursing and medical notes. During this inspection, we found that staff were aware of the Mental Capacity Act 2005 and completed assessments appropriately. However, patients held under Deprivation of Liberty Safeguards (DoLS) were not tracked.
- All staff we spoke with had an understanding of the Mental Capacity Act 2005 and we saw evidence in patients' medical and nursing notes that assessments and Deprivation of Liberty Safeguards (DoLS) assessments and referrals were completed appropriately. We saw written evidence in patients' notes outlining the outcomes of capacity assessments and details of the best interest actions taken by staff to ensure patient safety.
- We saw that patients with a learning disability were assessed appropriately for mental capacity and this was clearly recorded in patient's notes.
- Nursing staff confirmed that the service had introduced a standardised mental capacity assessment to be used across all clinical areas and these were seen in use on all wards.
- When we spoke to staff, we found that most staff understood the concept of Deprivation of Liberty Safeguards (DoLS) and could give examples of where the safeguards should be applied or considered.

However, we found that there was no system in place for the monitoring of DoLS use across the division. Nursing staff reported that patients were identified on ward boards, and through the electronic incident-reporting tool. We saw that three patients had been placed on a DoLS, in each case a MCA had been completed, however, there was no evidence of further DoLS reassessment and the initial authority had expired. There was no evidence of local authority review and agreement to conditions. Nursing staff reported that patients were not reassessed unless their clinical condition changed.

- We spoke to an endoscopy consultant who told us that all patients were consented prior to endoscopic procedures. For inpatients that did not have mental capacity, a ward consultant would sign a specific consent form which detailed why the consultant was consenting for the patient and that the procedure was in the patients best interest.
- We observed both written and verbal consent being sought by staff within all clinical areas including endoscopy and cardiac catheter lab. This included consent for photography, sedation and consent for care and treatments.
- The trust's quality improvement plan included the development of an e-learning package for mental capacity and deprivation of liberty safeguards training. During inspection, this remained under development with an expectation that this will be implemented by January 2017.

Are medical care services caring?

Good

Overall we found the service good for caring because:

- Patients and their relatives were treated with dignity, respect and kindness during interactions by all staff.
- Patients and relatives were included in decision-making and were assisted to make informed decisions about care, treatments and discharge planning.
- Data collected through patient satisfaction audits was generally positive and regularly shared with the team.

Compassionate care

- Most patients reported that staff were attentive and caring. Patients and relatives told us that they were spoken to respectfully and staff showed kindness.
- We saw that staff respected their patients, their individual preferences, habits, culture, faith and background.
- All staff we observed were polite and respectful towards patients, their relatives and visitors. This included one to one interactions, in person, or over the telephone and when discussing patients between staff members.
- Patients reported that staff asked how they preferred to be addressed, and spoke to them appropriately.
- We saw staff speak with patients in a respectful way, engaging and laughing appropriately with patients.
- We saw that staff closed curtains and door to protect patients privacy and knocked on doors before they entered. Patients told us that felt that staff respected their privacy and dignity.
- Nursing and administration staff ensured patient confidentiality at all times and were observed asking patients permission to share information with family members, seeking quiet rooms to hold conversations and covering medical and nursing notes to prevent them being read by unauthorised persons.
- We saw nursing staff on Sarratt ward accompanying upset relatives to the quiet room to allow them some privacy.
- Most patients and carers told us that they were happy with the care they received. One relative commented, "The nurses are lovely"; another said, "Staff are extremely kind and very patient"; and another commented, "Staff are incredible and wonderful people". However, two patients were not happy with their care on Sarratt ward. One patient was dissatisfied that they had not been assisted to wash until 10.30am, and another stated that nursing staff interrupted their meal to complete blood pressure recordings. Both patients blamed this on staffing levels.
- We observed a patient being discharged to a nursing home from Winyard ward. The ward receptionist contacted the nursing home, informed them of the arrival of the transport services, and then contacted the patient's relative informing them of the transfer. The opportunity was taken to complete the friends and family test questionnaire. The results of which were very positive.
- The ward sister on Winyard ward was observed making a courtesy call to the relatives of a newly admitted

patient, and introduced herself as the ward sister, advising of visiting hours, contact numbers and offering the opportunity to ask any questions regarding the care and treatment planned for the patient. The ward sister was also observed informing the relatives of when she was available if they wished to speak in person.
- Patients admitted to the ambulatory care unit were observed being informed of the admission process, what to expect from their visit and the location of toilet and drinks facilities.
- The NHS Friends and Family Test had a 54% response rate for inpatients. The July 2016 results showed that 93% of the inpatient respondents said that they were either likely or extremely likely to recommend the trust to friends and family. Results were comparable to the national average of 94%.
- The trust participated in the National Cancer Patient Experience Survey 2015, which was published in July 2016. Between October 2015 and March 2016, 411 eligible patients from the trust were sent the survey, and 240 questionnaires were returned completed. This represented a response rate of 62%, which was worse than the national rate of 66%. The trust performance was as expected for 43 of the 50 indicators. This included staff assisting to get financial help, free prescriptions, supporting patients and care planning. The service performed worse than national average in talking in front of the patient and discussing research with the patient. Overall satisfaction with the service scored 8.5, with zero (very poor) and 10 (very good).

Understanding and involvement of patients and those close to them

- We saw that staff involved patients and their relatives in discussions held relating to care and treatment.
- Staff communicated in a way that patients could understand and was appropriate and respectful. We observed ward rounds completed that were inclusive of the patient. Staff ensured that patients fully understood plans taking time to explain treatment processes and what to expect. This enabled patients to be involved with making choices and informed decisions about their care and treatment.
- Patients and their relatives were offered timely support from staff to enable them to understand the treatment and discharge processes.
- Families were involved in patient care and discharge planning. Those relatives we spoke with confirmed that they understood the treatment plans of their loved ones and had been included in decision-making.
- Staff used a "forget me not" flower motif on ward boards, and a blue tag on the patient's identification bracelet to symbolise patients with cognitive impairment. This enabled all staff to identify patients who required additional support when completing tasks or when leaving the ward. For example, we observed a porter assisting to transfer a patient to the x-ray department and the porter reassured nursing staff that he had noticed the blue tag and would ensure the patient was not left unaccompanied within the department.
- Therapy staff were observed completing treatment in timely and controlled manners, offering rest periods and assistance to sit when patients became fatigued.
- We observed therapy staff being respectful and discussing care and treatment and the impact of this on their recovery. This was observed on Winyard ward where one therapist was observed explaining why the patient could not go home, and what was required to ensure safety prior to discharge.

Emotional support

- Staff understood and showed how they would support the emotional and mental health needs of patients and said they were able to access specialist support if necessary.
- Relatives of distressed or confused patients were able to attend the wards at any time to assist with the care and support of the patient.
- The chaplaincy service provided a 24-hour service and offered support to patients and relatives, multi-faith options were available.

Are medical care services responsive?

Requires improvement

Overall we found the service requires improvement for responsive because:

- Patients were transferred multiple times within the acute admissions unit and between wards, often out of hours, which affected the patient's journey and experience.

Medical care (including older people's care)

- Care of patients transferred to non-medical speciality beds was managed through allocation of care to a speciality consultant, which was usually different to the admitting consultant.
- Patients were regularly transferred to non- medical speciality beds.
- Delays in completion of discharge letters affected the preparation of medications to take home and time spent waiting for discharge. Patients often choosing to return to the trust to collect medication.
- Not all non- medical speciality wards had admission criteria for medical patients being transferred to their care.
- The average length of stay for elective general medical and non- elective stroke patients was higher than the England average.

However we also found that:

- Senior medical staff reviewed patients admitted to non-medical wards as outliers each weekday.
- The service worked collaboratively with local authorities and agencies to manage streamlined patient care.
- The GP liaison nurses signposted patients to appropriate clinical areas to ensure timely management of condition and implementation of treatment.
- Systems were in place to provide patients and relatives with additional support and advice for conditions such as dementia, mental health conditions and learning disabilities.

Service planning and delivery to meet the needs of local people

- The service reported working collaboratively with local agencies to provide streamlined care. This was particularly evident in the management of patients with dementia and delirium. During our last inspection, we were informed of the delirium recovery programme, which aimed to reduce length of stay, readmissions, antipsychotic prescribing and promoted cognitive and physical functioning, by cognitive enablement, health, and wellbeing for patients. During this inspection, we were informed that following the initial trial period, an audit showed that 65% of patients who would have been placed in a care home prior to the project had been successfully discharged home. In response to this, the team were developing the service to include a wider variety of patients. This had been possible through partnership working with the local clinical commissioning group, care agencies and mental health services.
- The stroke unit had 13 dedicated hyper-acute and 20 sub-acute stroke beds, which were used to treat patients admitted with suspected strokes. Patients were admitted into a hyper-acute bed for the initial acute phase of their admission, transferring to a subacute bed as their condition became more stable.
- Stroke services included specialist stroke nurses who were available via a bleep. Their role was to assist with the management of patients admitted to the hospital with suspected strokes or transient ischaemic attacks (TIA- mini strokes). The team liaised with GPs assessing patients on admission and offering support throughout the inpatient period. The team followed patients through the service and provided on ward specialist advice and support.
- The trust had 24 cardiology beds and two cardiac catheter laboratories. Acute cardiac interventional services for patients experiencing a myocardial infarction with ST elevation (type of heart attack) were provided at the regional centre. Due to the environment within the coronary care unit, the number of acute beds could be flexed to meet clinical need. The unit was split into two 12 bedded bays, one male and one female. As all beds were, centrally monitored, acute patients could be admitted into any bed within the bay and monitored by nursing staff. This prevented multiple bed moves within the ward.
- The trust no longer provided a respiratory high dependency unit, however following developments within the service, the team were planning to reinstate this provision. Respiratory services had developed considerably since our last inspection. This included a new clinical lead, the development of additional respiratory clinics, in reach respiratory service within the emergency department, and separate medical cover from wards to admissions areas, which allowed timely assessment and intervention.
- The service had opened a frailty unit, which admitted patients using the Bournemouth criteria (admission criteria based on the assessment of age, pre-existing medical conditions or placement in a nursing home). A geriatric assessment nurse would complete initial assessments and refer for treatments from the wider multidisciplinary team. This included physiotherapy,

dietitian and tissue viability nurses. The medical team then reviewed patients and confirmed a treatment plan. Patients were either transferred to inpatient areas for ongoing care, or discharged home from the unit.

- The ambulatory unit offered a variety of services and was continuing to develop the services provided by the department. Nursing staff reported that they did not use pathways, but offered services that were accessed by a variety of clinicians. For example, patients referred by GPs with suspected cellulitis, first seizure or pulmonary embolism.
- The service employed a dementia tracker whose responsibility was to review all admissions into hospital and ensure that patients were correctly identified and recorded. This was to meet the commissioning for quality and innovation (CQUINs) payment framework, which encourages providers to improve the delivery of care to improve patient experience.
- The service had several projects in place, which were reflected in the quality improvement plan. This included the development of the ambulatory care pathways, further development of the delirium, dementia and cognitive impairment pathway, introduction of nurse lead endoscopy clinics and the implementation of additional clinics such as urology. These were joint ventures with other acute NHS trusts.
- The service had a dementia implementation group, which was chaired by the safeguarding lead. The group had commenced standardising documents and were implementing a pathway of care for patients with impaired cognitive function.
- We saw that external agencies such as mental health specialists, GPs and the local university were involved with the planning of care and treatment. For example, the university was used to assist with specialist skills training for nurses and the mental health team based within the trust regularly reviewed patients jointly to offer advice on treatments.

Access and flow

- The site coordinator and the bed management teams managed flow through the hospital, with overall responsibility lying with the chief operating officer (COO). There were two bed managers on duty at any one point, with one working predominantly in admission areas and the second working within the wards, assisting with discharges. The site coordinators worked from 8am to 8pm, and had an overview of the whole hospital and its pressure areas. They monitored the flow of patients through the emergency department (ED) and assisted with the escalation processes. Collectively the teams liaised directly with each other to track potential and actual discharges and plan admissions as timely as possible.
- We observed three bed management meetings during inspection. The meetings included a review of planned transport bookings, emergency department activity and ward activity. Meetings were structured and well managed. The 8am bed meeting included a review of staffing where matrons and clinical leads attended to briefly report on any pressure areas. This enabled the whole team to have an overview of hospital activity and offer support where possible. We observed staff discussing staff movements to ensure ward safety.
- Overnight responsibility out of hours lay with the director on call. The director on call would attend the 5pm bed meeting to ensure that they were informed of the situation concerning activity and flow. The operational manager reported that the night plan would normally be established by 3pm, which enabled all staff to be aware of the requirements of the team to ensure there were sufficient beds to manage the admissions to hospital overnight.
- There was a senior nurse on call out of hours. This role was rotated through the senior nursing staff across all medical specialities. Their role was to attend the bed management meetings and assist with the management of flow through the hospital, offering clinical advice and support to staff. The senior nurse on call during the inspection reported that cover was provided from 5pm to 10pm, but often individuals would remain on site later. Each senior nurse completed a templated report for the night's activity, which included any staff moves, details of any clinical emergencies and reasons for opening of escalation areas. The report was shared with the senior nursing team and the directors to ensure all staff were aware of demands on the service.
- The service provided a GP liaison service from 9am to 10pm. This service managed referrals from GPs, clinics and the emergency department, offering advice on best admission location, liaison with the medical team and an initial assessment on admission to the hospital. For example, during the unannounced inspection on the 19 September 2016, one patient declined admission to the hospital preferring to return as a day case admission to

ambulatory care. The GP liaison nurse was able to assess the patient to ensure that this was safe and then arrange attendance to ambulatory care. The patient was offered advice on actions to take if their clinical condition changed.

- Patients were admitted to the Admissions Assessment Unit (AAU) prior to being transferred to an inpatient ward. Here, patients were triaged by the GP liaison nurse or on call registrar before being allocated to the purple area within AAU.
- We saw evidence that all patients were reviewed by a consultant a minimum of twice daily within the admission areas. Medical and nursing records supported assessments and treatment plans devised during consultant reviews.
- On admission to the service, patients were given an estimated date of discharge based on their clinical condition and the treatment required. These were displayed on all ward boards and were used as guide for all staff.
- The purple area of AAU completed the patient's assessments and care commenced. This included taking of bloods, completion of routine tests and a baseline history. Following this assessment, the on call medical team reviewed patients. Staff reported that they aimed to complete a medical review of all admissions within four hours of admission to the purple area. During inspection, we observed that this was completed for all patients on the ward within that timeframe. However, the service did not audit times of patient arrival and time of review.
- The Acute Admissions Unit (AAU) was reconfigured in March 2016, and consisted of 15 four bedded male or female bays. Throughout the day, depending on whether more male or female patients were being admitted, beds and patients would be moved to create the male or female beds required. This meant that patients were moved several times within the admissions area. This was confirmed by patient tracking which showed that patients had multiple moves within AAU before being transferred to an inpatient specialist ward.
- Four out of six patients notes reviewed showed that they had been moved more than twice in one day to another bay within the Acute Admissions Unit. We spoke to one patient who informed us that they had been moved five times in one day however, this was not confirmed. The service completed an audit to capture the number of moves between wards; however, we did not see an action plan to address the findings.
- Patients were transferred where possible between 8am and 10pm; however, trust data showed that there were multiple moves between 10pm and 7am in all admission areas. There was an average of 300 patient moves between 10pm and 7am per month from December 2015 to May 2016 within the blue, green, purple and yellow suites of the admissions unit. The service was monitoring the number of moves within the departments; however had no plans in place to address this at the time of inspection.
- Trust data showed that between July 2015 and June 2016, 57% of patients experienced no ward moves during their admission. 32% of patients admitted were reported to move between wards once, and the remaining patients moved twice or more during their admission (12%). These figures were similar to those reported during our last inspection.
- If patients needed to stay in hospital, they were referred to the bed management team, who identified a suitable bed within the inpatient wards. Patients were allocated to appropriate beds in each ward. For example, patients requiring observation were placed in beds within sight of the nurses' station.
- All wards had named consultants, so when patients were transferred to the inpatient area, care was transferred to that consultant. Where possible, patients requiring specialist treatment were referred to the most appropriate clinical area.
- When there were more medical inpatients than there were medical beds patients were transferred to other clinical speciality wards, such as gynaecology and surgery. We were told that where possible patients were grouped together to ensure patient safety. Staff reported that this had improved patient care. During inspection, we identified that between four and15 medical patients were placed on Letchmore ward (surgery), in addition to six medical patients on Elizabeth ward (gynaecology). Patients on non-medical wards were managed by medical consultants and were reviewed daily. The bed management team informed us that service leads divided patients on non-medical wards to specific consultants and informed them of this by email. This process was not observed during inspection.

Medical care (including older people's care)

- Tudor and Castle wards were located in the Shrodells Unit, a short walk from the main hospital building. The wards had originally opened as escalation areas as part of the trust's winter pressures management plan and were now open on a permanent basis. Due to the position of the wards, only patients identified as being medically stable were permitted to transfer to these wards. During the last inspection, we noted that the operational policy governing the use of Tudor ward was in draft and not fully completed. There was no assessment checklist in place for the transfer of patients to this ward, and nursing staff said that individual's clinical judgement was used to identify those patients suitable for transfer. During this inspection, we saw that the referral process was now well established with referring wards sending completed screening referrals to the wards. Senior ward nurses would review the patients and complete a transfer checklist. If the patient were identified as being suitable for transfer, they would be placed on a waiting list and be admitted to the next available bed. During inspection, we saw that the ward kept copies of all patient referrals.
- During inspection, we saw that patients transferred to Elizabeth ward (gynaecology) were not assessed prior to transfer to identify whether they were suitable for placement on the ward. Medical care remained managed by the medical consultants, however nursing care was provided by the gynaecology ward staff. The patients transferred were deemed stable and were often awaiting ongoing care packages or placement in the community. Nursing staff were able to manage their care needs and escalate concerns to medical staff if necessary. Nursing staff told us that the doctors were responsive to their needs and attended the ward if requested.
- We saw that all clinical areas completed daily board rounds, which included nursing, medical, therapy staff, and discharge coordinators. These were completed at 9am and included a review of all patients, and what actions were required to enable a safe discharge.
- Wards had allocated discharge coordinators who assisted with discharge planning. These individuals would ensure that discharge letters were completed, relatives informed, transport booked and referrals completed. Ward staff reported that this worked well and told us that the discharge coordinator role enabled them to spend more time providing care and treatment and not making phone calls.
- The integrated discharge leads told us that there were significant problems in terms of home care and placement capacity across Hertfordshire. Delays to discharges were reviewed on a weekly basis. We saw three inpatients had been in hospital for 91 days, 119 days and 130 days in Tudor ward awaiting community beds and packages of care.
- The service data showed that the average length of stay for general medical patients was slightly longer than the England average for elective admissions, with an average of 4.5 days in comparison to 4.0. Non-elective admissions were better than the England average for general medicine and geriatric medicine and slightly longer for stroke medicine with 12.4 in comparison to 11.2 days.
- The service had introduced a transient ischemic attack clinic (mini stroke) at weekends, which had been developed to ensure that patients admitted with a suspected stroke on Fridays were seen within 24 hours of arrival to hospital. This service was being completed through a voluntary rota at the time of inspection, with service plans to develop the service further.
- The ambulatory care unit managed the treatment of patients referred by either their GP or through the emergency department. The service was open daily between 7.30am and 8pm with consultant cover between 9am and 8pm. On average nursing staff reported that they would see approximately 35 patients a day, with a variety of conditions. Admission data was analysed monthly and confirmed that less than two percent of patients were readmitted to the hospital following treatment within the department.
- The ambulatory care unit was also used to provide rapid access clinics for patients requiring urgent appointments for treatments or diagnostic testing.
- In addition to the ambulatory care unit, the Helen Donald Unit provided day treatments for patients with haematological conditions such as those undergoing chemotherapy and blood transfusions. The unit was a nurse led day unit and 20 to 50 patients attended daily.
- The discharge lounge catered for any patient awaiting discharge and were open between 8am and 8pm. Patients who had not been collected by 8pm were transferred back to wards to wait for their medication and/or their transport. At the time of inspection only patients able to sit, were managed through the department. We were told during inspection that there

were plans to expand the service to enable patients in bed to attend the department, and staff demonstrated how the changes would be made within the department.

- Staff in the discharge lounge told us that patients often waited between three and six hours in the lounge until they were discharged. We saw data entries in the admissions book and found that the majority of patients waited in the discharge lounge for three to four hours. Nursing staff reported that patients were often transferred to the discharge lounge before their discharge letters were completed. This meant that there was a delay in the ordering of medication to take home. This took between one and three hours to complete once the discharge letter had been reviewed by the ward pharmacist and taken to the pharmacy for dispensing. We saw a sign displayed in the patients lounge which said 'Please note that when waiting in the discharge lounge that the time for prescriptions to be completed is up to three hours and that transport can take up to three hours to arrive. If you are waiting for hospital transport and medication, you may need to wait up to six hours'. Staff within the discharge lounge could track patients' medications and regularly updated patients' on expected waiting times. However, some patients chose to return to the site for their medication. This was observed with two out of the four patients within the department at the time of inspection.

Meeting people's individual needs

- We saw patients were given a welcome pack on some wards to provide information about the ward including the complaints process.
- Clinical nurse specialists told us that there were limited rooms available on some/all wards to break bad news to patients. This meant that providing confidential emotional support for patients and their family was difficult. Sarratt ward had created a relatives room, and were awaiting delivery of comfortable furniture.
- Bluebell ward was the hospitals designated dementia care ward and organised activities for patients to participate in, such as gardening or bingo. During inspection, we observed one staff member completing a jigsaw puzzle with a patient, whilst other patients were engaged in activities with relatives. We found a lack of activities for patients on other wards.
- All wards offered extended visiting for relatives of patients with confusion or agitation, or patients with a learning disability or mental health diagnosis. We observed this on Bluebell ward, when visitors attended the ward out of normal visiting times prior to treatment. Staff told us that the extended visiting times enabled patients to see familiar people which assisted with administration of treatment, promoted wellbeing and recovery.
- Winyard and Bluebell wards had dining tables, which were used to encourage patients to sit out for meals. Nursing staff reported that these were used for activities when visitors attended. Relatives would often sit at the table with patients, have drinks, and play games.
- Bluebell ward had a dedicated assessment kitchen, which was used by the occupational therapists to assess patient safety prior to discharge. These assessments were completed for patients planning to perform kitchen tasks such as making hot drinks and meals to ensure they were able to complete these tasks safely.
- Patients with dementia or delirium being discharged through the trust's delirium recovery programme were offered bespoke care packages as part of their discharge plans. Families were involved with devising activity plans, which were as near to the patients preadmission activity as possible. For example, if the patient previously attended bingo every Wednesday evening, the patients were assisted to go to bingo on Wednesdays by the carer on discharge. This ensured that the patients' normal activities were maintained.
- Stroke services included specialist stroke nurses who were available via a bleep. Their role included attending the ED and assisting with the care and treatment of patients admitted with a suspected stroke. The team followed patients through the service and provided on ward specialist advice and support.
- The ambulatory care unit provided a separate clinical area for the admission of elderly patients. This enabled patients with a cognitive impairment to be cared for in a quieter environment, which could enable them to become less agitated, by noise and disturbances.
- We saw the "this is me" document in use across all areas for patients admitted to hospital with a learning disability. "This is me" is a standardised template, which is completed by carers or family members and details the patient's social and medical history, their likes and dislikes. The nursing documentation included a section on the "this is me" document, which gave guidance on completion of recording of key information.

- Medical staff completed electronic discharge letters prior to patients discharge. These included the admission details, treatment and medication to be taken on discharge. Nursing staff reported that there was frequently delays in obtaining discharge letters as medical staff were busy with other tasks. This affected the discharge process. During inspection of the discharge lounge, we saw that two out of the four patients in the department at the time had been admitted to the discharge lounge before their discharge letter had been completed. These patients were frustrated that they were waiting to go home and did not understand why they had to wait. One of these patients went home without their letter or medication, planning to return later in the day.
- The discharge lounge had limited facilities for patients with a small seating area and a shared toilet for both male and female patients. During inspection, we observed that staff engaged with patients waiting for discharge, and provided magazines and refreshments.
- Nursing staff reported that they had access to bariatric equipment such as specialist beds, chairs and mobility aids when necessary, although none was observed during inspection.
- There was a telephone translation services available. This could be booked through the Patients Advisory Liaison Service if an interpreter was required.
- Patients had a choice of meals to meet cultural and clinical requirements, such as Halal or gluten free food. Cold snacks were available for patients outside of meal times and relatives were able to bring food in for patients.
- Patients told us that nursing staff routinely assisted patients with meals and drinks if they were unable to manage by themselves. Nursing staff used a red tray system to identify patients who required additional support to eat and drink. This was a visual aid to highlight to staff the need for additional support and assessment of intake.
- We saw that oral fluids and snacks such as biscuits were readily available on the wards, and patients water jugs were replaced at regular intervals throughout the day.
- We spoke with one patient who had previously managed another trusts catering department, who informed us that the meals were very nutritious and well balanced.
- Patients awaiting discharge in the discharge lounge were provided with a hot meal at lunchtime and sandwiches at all other times of the day. Patient attending the ambulatory care unit and Helen Donald unit were provided with refreshments and snacks. Oral hydration was available at all times.
- Each ward area displayed staff uniform information to inform patients and visitors of each staff member's role so patients and relatives could identify the roles of staff.
- All clinical areas were accessible for wheelchair users and disabled toilets were available in ward and public areas.
- We saw hearing loop facilities across the hospital site.
- Patients had access to a chapel and multi faith room on site.
- Staff within the dementia unit were very proud of their contributions in supporting patients to return home following an admission with confusion. We saw that posters displayed the number of patients assisted to return home across the inpatient area. All staff were able to demonstrate awareness of patient outcomes and improved patient experience.

Learning from complaints and concerns

- Patients we spoke with were aware of the complaints process and knew how to raise concerns.
- Learning from complaints and concerns were shared amongst teams locally and across the service. Ward meetings and specialities meetings included sections on complaints, what investigations had shown and actions taken to prevent reoccurrence.
- Literature about the complaints procedure and information about the patient advice and liaison service (PALS) was on display on most wards.
- Complaints procedures and ways to give feedback were in place. Patients were supported to use the system using their preferred communication method, such as by telephone or email. Patients were informed about the right to complain further and staff encouraged patients to use the patient advice and liaison service.
- Medical services received 157 complaints from July 2015 to July 2016. These related to a number of topics, however the majority related to clinical treatment (34), poor communication (31), admission or discharge arrangements (24) and staff attitude (19). Service data showed that 118 (75%) complaints were resolved in less than 25 working days, which was the trusts target. Complex complaints were discussed with the complainant to agree a timescale for response. Delays

in response to the remaining complaints were reported because of the quality assurance processes, whereby the clinical leads and chief executive approved each response prior to being issued.

- Complaints were investigated by the senior nurse or doctor within the clinical area complained about. For example, Gade ward sister would draft a response to a complaint regarding care received whilst an inpatient on Gade ward. This process enabled staff to share concerns and complaints raised through team meetings and newsletters. Individuals identified within complaints were asked to complete accounts of incidents and reflect on their actions to identify any learning. All draft complaints responses were reviewed by the service leads and complaints department, before being reviewed by the chief executive for approval.
- We saw many compliment letters and thank you cards displayed in ward areas. These were laminated and used as place mats on Bluebell ward which enabled all patients, relatives and staff to see feedback.

Are medical care services well-led?

Good

Overall, we found that the service was good for well-led because:

- All staff had been engaged in the development of trust values, and service goals reflected shared values.
- The service had a robust system in place for managing risk, with clear escalation in place. Risks identified were accurate to local findings and were updated regularly with changes and mitigation.
- Risk registers were reviewed and updated regularly with a good knowledge demonstrated by ward staff.
- The division had a robust audit calendar with processes in place to monitor performance and benchmark against national standards.
- Staff, patients and relatives were generally positive about the services provided. Staff took steps to capture and share comments and learning with the teams.

However we also found that:

- Ward sisters did not have direct access to the risk registers, with amendments being completed through the risk management team.
- The bed management policy had expired in April 2016, however was planned to be reviewed by October 2016.

Leadership of service

- The service structure included a divisional director, head of nursing and a service manager. Associate divisional managers and assistant service managers for each speciality, plus a deputy head of nursing and matrons supported this team.
- During our previous inspection, we identified issues relating to the management of the service particularly relating to ward sisters working clinically rather than in a supervisory capacity and vacancies in lead clinical posts. During this inspection, we found that clinical leads were in post, and although ward sisters continued to work clinically, the frequency had decreased.
- The service had reviewed the structure of the teams since our last inspection and had recruited clinical leads. Medical and nursing staff reported that the recruitment of new clinical leads and ward sisters had introduced an enthusiasm, and staff were actively participating in change.
- Nursing staff reported that the clinical leads encouraged ward development and took ownership of the services provided. For example, the cardiology unit nursing staff told us that following relocation to the acute admissions unit building, staff completed a team-building day. The staff were taken off site to complete a day's activity programme, which included sessions on getting to know each other and goals. Photographs of the event were displayed on the ward noticeboards. The ward sister reported this event had enabled the new team to develop strong working relationships.
- The trusts quality improvement plan included several actions to address the quality of leadership within the service. This included the implementation of a leadership excellence programme and the development of continued professional development support systems. This included options for accredited courses. We spoke with three ward sisters who were new to post. They told us that the programme had enabled them to learn from each other's experience and share ideas on how they should be managing clinical areas.
- Ward sisters were observed working clinically and included in ward staffing numbers. However, this was observed to be in a coordination or supervisory role. Ward sisters reported working 7am to 3.30pm on weekdays, with junior ward sisters managing the ward

out of these hours. All ward sisters spoken with told us that the recruitment of staff had enabled them to balance managerial tasks and clinical workload. Nursing staff reported that clinical leads and matrons were accessible, supportive and visible. We observed matrons attending the clinical areas, discussing activity and any issues that had arisen. The matron on Winyard ward was observed offering support to the ward sister to complete a task, with which she was unfamiliar.

- Nurses said that doctors were responsive to their needs and always available to help with patients care. All nursing staff reported excellent local leadership, with several team members approaching the inspection team to praise their ward sisters. Similarly, clinical leads and ward sisters told us that they were proud of their teams and recognised that staff worked hard within their roles.

Vision and strategy for this service.

- The trust had a vision, which was "the very best care for every patient, every day" and displayed throughout the wards and public areas. Nursing staff told us that they had been involved with the production of the vision and had attended staff events. They were encouraged to submit their ideas and thoughts on what the trust values should be and these were amalgamated into the trust vision.
- The service had clear aims and objectives for their continued development. We saw service development plans, which included the expansion of the dementia, respiratory and cardiology services. The action plans also included the development of joint acute trust clinics for specialities such as urology.

Governance, risk management and quality measurement

- The previous inspection identified several issues relating to governance, risk management and quality measurements. This included an incomplete risk register, with risks not identified, lack of competency for cardiology and respiratory specialities, limited recording of outcomes from actions at governance meetings, and the use of inappropriate areas for additional beds during periods of high capacity. During this inspection, we identified that the service had developed a robust governance structure, reviewed risk registers and implemented competencies and systems for recording actions.
- The service had a robust governance structure, which included clear escalation processes from ward to board, and board to ward. Information was captured within departments, and then shared across the division, the trust quality and safety group and trust executive boards. We observed minutes from these meetings during inspection and saw that information was shared across the multidisciplinary team and actions were reviewed and completed.
- Minutes of the monthly medical services governance and quality group meetings showed that there were discussions and actions planned around safety and quality improvements, clinical effectiveness and patient experience.
- We saw that all serious incidents were reported to the serious incident panel, which met three times weekly. The panel reviewed all incidents to ensure that there was consistency in the escalation of reporting. The service leads informed us that the group assisted with identifying which incidents required internal investigation and notified clinicians of findings.
- The service had implemented a clinical advisory group to review investigations of incidents and near misses. Part of this role included the cross reference of incidents against complaints. The service had found that the complaints and incidents reported matched, which confirmed that incident reporting was effective within the service.
- We saw the service risk register which included 41 risks identified at ward level. This included areas such as staffing levels, risks associated with the estate and transport waiting times. Ward sisters reported that they did not manage the risk register themselves and amendments were completed at their request by the risk team. All staff were aware of their risk registers and were able to recall what the risks were for each clinical area, and what mitigating actions had been taken to address them. Risks with a score higher than 15 were also recorded on the trust corporate risk register.
- We saw that risk registers were reviewed regularly and updated with any changes or details of mitigation.
- We saw the hospital at night team standard operating procedure (SOP) detailed how the service worked and the roles and responsibilities of each team member. The SOP was robust and detailed giving all staff guidance on how the system should work.
- The service had a robust audit calendar, which included audits in infection control and prevention,

documentation and clinical tasks such as recording of patient observations. Ward audits were displayed as scorecards, which were used to identify trends and areas for improvement. We saw that matrons reviewed the scorecard results and reported findings to the clinical leads and trust board.

- Ward audits were reviewed and action plans devised to address findings. This included any environmental issues, such as estates work, specific training needs and compliance with cleanliness. Action plans were seen to be managed locally by the ward sisters with support from matrons and clinical specialists.
- Ward sister meetings were held monthly and discussions included a review of complaints and compliments, details of incidents including falls and medication omissions, NHS Safety Thermometer, clinical effectiveness audit results, details of activity and pressure on capacity, staffing and recruitment, training, finance overviews and risks. We saw evidence of these meetings and found that they were structured and inclusive.
- Previously we identified that due to ongoing bed capacity issues, the stroke gymnasium had been used as part of hospital's planned escalation beds for managing high demand for beds. During this inspection, we identified that the service had robust escalation plans in place, which included the use of non-clinical areas for additional capacity. This decision could only be made by a director on call and mitigation needed to be in place prior to agreement.
- We saw that the bed management policy expired in April 2016. However, the operational managers informed us that the planned review had been extended to October 2016 to allow each speciality to devise their own escalation plans. This was deemed necessary due to the complexity of services such as maternity.
- The endoscopy unit had a robust governance and quality management structure in place. We saw minutes of the alternating monthly meetings which included an operational meeting, user group meeting and global rating score specific meeting.

Culture within the service

- During our previous inspection, some nurses did not feel supported by their managers. Some staff told us that they had personally experienced or had witnessed bullying or aggressive behaviour, which had been reported to senior staff. During this inspection, staff reported that there had been an improvement in staff culture. They told us they thought this was a result of improved substantive staffing levels and recruitment of new clinical leads and ward sisters.
- All staff spoke positively about the service, and clinical area they worked in. This included clinical and non-clinical staff.
- Teams were observed working collaboratively, with support and advice being given when necessary. We observed staff being supervised completing tasks. Time was taken by supervising staff to explain processes and procedures to ensure they were fully understood.
- Nursing staff were very positive about the contributions they made to patients' health and wellbeing. This was particularly evident in the care of the elderly wards, where staff were very enthusiastic about the patient group.
- The volunteer working within the discharge lounge told us that they had worked within the unit for several years and enjoyed working with the team feeling valued.

Public engagement

- Staff within medical services recognised the importance of gathering the views of patients and actively sought comments. We saw that the service actively sought patients' views and feedback on services provided. This included "I want great care" surveys, discharge questionnaires and comment cards within clinical settings. We saw patient comment cards and questionnaires in all clinical areas.
- Each ward displayed their 'I want great care' score, which was a score out of five, one being poor care and dissatisfied and five being good care and very satisfied. For example, Sarratt ward scored 4.5 out of five and the frailty unit 4.88 out of five for August 2016. Patient comments included, "Care was excellent" and "Great care".
- The endoscopy unit held quarterly user group meetings, which were attended by patients and staff members to discuss plans of work, and any issues identified. These meetings were minuted and information gathered shared across the service to aid development.
- The bowel cancer-screening centre captured patient feedback through written questionnaires. Comments were discussed at quarterly meetings to identify

performance against targets and improve patient experience. For example, the team planned to develop nurse led clinics to improve patient access to the service.

- We saw evidence in ward meeting minutes that patient feedback was discussed. Additional comments were recorded on the ward notice boards and in staff newsletters. We saw each ward displayed feedback from patients in public areas, and any actions taken as a result of the comments were also displayed. For example, Sarratt ward had a comment stating, the ward needed a housekeeper. The response included the details of the role being advertised and interviews planned.
- We observed ward sisters approaching relatives of patients asking them to raise any concerns with them directly to enabled them to be resolved locally. This was completed as part of an introductory meeting/ conversation. Ward sisters were able to recall accounts where they had received complaints from family members, who had not approached them directly. Staff we spoke with reported that this was upsetting for them, as they were not able to improve the patients or relatives experience, stating that they would prefer to have the opportunity to make things better for patients whilst they were with them.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received. These were displayed in all ward areas to enable all staff to see responses from patients.

Staff engagement

- We saw effective team working across all clinical areas. The links between administration staff and ward sister and nurses were observed to be very strong, with staff offering support to each other regularly. Nursing staff reported that individuals performed beyond the requirements for their role.
- All nursing and medical staff told us that clinical leads were dedicated to their roles and the development of the service.
- The cardiology unit displayed a photograph of the ward domestic that had been voted as trust employee of the year, by both patients and staff. The staff member was very proud of the recognition for their hard work and was awaiting a meeting with the chief executive the following week to have official photographs taken.
- During inspection, we observed evidence of regular team or ward meetings and local newsletters detailing key information about the service. Agendas for meetings included trust, service and ward news, details of staffing changes, updates on complaints and incidents and learning opportunities.
- Red Suite celebrated the diversity of the team and had a world map displayed where staff placed a mark on their country of birth. The ward sister told us that this had helped staff to talk about their background, cultures and families.

Innovation, improvement and sustainability

- The senior ward sister on Winyard ward had developed a ward social network site, which was used to share information between the team. The site was accessed through a password, and updated regularly with information relating to the ward, any changes and news. The ward sister confirmed that patient information was not shared on this site.
- The service had made improvements in the following:
  - The recruitment and retention of staff, and their use across clinical areas to maintain patient safety.
  - Understanding of the Mental Capacity Act 2005 and use of mental capacity assessments to maintain patient safety.
  - Patient focused nursing records.
  - The structure and understanding of roles and responsibilities about governance, risk management and incident reporting.
  - Support mechanisms for new and agency staff including effective induction and orientation.
  - Support mechanisms for ward sisters and senior nurses, including a development programme.

The service had made some progress with the following:

- The safe management and storage of medications.
- The management of patient flow through the hospital with systems in place to address activity pressures.

Surgery

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

Surgical services provided by West Hertfordshire NHS Trust are located on two hospital sites, Watford General Hospital and St Albans Hospital. Services at St Albans Hospital are reported on in a separate report.

Surgical services at Watford General Hospital are located within the surgery, anaesthetics, and cancer division. The division has been recently reconfigured and the structure includes a divisional director, head of nursing and service manager.

Watford General Hospital has five operating theatres, four inpatient wards, a pre-assessment unit, emergency surgical admissions unit, and a day surgery unit. The hospital provides a range of elective and unplanned surgical services for the community it serves. This includes, but not limited to, trauma and orthopaedics, ophthalmology, urology and general surgery.

The hospital performance summaries between March 2015 and February 2016 showed there were 14,211 elective spells (continuous stays of patients using hospital beds) at Watford Hospital. Of these approximately 30% were day case procedures, 20% elective (planned) and 50% emergencies.

During our announced inspection on 6, 7 and 8 September 2016 and unannounced visit on 20 September, we visited all surgical services and spoke with 37 staff, which included health care assistants, nurses, doctors, consultants, allied health professionals, and ward managers. We observed care and treatment and reviewed 21 patient records. We also spoke with 11 patients and acknowledged the views expressed by patients on Care Quality Commission (CQC) comment cards, those expressed at the CQC stand and comments made at focus groups attended by staff. We also reviewed documentation from stakeholders and performance information from the trust.

Surgery

Summary of findings

Overall, we rated surgery services as requires improvement. We rated the service requiring improvement for safe and responsive. Surgical services were good for effective, caring and well led, because:

- Not all staff received feedback after reporting incidents
- There was no separate recovery area in theatres for children and young people.
- Not all staff involved in the assessment, treatment, and care of children and young people had received the appropriate level of safeguarding children training.
- Theatre five had a scrub area that was not compliant with Department of Health, Health Building note guidance HBN 26 (2004).
- The emergency surgical admissions unit (ESAU) did not have a dirty utility area.
- Venous thromboembolism (VTE) assessments were being completed on admission, but not consistently repeated in line with best practice.
- Junior nursing staff we spoke with were not able to explain when a Deprivation of Liberty Safeguard (DoLS) application was appropriate.
- Staff were unaware of the trusts, vision, and strategic objectives.
- The Five Steps to Safer Surgery checklist were not consistently used; there was a mixture of five and three step processes in operation.

However we also found that :

- All policies were current and followed the appropriate guidelines, such as National Institute for Health and Care Excellence (NICE).
- Staff understood the importance of reporting incidents and had awareness of the duty of candour process. The team meeting minutes reviewed shared learning from incidents.
- The environment was visibly clean and staff followed infection control policies.
- Patient notes had documented risk assessments undertaken.
- There were competency frameworks for staff who worked in all surgical areas.
- Patients told us staff requested their consent to procedures and records seen demonstrated clear evidence of informed consent.
- The hospital had a nurse led pre-assessment clinic, which provided choice to patients regarding their appointments.
- There was a sense of pride amongst staff working in the hospital.
- The service recognised the views of patients and carers.
- Staff working within the service felt supported by their managers
- Ward sisters had access to leadership programmes.
- Patients told us that the care they received was good and that they felt safe.

Surgery

Are surgery services safe?

Requires improvement

We rated surgical services as requires improvement for being safe because:

- Not all staff received feedback after reporting an incident.
- The post-operative recovery area did not have a separate area for children and young people.
- The temperature of some treatment rooms was consistently above the recommended temperature for storing medicines and dressings.
- Staff were not following the trust's medicine policy of reducing expiry dates of medications in line with increased storage temperatures.
- Staff who cared for children and young people had not received level 3 safeguarding children training.
- Theatre five did not have a dedicated or recessed scrub area which was not in line with Department of Health Building note guidance HBN26 (2004).
- The emergency surgical admission unit (ESAU) did not have a dirty utility area.
- Theatre teams were not consistently using the Five Steps to Safer Surgery checklist. A mixture of three and five step processes were being used as an alternative.
- Venous thromboembolism (VTE) assessments were being initially completed but not consistently repeated in line with best practice.
- Patient own controlled drugs were stored in envelopes but not counted and recorded daily in line with the controlled drugs policy.

However we also found that:

- Staff were encouraged to report any incidents. Team meetings and staff information leaflets provided staff with the opportunity to discuss and learn from incidents.
- Staffing levels and skill mix were appropriate to the patients' dependency and acuity.
- There was access to appropriate equipment to provide safe care and treatment.
- The service had a procedure for reporting all new pressure ulcers, slips, trips and falls.
- The environment was visible clean and staff followed the trust policy on infection control.
- Staff were aware of how to escalate risks that could impact on patient safety.
- Nursing and medical handovers were comprehensive.

Incidents

- The surgical team had identified systems, processes, and practices that were essential to services to keep patients safe from avoidable harm.
- Staff understood their responsibility to raise concerns, to record safety incidents and near misses and to report them internally and externally.
- A system and process for reporting incidents was in place. Staff understood the mechanism of reporting incidents. Most staff told us that if they had reported an incident they received feedback via the email system. However, staff we spoke to in theatres and recovery said that they had not received feedback from incidents that they had reported.
- There was a monthly 'stories about safety' meeting held in the hospital to which all staff were invited where learning from incidents was discussed. The service also had 'Schwartz' rounds where staff reflected and learnt from clinical situations and incidents, 87% of staff who attended had rated the sessions as excellent or exceptional. The confidential rounds were run by a mixed panel of staff and had a positive impact on individuals and teams. For example, in August 2016, there had been a reflection about a patient death that had been particularly traumatic. Staff reported that they benefited emotionally from learning about the incident.
- There were 2384 clinical incidents reported in the surgical division at Watford Hospital in the period October 2015 to October 2016. This included reporting of pressure ulcers, falls and anaesthesia incidents. 147) resulted in low harm, 53 caused moderate harm, eight resulted in severe harm and 29 resulted in death or catastrophic injury.
- Lessons learnt from serious incidents were analysed by senior staff and cascaded to the team. The staff we spoke with told us they were informed about incidents and lessons learnt via team meetings and we saw copies of ward meeting minutes during our inspection, which confirmed this. The service also produced a quality and governance newsletter, which included shared learning.
- There had been no 'never events' in the service between July 2015 and June 2016. A never event is a serious incident that is wholly preventable, as guidance or

safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Staff were aware of the duty of candour regulation (to be honest and open) which helped to ensure patients received a timely apology when there had been a defined notifiable safety incident. Staff were able to tell us about incidents and learning and were able to give examples of situations where duty of candour had been applied.
- Mortality review meetings happened every two months and were chaired by the medical director. The meetings reviewed performance data relating to mortality, including the Hospital Standardised Mortality Ratio (HSMR) data, clinical coding, and patient safety indicators. Consultants reported that the meetings were well attended. Mortality data was shared in the integrated performance report.

Safety thermometer

- The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing patient harm and 'harm free care'. Data is collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter associated urinary tract infections and falls.
- NHS Safety Thermometer information was displayed at the entrance to each ward, which provided staff, patients and visitors information on the service's performance.
- For surgical services overall, between June 2015 and July 2016 there were no catheter associated urinary tract infections, five pressure ulcers, at grade two or above, and three falls with harm reported.
- In the period April 2016 to August 2016, the trust reported 14 new trust wide venous thromboembolism (VTE) over both its hospital sites. This gave a VTE rate of 0.47 which was above the national average of 0.38, although not significantly higher. This meant that more patients had acquired a VTE while receiving treatment at the trust on average, than at other hospitals.
- The surgical services had a performance dashboard that was used to monitor the quality of care provided. Nursing standards were measured by a system called: Test Your Care, which was a collection of nursing care indicators that monitored and improved the standards of patient care. For example, missed doses of medication and nutritional assessments were recorded. There were nine groups of questions and 76 checks were made each month by two members of the nursing team. The overall percentage was displayed on the board of each surgical area. For example, we saw that for August 2016 Cleaves ward had 96% and Letchmore ward had 93% overall compliance with nursing care standards. The trust target was 90%.

Cleanliness, infection control and hygiene

- The surgical areas visited were visibly clean, and the appropriate green 'I am clean' stickers were on equipment to demonstrate it was clean.
- Personal protective equipment such as gloves and aprons, were used appropriately and were available in sufficient quantities. However, we observed a doctor approach a patient whom was being isolated due to an infection without putting an apron and gloves on. This was brought to the attention of the ward sister who told us she would raise the issue with the doctor concerned.
- Hand hygiene gel was available outside the wards, in bays and side rooms. Hand-wash basins were also available in bays and side rooms. We observed staff washing their hands before and after patient contact during our inspection.
- The service conducted hand hygiene audits each month. For all surgical areas between January 2016 and May 2016, results showed 100% nursing staff compliance with hand hygiene. However, results for doctors showed that compliance was consistently poor on Langley ward ranging from 63% in January 2016 to 77% in May 2016. We were not made aware of an action plan to address this poor compliance. Doctor's compliance on other ward areas was 100%.
- We observed staff comply with the trust's 'arms bare below the elbow' policy across all the areas visited.

- Instructions and advice on infection control was displayed in the ward entrances for patients and visitors. This provided information on how to prevent and reduce the spread of infection.
- The hospital had a lead nurse for infection prevention and control. The infection control committee met monthly and monitored the trust's performance. Infection control policies were available on the trust's intranet system and staff told us they knew how to access them.
- There were no cases of MRSA recorded between December 2015 and May 2016. All patients attending the pre-assessment clinic were swabbed for MRSA and treatment was provided if results were positive. All patients who had joint surgery were also swabbed for Methicillin Sensitive Staphylococcus Aureus and appropriate treatment was provided if results were positive.
- There had been no cases of Clostridium difficile in surgical services between December 2015 and May 2016 .Clostridium difficile is a potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patients who have been exposed to antibiotic therapy.
- All surgical wards had isolation rooms where patients with infections could be isolated to reduce the risk of the spread of infection.
- Between April 2015 and March 2016, the trust reported that 310 total hip replacements had been carried out and zero surgical site infections (SSI). There was one SSI reported for total knee replacements between April 2015 and March 2016 equating to a rolling average of 0.2%. The trust had an SSI prevention nurse and lead surgeon who discussed, classified and agreed all SSIs, completed incident reports and conducted root cause analysis of reported SSI incidents. Learning was shared through SSI and divisional governance meetings.
- The hospital outsourced decontamination and sterilisation services and there was a system in place for the tracking of surgical instruments, which we saw evidence of during our inspection
- The emergency surgical unit did not have a dirty utility area, this meant that bodily fluids and commodes had to be taken into the ward next door to be disposed of which was a potential infection control risk. It was unclear if this had been risk assessed by the trust, as it was not identified on the services risk register.
- The theatre manager told us that all theatres were deep cleaned on a three-month rolling programme. However, we did not see any evidence of this during our inspection.
- Each surgical area had an infection prevention and control notice board, which displayed audit results, cleaning rotas and other information about infection control.

Environment and equipment

- There was sufficient equipment to maintain safe and effective care.
- Resuscitation equipment, for use in an emergency in the operating theatres and ward areas, were regularly checked, and documented as complete and ready for use.
- There was also a paediatric resuscitation trolley for use in the recovery department, which was checked regularly and ready for use.
- The pre-assessment unit had recently moved to a different building and did not have appropriate resuscitation equipment. There was a trolley, which contained a defibrillator, oxygen cylinder and basic airway management equipment but was not fully equipped. It was stored behind a locked door, which required a key code to gain entry. We were concerned that in the event of a cardiac arrest or medical emergency there was no immediate access to a fully equipped trolley. We raised this with the lead nurse and directorate manager who informed us that advice from the resuscitation officer was that the equipment was appropriate. However we were also told that an outpatients clinic would be moving to the area shortly and that a standard resuscitation trolley had been delivered but had not been commissioned, stocked and in use. When we returned on our unannounced visit the trolley was fully stocked with standard recommended equipment, was stored within easy access, and had been checked regularly since being in use.
- The emergency surgical admissions unit did not have resuscitation equipment available. If there was a medical emergency, the resuscitation trolley from the ward next to the unit would be used. The ward was in very close proximity to the unit.
- In theatre, the storage room outside the recovery area was cluttered and unorganised and medication fridges were stored on top of each other. This meant items could not be accessed in an emergency.

- Staff told us they could access bariatric equipment when required, for example, bariatric beds and hoists.
- Equipment had safety test stickers with appropriate dates. This meant that there were procedures in place to ensure that equipment was maintained and used appropriately.
- Dirty utility rooms were observed to be clean and tidy with appropriate storage for clinical waste and chemicals. However, ESAU did not have a dedicated sluice area and shared this with the adjacent surgical ward.
- Clinical rooms were found to be well organised with adequate storage for consumables such as wound dressings and syringes. Appropriate coloured waste disposal bags were used for the disposal of waste in all clinical areas. General waste and recycling facilities were available to staff, patients and visitors. Most sharps boxes for the disposal of needles were found to be appropriate to clinical area and detailed the date, time, and person responsible for assembling them. All were assembled correctly. However in the ESAU we observed a sharps bin, which was full. This meant that there was a risk to staff of receiving needle stick injuries if they continued to use it.
- Theatre five had no anaesthetic room and therefore patients entered directly into the operating theatre. Department of Health Building Note Guidance 26 (2004) states that it is common place for theatres to have separate anaesthetic rooms as this provides a satisfactory environment to prepare patients for theatre. However, it also acknowledges that some trusts have chosen to provide theatres without anaesthetic rooms.
- Theatre five had no dedicated scrub room and the scrub facilities were inside theatre and not recessed. This did not comply with The Department of Health Building Note Guidance 26 (2004), section 4.54 which states that if there is no separate scrub room that there should be a recessed scrub and gowning area with space for a minimum of three people

Medicines

- Arrangements were in place for managing medicines. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- There were processes and procedures in place to complete weekly checks and reconciliation of medicines as well as monthly audits to check stock and utilisation.
- During the week, a clinical pharmacist monitored the prescribing of medicines, visited the wards daily, and was readily available for advice about medicines. A medicines reconciliation had been completed for each patient record we reviewed. Medication reconciliations are a check to ensure that people receive the correct medicines on admission to hospital. On each ward, the pharmacist also attended multidisciplinary team (MDT) meetings.
- A pharmacist was present as part of surgical pre-admission clinics to ensure that patients received the correct medicines once they were admitted to hospital. In addition, a review of medicines that may need to be ceased prior to surgery, for example, Warfarin.
- Some prescription medicines were controlled under the Misuse of Drugs Act legislation (1971). These medicines are called controlled drugs (CDs). We examined the CD registers and found these to be appropriately completed, reconciled and checked.
- There appeared to be no process for the safe storage of patients own controlled medications. Some wards reported that patients own medication was sealed in envelopes and checked daily with stock medication. Other wards were leaving the envelope sealed and not checking the contents daily. The problems associated with sealing controlled medication in an envelope were discussed with the trust during our inspection. During the unannounced inspection on the 19 September 2016, we were advised that all staff had been informed that all patients own medications were to be checked and recorded daily in line with stock controlled drugs, and not sealed in envelopes.
- Medicines within the wards and theatres were stored correctly, including in locked cupboards or fridges when necessary. However, in theatre five, we observed that on one occasion the CD cupboard had not been locked after use. This was raised with staff at the time and it was immediately locked.
- Fridge temperatures were recorded in all of the surgical areas we visited. This ensured that medicines that are temperature sensitive are stored correctly. In two of the wards we visited, Flaunden and Ridge, the temperatures of treatment rooms were consistently above the recommended storage temperature of 25°C.The service had not followed trust policy of reducing expiry dates of medicines when stored outside of the recommended range. We raised this with the senior management team

at the time of our inspection and subsequently, an action plan to ensure safe storage of medicines was sent to us. On our unannounced inspection we found in Ridge ward, the treatment room temperature was still above the recommended range and an incident form had been completed a day before our visit. The ward sister told us that pharmacy had not visited the ward to review medicine storage in light of the high temperature. We raised the issue again with a senior manager who assured us that pharmacy and estates would be contacted to rectify the situation.

- We reviewed 21 medicine administration records and found no concerns with the administration of medicines. When medicines had been omitted, it was clearly recorded with an appropriate code as to the reason why. Allergies were clearly documented in all the records we saw.
- Pharmacy and nursing staff audited the medicine records.
- The administration record showed that antibiotics had been prescribed in accordance with local antibiotic formularies. This complied with National Institute of Health and Care excellence (NICE) Quality standard 61 Infection Prevention and Control.
- Doctors and nursing staff were aware of and sought guidance from the hospitals medicine policy and British National Formulary (BNF), which was the latest up to date version. The BNF is a pharmaceutical reference book and contains advice on prescribing and pharmacology.
- The hospital had a medicines use and safety panel (MUSP), which met regularly to advise on the use of medicines within the trust and to review medicines incidents.
- There was a policy to support patients who wished to self-administer their medicines. Patients were suitably assessed to determine whether they were capable of administering their own medication

Records

- In the surgical wards and operating theatres, we examined 21 patient notes, which included assessments for patients undergoing surgery. Within the patients' surgical notes, there were detailed and comprehensive pre- operative assessments. These were contained within a pre-assessment pathway booklet for patients prior to admission.
- In the ward areas, nursing notes were comprehensive and well organised. Care plans were used to ascertain what care patients required. This meant that staff had access to information on how to care for each patient.
- Within the patients' notes there were completed risk assessment booklets with related care plans, which were completed on admission. These were reviewed weekly, as a routine, or more frequently if the patient's condition changed.

Safeguarding

- There were clear systems, processes, and practices in place to keep patients safe. The hospital had safeguarding policies and procedures available to staff on the intranet. Records showed that 90% of doctors and 94% of nursing staff had received their safeguarding adults training level one, 96% of surgical staff and 94% of nursing staff had received level two safeguarding children training, against a trust target of 90%.
- Children aged 16-18 years were cared for on the main adult surgical wards. The Intercollegiate Document: "Safeguarding Children: Roles and Competences for Health Care Staff" (2014) states that: All clinical staff working with children and young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting where there are safeguarding/ child protection concerns must be trained to level three. Seven doctors and five nurses in the service had received this training therefore we were not assured that all staff had the appropriate competences to safeguard children appropriately.
- Staff received training through electronic learning and face-to-face sessions and had a good understanding of their responsibilities in relation to safeguarding adults and children in vulnerable circumstances. The surgical teams were able to explain safeguarding arrangements. Staff knew when to report issues to protect the safety of patients.
- Staff reported that the trust safeguarding lead was accessible. We saw posters on the walls by the nursing station, which included contact details for making a safeguarding referral.

Mandatory training

- All staff within the surgical service attended mandatory training for example, moving and handling, safeguarding, and basic life support.

- The records showed that 85% of surgical and nursing staff had completed mandatory training at the time of our inspection. This was an improvement from our last inspection in 2015 where there was a 63% compliance rate on the surgical wards and an 80% compliance rate in theatres. This did not meet the target set by the trust of 90%.
- Senior staff kept records of staff training needs and sent reminders via e-mail of any outstanding training that was required. If staff persistently failed to complete their training ward managers told us that they would involve the human resources department, as mandatory training was a contractual requirement. Staff told us that there were procedures in place to release them from clinical duties in order to attend training, or complete on-line modules as required.
- Staff chose how they completed their annual mandatory training, whether by e-learning, face-to-face or ad-hoc sessions for practical work.
- A sepsis bundle had been rolled out across the trust; this was used to document and to assess patient's risk of developing sepsis. Doctors we spoke with confirmed that they had received training in relation to the sepsis bundle. However, nursing staff in the surgical areas visited had not yet received training. This meant that we were not assured that staff had the right training to recognise patients that may be at risk of sepsis.
- The trust subsequently reported that additional training had been commenced in relation to sepsis, however, could not assure us that any training had taken place, apart from new staff induction, within the surgical departments.

Assessing and responding to patient risk

- Staff were aware of how to escalate risks that could impact on patient safety, such as staffing and bed capacity. There was daily involvement of ward managers, matrons and discharge and bed coordinators to address these risks.
- A pre-operative assessment was undertaken for all patients prior to surgery. A pre-operative assessment is a clinical risk based assessment where the health of a patient was appraised to ensure that they are fit to undergo anaesthetic and therefore the planned surgical operation. In addition, patients had the opportunity to ask questions and be fully informed about what to expect from their surgical procedure. Post-operative arrangements, including discharge and care at home were also assessed and discussed.
- The pre-operative assessment clinic was nurse led and all patients undergoing a surgical procedure attended.
- The pre-operative assessment unit had the presence of a consultant anaesthetist two days a week, who saw all patients who were having upper gastrointestinal surgery, colorectal surgery, or gynaecological procedures. Nursing staff triaged patients and referred them to the anaesthetist when necessary.
- Pre-operative investigations, for example blood tests were carried out during clinic in accordance with the National Institute of Health and Care Excellence (NICE) guidance: Preoperative tests for elective surgery, Clinical Guideline CG3(2003)
- Staff we spoke with told us that if a patient required a medical opinion, their consultant made a referral to the appropriate medical consultant, prior to being admitted for surgery.
- On admission and throughout a patient's stay in hospital, assessments were undertaken in areas such as; falls, malnutrition and pressure ulcers. Actions to mitigate risks were identified and documented in the patient's records. We reviewed a sample of risk assessments and found that these had been completed.
- Venous thromboembolism (VTE) assessments were completed on admission, but not consistently repeated and recorded after 24hrs, according to best practice. We were told during the inspection that VTE repeat assessments were recorded on the front of the patient's medication chart and not in the risk assessment booklet. We reviewed medication charts and found this was not always the case.
- In July 2016, the trust VTE audits showed 91% compliance that VTE assessments were being done, against a target of 95%. Senior managers informed us that the proforma for VTE risk assessments was being updated to emphasise the requirement for an additional VTE assessment to be completed within 24 hours of admission. It was planned that further monitoring of VTE assessments would be undertaken by the surgical divisional director at the next surgical governance meeting, due to take place in October 2016.
- The National Early Warning Score (NEWS) as used. NEWS is a tool to identify, monitor and manage deteriorating patients. Staff recorded routine physiological

observations such as blood pressure, temperature, and heart rate all of which were scored according to pre-determined parameters. There were clear directions for actions to take when patient's scores increased. Staff were aware of these and we saw evidence of appropriate actions being taken and recorded in patient notes.

- Staff we spoke with in the anaesthetic and recovery areas were competent to recognise deteriorating patients. In addition to NEWS, a range of observation charts and procedures, pathways and protocols for different conditions or operations were used to identify patients who may be deteriorating.
- A sepsis-screening tool had been incorporated into the risk assessment documentation within patient notes. This gave clear, best practice guidance on the assessment and treatment for sepsis and was incorporated into the NEWS chart.
- The trust assessed the appropriateness of patients for surgery using the American Society for Anaesthesiologist (ASA) physical status classification. This is a nationally recognised system for assessing the fitness of patients before surgery. For example, ASA1 meant the patient was healthy, ASA2 meant that the patient had mild systemic diseases. We saw that patients with ASA3 (severe systemic diseases) were reviewed on the morning of surgery. This meant that patients were appropriately assessed to ensure their safety prior to surgery
- Theatre teams did not consistently use the World Health Organisation (WHO)' 5 Steps to Safer Surgery' checklist for surgical procedures and interventional radiology, to prevent avoidable errors. As an alternative, a mixture of three step and five-step process checklists were being used across the teams. This meant that step one; team brief and step five; debrief, were not always being carried out. The surgical safety checklist incorporated a core set of safety checks briefing and debriefing. By using the five-step process there was greater impact on team performance and safety. Briefings are an opportunity to share vital information about patients, for example allergies and site to be operated on, and discuss potential and actual safety issues before and after procedures. During our inspection, we raised this issue with the senior management team who told us that the hospital would use only the 5-step process in the future. When we returned on our unannounced visit, we saw that a mixture of three and five step processes were still being used. Senior managers told us that the trust were trialling a new form using the five step process and planned to launch this throughout the trust after the pilot results had been reviewed.
- The critical care outreach team were available to all staff from 8am to 9pm. Between 9pm and 8am the critical care outreach team calls were triaged by the 'hospital at night' team.

Nursing staffing

- Senior staff used the national safer nursing tool to assess, identify and plan staffing levels. The wards we visited displayed the required and actual staffing numbers. During our inspection, the records we reviewed demonstrated that adequate arrangements for staffing were in place. Skill mix was appropriate on all wards with sufficient registered and unregistered staff to enable delivery of patient care and treatment. Staffing establishments had been reviewed in line with ward bed numbers and activity.
- Across surgical services the planned staffing levels was a ratio of 66 registered nurses to 34 health care assistants. However, the actual staffing levels were 62 registered nurses to 38 healthcare assistants.
- Recruitment, particularly for theatre staff, remained a challenge for the hospital and was on the local and directorate risk register. Vacancies existed within surgical services despite recent recruitment campaigns. The vacancy rate for nursing staff was 10%. We reviewed staffing rotas during our inspection and bank and agency staff were used to fill gaps. Ward sisters we spoke with told us that they requested the same agency staff (where possible) to ensure continuity within the wards.
- All bank and agency staff were required to complete a local induction on their first shift to the ward or surgical unit. We saw completed induction booklets in place for bank and agency staff within the surgical wards and units.
- Nursing handovers happened at the change of each shift. We observed that handovers provided concise information on each patient. During the handovers we observed the nurse in charge summarise the plan of care for each patient and at the end of handover discussed the 'weekly 3', which was the three most

important pieces of information that needed to be shared with staff. For example clinical governance updates and new staff training dates. Staff had to sign to say that they had received this information.
- The hospital had a 'hospital at night team' which included a band 7-night practitioner who supported nursing staff clinically. This meant that nursing staff had access to advice and support and that there was senior nurse oversight.
- On the surgical wards visited ward huddles took place throughout the day. This meant that staff were continually updated on the plan of care for every patient and the nurse in charge was able to maintain an effective good oversight of patients in their care.

Surgical staffing

- Each surgical ward had dedicated doctors based there each day. Consultants worked throughout the week within the surgical services and led a team of doctors.
- Out of hours and at weekends consultants were on call.
- At night, surgical wards were covered by a surgical registrar, senior house officer, and foundation year 1 doctor. Surgical handovers from day to night doctors took place. Doctors we spoke with told us that during these handovers, both patients whose condition was causing concern as well as new patients, would be fully discussed
- During the inspection, we attended an orthopaedic ward round which was concise and well organised, with clear plans of treatment discussed for each patient.
- The proportion of consultants was slightly lower than the England average at 39% compared to 43% as was the registrar group at 29% compared to 35%. The proportion of middle grade was higher than the England average at 19% compared to 10% and junior doctor level was similar to the England average.
- The clinical leads for the service reported recent challenges in the recruitment of foundation year 2 doctors' doctors and registrars .There had been a recent recruitment drive and the trust had offered rotational rotas with another specialist NHS trust to attract junior doctors to the post.
- The trust employed six physicians' assistants, which allowed junior foundation year one doctors to be able to concentrate on more complex clinical needs.
- Ward rounds took place twice daily, once in the morning and again in the afternoon, and were consultant led.
- On the trauma and orthopaedic surgical wards, there were boards that displayed the patients' initials and bed location. In addition, the bleep numbers for the consultant and team responsible for their care were shown so that they could be contacted if required.

Major incident awareness and training

- Senior staff were aware of the procedures for managing major incidents and there was a link to the policy on the trust internal website.
- There was a bed management system in place which was aimed at ensuring patients' needs were met when there were increased demands on beds.

Are surgery services effective?

Good

We rated the service as good for effective because:

- All policies we reviewed were current and reflected evidence based guidelines. There were systems in place to provide care in line with best practice.
- Patient's pain was assessed, treated, and discussed at handovers.
- There were competency frameworks for staff in all surgical areas.
- The Malnutrition Universal Screening Tool (MUST) was used to assess patients' risk of malnutrition. Patients' fluid and nutritional intake was monitored and recorded.
- Effective multidisciplinary team working was in place that delivered co-ordinated care to patients.
- Patients told us that doctors discussed consent prior to any procedures and the records demonstrated clear evidence of informed consent.
- The trust had reviewed its hip fracture care pathway and had reduced mortality from hip fracture from 12% to 4%.

However we also found that:

- Overall, only 64% of staff had undergone an appraisal against a trust target of 90% from April 2015 to March 2016, although the trust were working to improve this for 2016/17.
- Junior staff we spoke with were not able to explain when a Deprivation of Liberty Safeguard (DoLS) application was appropriate.

- Pre-assessment documentation did not specifically include identification of patients who were living with dementia or learning disabilities.

Evidence based care and Treatment

- Staff provided care to patients based on national guidance, such as the National Institute for Health and Care Excellence (NICE) and the Royal College guidelines.
- The trust recorded medical device implants on the National Joint Register to ensure outcomes for patients undergoing joint replacement surgery were monitored.
- Trust polices were current and we saw that the hospital had systems in place to provide care in line with best practice guidelines. For example, the service used an early warning score to alert staff should a patient's condition deteriorate (in line with NICE CG50 Acutely ill patients: Recognition of and response to acute illness in adults in hospital 2007).
- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, orthopaedics and ear nose and throat (ENT). These focused on thorough pre- assessment, less invasive surgical techniques, pain relief, and the management of fluid and diet. This helped patients to recover quickly post operatively. We reviewed the enhanced recovery pathways for total hip replacement and spinal surgery and saw that they followed current guidance.
- Local policies, such as the pressure ulcer prevention and management policies were written in line with National Institute for Health and Care Excellence, national guidelines. Staff accessed these policies on the trust's intranet.
- Local audits monitored adherence to policies and procedures such as, National Early Warning Score (NEWS) and the World Health Organisation's (WHO) Five Steps to Safer Surgery.
- We saw a number of five steps to safer surgery audits, the latest, date September 2016 which showed compliance of between 84 -100%. There were associated action plans in place, which had driven improvements. However, the audits were of the checklists only and not of observations of the steps being carried out.
- NEWS audits were carried out, which considered whether a full set of observations of patients' vital signs had been carried out regularly and whether the appropriate triggers to escalate care had been carried out. We saw that in January 2016, there had been 74% compliance; however, in July 2016 after action planning, compliance had improved to 87%.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death recommendations and national guidelines including Royal College of Surgeons, standards for unscheduled surgical care (2011).
- The pre-operative assessment clinic assessed and tested patients in accordance with NICE guidance: Preoperative tests for elective surgery, Clinical Guidance (CG3), (2003). Examples included MRSA testing.
- When patients attended pre assessment clinic they received advice on smoking cessation and reducing alcohol consumption to ensure that they were supported in being as fit as possible for their surgery.
- There was a hip fracture pathway in place within the trust. Patients who had suffered a fractured hip have high mortality and morbidity rates and often need long term care post fracture. A hip fracture pathway ensures that care is co-ordinated and is evidence based to reduce length of stay and any associated mortality and morbidity.

Pain relief

- Patient records showed that pain relief had been assessed using consistent and validated tools, such as the pain scale found within the National Early Warning Score (NEWS). Results were recorded alongside other vital signs. Patients' pain and management of their pain was discussed at daily handovers when appropriate.
- When required, patients could access pain relief in accordance with the trust policy and we saw evidence that patients had been given pain relief in a timely manner.
- The acute pain team were available during Monday to Friday 9am till 5pm, to provide on-going pain management to patients. Out of hours, the on call anaesthetist could be contacted to support pain management.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition. Patients identified at risk of malnutrition were referred to the hospital dietetic service for assessment, with regular monitoring of their nutritional condition in place.

- Patient's nutrition and hydration intake was recorded when applicable.
- We observed staff used fluid balance charts to monitor patients' fluid intake. We saw that patients had jugs of water within reach, on their bedside tables, to promote hydration.
- There were processes in place to ensure that patients that needed assistance with eating and drinking were identified and supported. For example, the hospital used a red tray system where patients who required support with eating and drinking had their food offered to them on a red tray.
- Day surgery patients were offered drinks and snacks post operatively.
- There was evidence in notes that dietitians had reviewed patients' nutrition requirements.
- Patients who were undergoing bariatric surgery had access to a dietitian.

Patient outcomes

- The service continuously reviewed and improved patient outcomes through participation in national audits, such as the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry, and the National Emergency Laparotomy Audit.
- PROM audits measured health gain in patients undergoing hip and knee replacement, varicose vein and groin surgery in England. The patient related outcome measures for the hospital for groin hernia were slightly better than the England average with less patients reporting worsening in their condition after the procedure and more patients reporting improvement. The outcomes for hip replacement, and varicose veins were mixed, but similar to the England average.
- The National Emergency Laparotomy Audit considered the structure, process and risk adjusted outcome measures for the quality of care received by patients undergoing emergency laparotomy. The audit rates performance on a red, amber, green scale where green is best and red is the worst. The hospital had two greens for when computerised Tomography (CT) was reported before surgery and consultant anaesthetist presence in theatre. The hospital had red results for; final case ascertainment, consultant surgeon review within 12 hours of emergency admission, risk documented pre-operatively, direct post-operative admission to critical care and assessment by a medical crisis in older people specialist. The hospital scored ambers for the remaining four measures. We were not made aware of any further action plan that addressed issues from the audit.
- The data from the National Bowel Cancer Audit (2015) showed that 74% of patients stayed in hospital more than five days, which was worse than the England average of 69%. The remaining results were within the expected ranges.
- The National Hip Fracture Database (NHFD) is part of the national falls and fragility fracture audit programme. A review of the 2015 report indicated that overall hospital length of stay was 13.8 days, which was lower than the England average of 20.3 days. The hospital was within the expected ranges for the remaining three measures. The trust reduced the mortality rate for hip fractures, from February 2013 to February 2016 from 12% to 4%, with a continuing downward trajectory, by reviewing their hip fracture care pathway. Other indicators, for example, the time taken to being admitted to an orthopaedic ward, time from admission to theatre and inpatients stay, were all better than the national average. In November 2015, the trust was awarded the Health Service Journal award for patient safety for their work in improving mortality rates for patients who had sustained a hip fracture.
- The National Vascular Registry audit (2015) data showed that the hospital performed better than or within the expected range for all measures such as the risk adjusted 30 day mortality and stroke rate
- The surgical service monitored and reported information through the governance structure to ensure early intervention. Hospital mortality was reviewed monthly to identify root causes and share learning across clinical teams.

Competent staff

- Annual appraisals are a method through which skills and performance are assessed and objectives for improvement and development are set. Data provided by the trust showed that for surgical services 64% of staff had undergone their annual appraisal from April 2015 to March 2016. This did not meet the trust target of 90% in all surgical areas. The trust provided us with updated information for April 2016 to September 2016 which showed that the service was on track to exceed the target for 2016/17.

- There was an induction programme for all new staff. This included mandatory training and competency based ward skills. All staff that we spoke with confirmed they had attended an induction and that the process had been helpful.
- Ward managers informed us that nursing staff worked on a supernumerary basis when commencing a new role. This was to ensure competence and offered new staff the opportunity to learn new skills and methods of working.
- Newly qualified nursing staff were supported through the preceptorship programme, which offered role specific training and support.
- Agency staff were inducted to the ward area. This included a tour of the ward, introduction to staff and details of the equipment used. We saw records of completed inductions. Locum doctors confirmed that they had received an induction.
- All staff spoken with said that they were able to access study days relevant to their area of work, both internally and externally.
- There were competency frameworks for staff in all surgical areas and we saw a sample of these were completed and up to date.
- Junior doctors informed us that they had received an induction and that they had two training days per week and had regular clinical supervision. However, supervision was not routinely or formally offered for nursing staff.
- Leadership courses were available to nursing staff band 6 upwards. Staff that had recently completed a leadership course told us that they felt more confident in carrying out their senior duties after completing the course.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices that delivered co-ordinated care to patients.
- Surgical ward rounds took place twice a day, seven days a week. This involved medical and nursing staff together with physiotherapists and/or occupational therapists as required.
- We observed a good working relationship between ward staff, doctors, and therapists.
- Overall responsibility for the patient remained with the named consultant who was responsible for the patient's care and treatment.
- The hospital had a critical care outreach team who provided seven day, 24 hour service and worked closely with nursing and medical staff.

Seven-day services

- The pharmacy was open Monday to Friday 9am-5pm as well as Saturday and Sunday mornings. Outside of these hours, there was an on-call pharmacist to dispense urgent medicines.
- The trust provided a seven-day diagnostic service. There was access to all key diagnostic services 24 hours a day. This supported clinical decision-making.
- Consultants conducted ward rounds every day, including weekends and participated in on call systems.
- Sufficient out of hours medical cover was provided to patients in the surgical wards as well as by on site and on call consultant cover. Newly admitted patients were seen by a consultant, even at weekends. Existing patients were seen by the registrar on duty at weekends.
- Theatres, anaesthetics, and recovery had staff on duty out of hours and at weekends to cover emergencies. In addition there was as second team on call.
- A full seven-day service was in place for physiotherapy and occupational therapy. Speech and language therapy and dietetics services were provided Monday to Friday 9-5pm.

Access to information

- Staff, including agency and locum staff, had good access to patient-related information and records when required. This included care and risk assessments, care plans, case notes, and test results to enable them to care for patients appropriately.
- Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Medical staff completed electronic discharge letters, which included details of patient's admission, medication to take home and details of any follow up appointments.
- GPs received copies of discharge letters to ensure continuity of care within the community. The summary had the consultant surgeon's contact details. This meant that the GP had a point of reference if further information was needed.

- There was an electronic system for managing blood test requests and results. Staff told us they were able to access the system and it worked well.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood consent, decision-making requirements, and guidance. The hospital had an up to date policy on consent for surgical treatment.
- The hospital had five nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure and another for procedures that were not going to be done under general anaesthetic.
- Patient records, showed clear evidence of informed consent, which identified the possible risks and benefits of surgery.
- Patients we spoke with confirmed they had received clear explanations and guidance about their surgery, and said they understood what they had consented to.
- Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 (MCA).
- Staff had received training about the MCA and Deprivation of Liberty Safeguards (DoLS) training and compliance rates were between 82% and 100%. Staff and had a reasonable understanding of when a mental capacity assessment should be completed and understood the need for and how to make best interest decisions for patients who did not have capacity to do so. However, junior staff we spoke with were not able to explain when a DoLS application was appropriate. This meant that they were not competent to meet patients' needs and protect their rights when required.
- Staff in the pre-assessment unit told us that if they were concerned about a patient's mental capacity they communicated this to the surgeons and anaesthetists; however within the assessment documentation there were no prompts to determine whether a patient lacked capacity to make certain decisions, for example, if the patient lived with a learning disability or with dementia.

Are surgery services caring?

Good

We rated surgery services as good for caring because:

- Staff were caring and compassionate and met the needs of patients.
- Staff were respectful of patient's privacy and dignity.
- Patients told us that care they had received was good.
- The NHS Friends and Family Test results for May 2016 showed that between 92% and 100% of patients would recommend the surgical services to their family and friends.
- Patients we spoke with felt informed about their care and treatment and were all aware of their estimated discharge date
- Patients were encouraged to be as independent and mobile as possible following their surgery.

Compassionate care

- Staff responded to patients in a compassionate, timely and appropriate way.
- We saw staff respected patients' privacy and dignity during personal care, for example, staff pulled curtains around the bed space.
- Patients told us that staff treated them with respect and that their personal. Cultural, social, and religious needs were understood by staff caring for them.
- The NHS Friends and Family Test results for May 2016 showed that between 92% and 100% of patients would recommend the surgical services to their family and friends. The response rates between June 2015 and May 2016 was between 40% and 70%.
- We observed staff communicating with patients in a calm and kind manner.
- A patient we spoke with in theatre recovery told us that staff were kind and caring. This had made them feel less anxious and that they were happy with the service they received.
- Patients told us that staff introduced themselves and that they were aware of who their named nurse was.
- One relative described the care his wife had received as: "Fantastic".
- Other comments received by patients included: "Nothing was too much trouble, a brilliant service" and: "Staff listened to me and were very approachable".

Surgery

- During our inspection, we heard staff use reassuring and encouraging language when talking with patients and their relatives.
- We saw a housekeeper on Letchmore ward giving out breakfast to patients; they had a pleasant manner and were smiling.
- One patient we spoke with praised the ward housekeeper, said that they were very friendly and chatted to them whilst they were working on the ward. The same patient had lost a personal item and the housekeeper helped them to find it.
- Patients said that nurses were always discreet when giving them personal care and that their privacy and dignity was respected.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt informed about their care and treatment and were all aware of their estimated discharge date.
- Consultants visited their patients daily and were available to answer any questions they might have. They kept patients informed of what to expect and their plan of treatment.
- Patients told us that they felt comfortable asking questions and that staff took time to explain and answer their queries.
- One patient told us that they had felt very involved with their own care and had been supported in making decisions.
- A patient whose first language was not English told us that staff had spent time going through information using simple English to ensure they understood, which they found helpful.
- Patients told us that both nurses and doctors explained their treatment and that they felt involved in their care.

Emotional support

- There was information available to staff on how to contact members of the chaplaincy team to meet patient's individual spiritual needs.
- Patients had access to a chapel and multi faith room on site.
- Patients had access to clinical nurse specialists, for example, breast care nurses and stoma care nurses. This meant that patients received specialist advice and emotional support when coming to terms with any adaptions required in their everyday lives.
- One patient told us that she had become very upset and a nurse had given her a hug and spent time reassuring her.
- We observed staff in theatre supporting a patient who was extremely anxious.
- One patient told us that staff were very approachable and had time to listen to their concerns.
- The patients we spoke with told us that they felt safe.

Are surgery services responsive?

Requires improvement

We rated surgery services as requires improvement for being responsive because:

- Although the trust had improved referral to treatment times for patients in many specialities overall between June 2015 and May 2016, they were below the England average.
- Pre-assessment documentation did not specifically identify if patients were living with dementia or a learning disability.
- The service performed worse than the England average for the number of patients not offered another appointment within 28 days of a cancelled operation.
- Level two patients were sometimes cared for in the recovery area. These were not recorded, neither was the impact on surgical lists.

However we also found:

- The hospital had a nurse led pre-assessment clinic, which offered some flexibility to patients.
- There was a translation service available to patients to ensure that they had relevant information about their care
- There was a 'This is me' scheme to support patients who lived with dementia and a learning disability.
- Complaints were handled in line with the trust's policy and staff attempted to resolve them locally where possible.

Surgery

Service planning and delivery to meet the needs of local people

- The service was committed to the vision set out in: 'Your Care, Your Future', which is a system wide strategy for developing health and care services for the local population of West Hertfordshire. The service had been planned taking into account this strategy.
- The facilities and premises were appropriate for the services provided to patients.
- The senior management team told us their surgical strategy for the next three to five years included maximising the separation of planned surgery from emergency surgery to ensure planned care, for example knee replacements, were protected from emergency care pressures.
- Staff we spoke with told us that appointment times could often be arranged to accommodate patients' needs, as there was some flexibility of the booking system.
- On the day of surgery, patients listed for elective (planned surgery) were admitted to the surgical admissions lounge where they were seen by a nurse and prepared for surgery and the post- operative ward.

Access and flow

- Patients did not always have timely access to initial assessment, diagnosis and treatment. Between June 2015 and May 2016, the trust's referral to treatment (RTT) indicators were below the England average across all six surgical specialities. For example, in general surgery 66% of patients were treated within 18 weeks of referral compared to an England average of 80%, in ENT 59% of patients were treated within 18 weeks, and for trauma and orthopaedics 68% of patients were treated within 18 weeks compared to an England average of 70%.
- Following the inspection, the hospital provided updated RTT data which showed that as of 31 August 2016, RTT had significantly improved across all specialties. This was achieved by the reinstatement of waiting list initiatives, (outpatients and theatre lists,) streamlining referral processes and introduction of demand management where appropriate, for example, spinal surgery, and identification of capacity with other providers.
- Data from NHS England showed the trust's referral to treatment time (RTT) for admitted pathways for surgery has been worse than the England overall performance from August 2015 to July 2016. The data for August 2016 showed that the trust was performing at 72% compared with the England average of 81%. In ENT for example, the trust performance for that period was 52% compared to the England average of 73%.
- RTT times had been improving in the service over time. Most recently, data supplied by the hospital for the month of August 2016 only, indicated that the trust had made improvements in RTT times with urology 86%, trauma and orthopaedics 84%, ENT 73% and ophthalmology 88% of patients treated within 18 weeks. The trust told us they reviewed the records of patients who had waited over 18 weeks for treatment but it did not contact patients' GPs and inform them of extensive waiting times. This meant patients who required their surgery quickly, may not have been assessed appropriately and in a timely manner. The clinical leads we spoke with informed us that a private project management company had assisted the directorate in completing a review of the theatre template, to increase efficiency, by redesigning the use of theatre time. The new template was due to be introduced in October 2016. This was aimed to increase theatre capacity and help to reduce RTT.
- Emergency surgery was facilitated by an on call theatre team. Consultants in each speciality were on call at night and weekends and therefore could undertake emergency procedures if necessary.
- The percentage of patients who had operations cancelled and were not offered another appointment within 28 days was worse than the England average of approximately 8%. NHS England data showed that between April 2016 and June 2016, 122 patients had their surgery cancelled and 26 (21%) were not offered another appointment within 28 days.
- The trust advised us that for the 12-month period ending May 2016, there were 49 patient operations cancelled on the day. The reasons for cancellation included lack of anaesthetic cover, or a previous list running over its scheduled time.
- Patients attended the pre-assessment clinic as soon as possible following their consultation with their surgical consultant. This meant that they were assessed in a timely manner.
- At the time of our inspection over half the patients, 15 out of 25 patients, admitted to Letchmore ward were medical 'outliers.' These were patients who had been

admitted on an unscheduled basis for medical rather than surgical care and there was no bed on the medical wards for them. The ward sister explained that the number of medical patients varied depending on pressures within the medical division. Furthermore, told us that having medical patients on the ward sometimes affected the capacity to admit surgical patients from the emergency surgical admissions unit. We did not find any further medical outliers on the other surgical wards visited.

- Recovery room staff we spoke with told us that on occasions when there was a shortage of critical care beds, patients would be cared for by critical care nurses in the recovery room area. It was unclear as to how often this actually happened, as they had not been reported as incidents, neither had impact it had on elective surgical lists ben recorded.
- Recovery staff we spoke with told us medical patients were frequently accommodated overnight, in theatre recovery. This impacted on the surgical elective lists resulting in cancellations. It was unclear as to how often this actually happened and how the area was staffed.
- The booking system within the pre-assessment clinic offered some flexibility to patients allowing them where possible to select an appointment date around family and work commitments.
- The discharge lounge was open from Monday to Friday between 9am to 8pm.
- There was an integrated discharge team and each surgical ward had a discharge coordinator, who attended the ward daily to ascertain which patients were ready for discharge and provide assistance to ensure patient's discharge was as smooth as possible.
- The hospital episode statistics between January 2015 and February 2016 showed that the length of stay was higher than the national average of 3.4 days for elective general surgery at 4.1 days. For trauma and orthopaedics, the length of stay was five days, against a national average of 3.4 days. Length of stay in non-elective surgery was lower than the England average across all specialities.
- The Day Care Unit (DCU) was a combined area, which also provided a surgical admissions lounge. On arrival in the day surgery unit, the nurse assessed patients' wellbeing and processed them for surgery and the post-operative ward.
- Information leaflets about the service were in English only and available in all the areas we visited. Staff told us that they could provide leaflets to patients in different languages if required. Leaflets were also available on request in Braille.
- The trust had a named lead to support patients and offer advice to staff with regards to learning disabilities. Staff told us that they knew how to contact the lead nurse and were able to seek advice when needed.
- Staff demonstrated an awareness of the dementia 'This is me' scheme. Staff documented patients' care needs in the care passport, including patient preferences and other useful information, which enabled staff to support them.
- There was a dementia care lead nurse within the hospital who offered advice and support to staff, who cared for patients who were living with dementia. There were also dementia champions within each ward area.
- A blue plastic disc that was designed to fit their hospital identification bracelet discreetly identified patients, who lived with dementia. The symbol-enabled staff to identify those who may need more care, understanding and support.
- Recovery room staff told us how a patient who had lived with a learning disability had been anxious about the theatre environment. Therefore, it was arranged for the patient to visit recovery and the main theatre area prior to their surgery. This meant that the patient was more familiar with the environment and was less anxious on the day of their surgery.
- Staff who worked in pre-assessment advised patients on healthy weight loss where required and gave patients information on how to get advice and support.
- Translation services were available within the hospital.
- The ward had protected visiting times during mealtimes. There was 'red equipment' to identify patients who needed help with eating and drinking.
- Patients were encouraged to be as independent and mobile as possible following their surgery. For example, we saw physiotherapists walking with patients around the ward area. We saw that during mealtimes, patients were encouraged to get out of bed in order to eat, and staff provided assistance to patients, when needed.
- Lifestyle information leaflets were available in the pre-assessment clinic for example on reducing alcohol consumption and increasing daily activity for health.

Meeting people's individual needs

- Pre-assessment documentation did not include questions to identify patients that lived with dementia or learning difficulties, which meant that surgical wards may not have been aware of a patient's particular needs and support required prior to their admission.
- Discharge planning commenced at pre-assessment where a patient's expected discharge date was discussed so that patients could plan what may be required for going home. For example, someone to take them home and help with shopping.

Learning from complaints and concerns

- Staff reported complaints were handled in line with the trust's policy. Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns immediately.
- The ward/unit sisters received all the complaints relevant to their service and gave feedback to staff regarding complaints in which they were involved. Lessons from complaints were shared within the department during team meetings.
- We saw evidence of actions put into place because of concerns raised by patients. For example, a patient complained that the call bells kept them awake at night. As a result, earplugs were offered to all patients and the call bell volume was adjusted at night.
- Literature and posters displayed within the wards advised patients and their relatives how they could raise a concern or complaint, either formally or informally. Staff reported complaints were handled in line with the trust's complaints policy. Staff directed patients to PALS if they were unable to deal with their concerns directly.

Are surgery services well-led?

Good

We rated surgery services as good for well-led because:

- There was a clear and robust strategy, which set out service priorities for the next three to five years.
- There were systems in place to identify and monitor risks.
- Each ward had a lead nurse who provided day-to-day leadership to staff.
- Staff we spoke with were clear about their roles and responsibilities.
- There was a sense of pride amongst staff.
- Staff described a supportive working environment.
- The views of patients and the public were recognised.
- Divisional governance meetings where performance indicators were discussed.

However we also found that:

- Staff were unaware of the trust's new vision.
- Feedback from incidents was not consistently shared with all staff.
- There was inconsistencies in the monitoring of assurance systems which the service had in place to keep patients safe.

Leadership of service

- Surgical services were within the surgery, anaesthetics, and cancer division and had a divisional director, manager, and head of nursing. Each clinical ward area had a ward manager and matron.
- Staff we spoke with were aware of who their manager was and confirmed that that they were visible, approachable and were effective and capable leaders.
- Most staff of the staff we spoke with said they familiar with who the chief executive officer (CEO) and the director of nursing (DON) were and that they saw them around the hospital.
- The CEO had an open door policy that staff could access when required.
- Staff within the surgical services said they felt supported by their managers who looked after their welfare. They felt able to raise concerns and that their concerns would be acknowledged.
- Each ward had a lead nurse who provided day-to-day leadership to members of staff on the ward.
- Ward sisters said they had access to leadership development programmes.
- Staff we spoke with were clear about their roles and understood what they were accountable for.

Vision and strategy for this service

- The trust had implemented a new mission, vision, and values. This had recently been updated. Staff we spoke with were not aware of the vision which was to deliver 'the very best care for every patient, every day'. However most staff were aware of the trust values of 'commitment, care and quality'.

- Staff we spoke with told us they were not involved in the development of the trust's values and vision.
- The strategy for the service was incorporated into the trust's overarching clinical strategy that set out the priorities for the trust over the next three to five years. These priorities included ensuring timely and streamlined access to meet national 'referral to treatment' standards, redesigning pathways and implementing one stop models where possible and maximising the separation of planned surgery from emergency.

Governance, risk management and quality measurement

- The trust had a governance structure in place. Staff we spoke with were aware of the local governance structure and how it informed the hospital governance arrangements. Each division within the trust held governance meetings that fed into the trust's quality safety group. In turn, these fed directly into the trust board. In addition, there were divisional efficiency, meetings where incidents, complaints, innovations and risk management were discussed. Senior nurses from across the surgical, anaesthetic, and oncology division had monthly meeting with the chief nurse and consultants across the division had joint meetings. Each unit and ward had team meetings to disseminate information to staff. However, this was not always effective as not all staff received feedback and learning from incidents.
- The service used a risk register to record identified risks. We reviewed the surgical and anaesthetic division services risk register, which contained 34 risks. The list included a description of the risk and the controls in place to mitigate the risk. Each risk had an identified owner. There was a risk review group in place that met monthly, reviewed existing risks and discussed any new ones.
- We saw inconsistencies across the service in the use of two different forms and methods of recording WHO 5 steps to safer surgery checklists. Although this was raised with the senior management team during our initial inspection, we found that during our unannounced visit, the same inconsistencies were found. This meant that action has not been taken to ensure that risks to patients were mitigated.
- There was system of local audits in place, which were divided by speciality, for example anaesthesia, orthopaedics and ophthalmology. We saw that these audits and associated action plans were discussed at divisional governance meetings in order to drive improvements.
- Each surgical area we visited held staff team meetings to discuss day to day issues and to share information such as complaints and audit results.
- The service had quality dashboards on display in all the areas visited. This showed performance against quality and performance targets. Ward managers told us that these were also discussed at team meetings.

Culture within the service

- Leadership within the surgical services reflected the vision and values of the hospital and promoted good quality care.
- There was a sense of pride amongst staff towards working in the hospital and they felt respected and valued by their colleagues and managers.
- Staff described a supportive and encouraging working environment and one in which openness and honesty was encouraged.
- There was evidence of collaborative working throughout the service and a shared responsibility to deliver good patient centred care.
- Each clinical area displayed thank you cards from patients and relatives.

Public engagement

- All wards distributed patient feedback forms regularly to ensure they captured patient comments and any concerns.
- The staff within the surgical service recognised the importance of gathering the views of patients and actively sought comments and offered comment cards within clinical settings.
- Data from the Friends and Family Test was used to monitor and influence the standards of the services provided.
- Each ward board displayed their: 'I want great care' score. For example, Cleave ward and Flaunden ward scored 4.5 out of 5 for August 2016.
- Information on patient experience was reported alongside other performance data at divisional efficiency meetings. This information was used to inform decisions about the service.

Surgery

Staff engagement

- All staff we spoke with were focused on and committed to providing a high standard of safe care and were proud of the services that they provided.
- The trust had a Celebrating Excellence award scheme and one of the surgical areas visited had been given the team award in April 2016 for going to extraordinary lengths to provide exceptional care and support to patients and families.
- Staff in all surgical areas visited were focused on continually improving the quality of care for patients.

Innovation, improvement and sustainability

- The pre assessment department had recently developed an outreach service that enabled elderly and frail patients to be pre-assessed in their own home.

Critical care

Safe	Good
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Good

Information about the service

West Hertfordshire NHS Trust offers critical care services at Watford Hospital Critical Care Unit (CCU) to level two and level three critically ill patients, who require either organ support or closer monitoring in the immediate post-operative period. Critical care includes areas where patients receive more intensive monitoring and treatment for life threatening conditions. It provides special expertise and the facilities for the support of vital functions and uses the skills of medical, nursing and other personnel experienced in the management of these problems.

There are a total of 19 critical care beds for the care and treatment of people aged 16 years and above. The unit has five side rooms, for the safe management of patients who require isolation for infection control purposes. The main source of referrals was received from the acute admissions unit at Watford Hospital.

Patient care was consultant led and consultant cover was available 24 hours a day on site, seven days a week, ensuring out of hours and weekend cover was provided.

Critical care services also provided a critical care outreach team, which supported patients at risk of clinical deterioration on the wards of the hospital; this was provided 24 hours a day, seven days a week.

There were 988 admissions to the unit from July 2015 to June 2016 with 834 emergency admissions and 154 elective admissions.

As part of our inspection we spoke with 30 staff including nursing staff, junior and senior doctors, administrative staff, and allied healthcare professionals working within CCU as well as other doctors and nurses admitting patients to or receiving patients from CCU. We spoke with four patients and three visiting relatives.

We checked the clinical environment, observed ward rounds, nursing and medical staff handovers and assessed all or part of patients' health care records.

The Care Quality Commission carried out an inspection at West Hertfordshire NHS Trust hospitals in April 2015. At that time, overall the critical care service was found to be inadequate.

Critical care

Summary of findings

Overall, we rated the critical care service as good. We rated safe, effective, caring and well-led as good and responsive as requires improvement because:

- Staff caring for young people aged 16 to18 years of age were not always trained to level 3 in safeguarding children. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014).
- CCU contributed to the Intensive Care National Audit and Research Centre (ICNARC) database and indicators were generally similar to other units apart from delayed discharged which was higher than the average.
- The ICNARC results 2016 showed the unit had a higher than national average for delayed discharges of 14% compared to the national average of 5%. The trust was in the worst 5% of units for this element. On occasions the unit was unable to admit or discharge patients due to the unavailability of beds within the trust, which resulted in single sex breaches. Patients could be nursed in theatre recovery for over 10 hours whilst waiting for a bed either in CCU or on the ward. Although this was highlighted on the CCU and trust risk register, there was no evidence that an effective plan was in place to address this.
- A microbiologist did not visit the unit during the inspection period.
- The safety of medication management was not always maintained
- The trust's clinical strategy 2016-2020 did not include any specific reference to critical care.

However we also found:

- Staff were encouraged to report incidents and were confident in reporting incidents and were aware of the importance of duty of candour.
- There was access to appropriate equipment to provide safe care and treatment.
- The environment was visibly clean and staff followed the trust policy on infection control practices.
- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls and actions were taken. Staff were aware of safeguarding procedures to keep patients safe.
- Medical staffing was appropriate and there was good emergency cover. Care was consultant led.
- Nursing and medical handovers were well structured.
- Safe staffing levels were being achieved by the use of bank and agency staff.
- Staff had completed their mandatory training.
- Policies and procedures were accessible, and staff were aware of the relevant information. Care was delivered in line with best practice guidelines.
- Patient's pain, nutrition and hydration was appropriately managed.
- Care bundles (evidenced based procedures) were in place for the use of ventilators and central lines.
- Patients in the unit were screened for delirium using a recognised screening tool.
- A practice development nurse was in post.
- Staff had awareness of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).
- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect. Patients spoke highly of the care they had received.
- Between June 2015 and May 2016, the trusts Friends and Family Test, were consistently above 95 % for each month.
- Patients were kept up to date with their condition and how they were progressing and people were aware of how to make complaints.
- The unit offered a monthly coffee, cake and chat session for relatives past and present to meet medical, nursing and allied professionals.
- There were appropriate arrangements for meeting the needs of people who may not have English as their first language.
- Staff were aware of the ICNARC data and some information was displayed on staff noticeboards.
- Strong leadership, commitment and support were evident.
- A strong supportive teamwork and culture was evident within the unit with improved communication between divisions.

Critical care

Are critical care services safe?

Good

Overall, we rated the service as good for safe because:

- Staff told us they were encouraged to report any incidents, and serious incidents were discussed at team meetings. Staff were confident in reporting incidents and were aware of the importance of duty of candour.
- There was access to appropriate equipment to provide safe care and treatment.
- The environment was visibly clean and staff followed the trust policy on infection control practices.
- Medicines were appropriately managed and generally stored safely within the service, apart from one broken medication fridge.
- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls. Some of this information was displayed at the entrance to the CCU.
- Medical staffing was appropriate and there was good emergency cover.
- Nursing and medical handovers were well structured.
- Safe staffing levels were being achieved by the use of bank and agency staff.
- Staff had completed their mandatory training.

However we also found:

- One medication fridge had a broken lock which was waiting for repair; this had been reported as an incident but had not repaired during the inspection period.

Incidents

- During the previous inspection, there was no evidence to show there was a systematic timely approach to the analysis of reported incidents, that action plans had been introduced or that staff received regular feedback so that there was learning from them. We saw an improvement during this inspection, we found staff were using the electronic reporting system to record incidents and were receiving feedback at staff meetings on incidents, action plans and lessons learnt.
- Staff were able to discuss incident reporting and types of incidents that should be reported. They felt that they were actively encouraged to report these both internally and externally.
- There were no never events or serious incidents reported between July 2015 and June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- There were 406 incidents reported between November 2015 and August 2016. This was an increase on the previous years, as staff had been encouraged to report incidents. A majority of the incidents were categorised as low or no harm. The most common themes related to delays in discharge from CCU to wards due to lack of beds within the trust and mixed sex breaches for patient waiting to be transferred back to the wards. We saw action in place included the senior nurse attending the bed meeting to discuss a patient waiting to be transferred to a ward, reporting all patients waiting for ward beds to the bed manager and delayed discharges discussed at monthly meetings. Patient's privacy and dignity were maintained and when appropriate patients offered a side room.
- The trust reported five level two pressure ulcers between June 2015 and June 2016. This showed a reduction from the previous inspection when 18 incidents of pressure ulcers had been reported, which were mostly device related. We saw a specific action plan was in place to reduce the number of pressure ulcer incidents, which included additional staff training, regular reviews by senior staff and a review of protective products.
- During the last inspection we did not see any evidence that CCU staff attended weekly mortality meetings. However during this inspection we saw evidence of their attendance at the meetings. CCU consultants had presented mortality cases at the meeting and discussions and action had taken place which included raising awareness and staff vigilance in all patients at risk of developing an embolism (blood clot), early interventions and patient reviews by consultants, the importance of early Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) review and realistic family expectations and placing a difficult airway trolley in emergency care for CCU staff to access.

Critical care

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.
- Nursing staff and medical staff were fully aware of the duty of candour and described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not. There were no incidences where duty of candour had been required to be applied.

Safety thermometer

- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harms including new pressure ulcers, catheter urinary tract infections and falls. The information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. Some of this information was displayed at the entrance to CCU, such as number of falls and pressure ulcers.
- Between June 2015 and June 2016, five grade two pressure ulcers had been reported. There was one fall reported in July 2016 and one Clostridium Difficile infection reported in June 2016.
- Venous thromboembolism (VTE) assessments were recorded on the drug charts. Audit results showed compliance was 94% in June 2016, 93% in July 2016 and 94% in August 2016 against the trust target of 95%.

Cleanliness, infection control and hygiene

- At the time of our inspection, the environment and equipment in the unit were visibly clean and tidy.
- Staff had received training about infection prevention and control during their initial induction and during annual mandatory training. The majority of CCU staff had completed their infection and prevention control training which was part of the mandatory training. Records in August 2016 showed that 92% of medical and nursing staff had completed this training.
- There was a specific environmental cleaning schedule in place. Housekeeping staff told us that their supervisor checked the standard of cleanliness and compliance with the schedule and we saw evidence that regular checks had been completed.
- Disposable curtains were used, these were clean and due dates for changing them were visible.
- There was a cleaning schedule for cleaning all the equipment. We saw daily cleaning schedules for commodes, and each patient bed space was cleaned daily. Vacant bed spaces were also cleaned daily to ensure they were ready to receive a new admission. We saw 'I' am clean' sticker on equipment that had been cleaned after use.
- We observed that staff followed the trust's policy regarding infection prevention and control. This included staff being 'arms bare below the elbow', hand washing and the correct wearing of disposable aprons and gloves.
- Hand hygiene gels were available throughout CCU. There was access to hand-wash sinks in the main area and side rooms on the unit. We observed all staff using alcohol hand gel when entering and exiting CCU.
- Personal protective equipment (PPE), such as gloves and aprons were used appropriately and were available in sufficient quantities.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste, sharps bins and the bins were not overfilled.
- There were five side rooms available on the unit, two had anterooms (this is a small room adjacent to the side room where staff have access to appropriate protective clothing prior to entering the room with the patient) and positive and negative pressure which enabled patients with infections to be nursed in an appropriate environment.
- During the last inspection it was reported that there were no disposable blood pressure cuffs available, during this inspection we saw that disposable blood pressure cuffs were now available.

- We saw audits of cleaning and decontamination of clinical equipment between December 2015 and April 2016 had been completed with an average compliance score of 97%.
- Monthly hand hygiene audits between December 2015 and May 2016 which showed an average compliance of 96%.
- Between December 2015 and July 2016 there had been no reported cases of MRSA and one reported case of Clostridium Difficile.

Environment and equipment

- The environment was spacious and well-lit and corridors were free from obstruction to allow prompt access. The unit complied with the national standards Health Building Notes 04-02 in terms of space and equipment required for intensive care facilities.
- The security of the unit was safe, the entry to the CCU was controlled by an intercom and video link and visitors were required to identify themselves upon arrival.
- Staff had access to adequate supplies of equipment. CCU was equipped to provide care for 19 ventilated patients. In addition, there was an anaesthetic machine available for use in the theatre recovery area to mechanically ventilate a patient in the short term, when there was no bed available in CCU.
- Resuscitation equipment, for use in an emergency was checked daily, and documented as complete and ready for use. The trolleys were secured with tags which were removed daily to check the trolley and contents were in date.
- During the previous inspection it was reported that CCU did not have an appropriate emergency tracheostomy kit. However during this inspection we found there was a specific tracheostomy kit available, which was checked daily.
- During the previous inspection it was reported that CCU staff were not checking the contents of the difficult airway trolley regularly. During this inspection we saw improvements and the trolley was checked daily by medical staff. We observed a doctor checking the trolley thoroughly and documenting that checks had occurred.
- There were systems to maintain and service equipment as required and a rolling programme with items at high risk highlighted to ensure that older and more sensitive equipment was replaced first. Electrical appliances and equipment had been electrical equipment tested to ensure they were safe to use and each had a stickers with appropriate dates.
- It was reported that during the previous inspection the maintenance team were repairing some of the paint work. During this inspection we did not observe any concerns with the paint work within CCU. Staff told us they had access to maintenance staff for repairing equipment and the environment.

Medicines

- The pharmacy department was open seven days a week 9am to 5pm and an out of hours cupboard containing medicines that may be required in an emergency was provided or medicines could be obtained through the on-call pharmacist service.
- There was a dedicated clinical pharmacist for CCU that worked on the unit daily Monday to Friday and the on call pharmacist would visit the unit during the weekend. The CCU pharmacist checked medicines daily, reconciled patient's drugs daily as well as monitoring the prescribing of medicines. The pharmacist was available for advice about medicines management and attended the twice weekly multi-disciplinary team (MDT) meeting.
- Medicines were stored in a secure temperature controlled room that had suitable storage and preparation facilities for all types of medicines such as controlled drugs and antibiotics. We saw records of the daily checks of ambient temperatures in the medicines storage room had been routinely completed and were within acceptable ranges.
- Medicines that required refrigeration were kept at the correct temperature. We checked the refrigeration temperature checklists in the unit, which were signed to say the temperature had been checked each day as required. The checklists indicated what the acceptable temperature range should be to remind staff at what level a possible problem should be reported. All the temperatures recorded were within the required range. Staff were aware of what action to take if the fridge temperature was outside safe parameters.
- Controlled drugs were stored in a locked unit and the keys held separately from the main keys. We reviewed the controlled drug cupboards which were tidy and did not hold any other drugs in these cupboards. The pharmacist checked the controlled drugs daily.

- Entries in the controlled drug register were made as required in that the administration was related to the patient and was signed appropriately, new stocks were checked and signed for, and any destruction of medicines was recorded.
- There was a medicines management policy which included information on safe administration of controlled drugs and administration of drugs, which staff could access via the hospital intranet.
- All medicines including intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.
- There were two refrigerators for medicines requiring cold storage; one had a broken lock which was waiting for repair, this had been reported as an incident the previous week, but had not repaired during the inspection period. Although the fridge was in a locked room, we were not reassured of the safety of all medication within the broken fridge. This was brought to the attention of a senior nurse who would investigate why the fridge had not been repaired.
- Medicines were recorded and administered accurately. We observed the preparation and administration of intravenous infusions. These were administered safely and correctly in accordance with the hospital's policy.
- CCU had a separate prescription chart for prescribing intravenous infusions which reduced delays in getting these medicines prescribed.
- Medicine incidents were reported via the electronic reporting system and were reviewed in staff meetings. Staff were able to describe changes that had taken place as a result of learning from these incidents, such as a change to the way charts were marked to ensure no ambiguity in dosing schedules.
- We reviewed the prescription and medication charts of six patients and found records of drug administration were completed correctly. These records were clear and fully completed. Patient's allergies to any medicines were appropriately recorded and antibiotics prescribed in line with the trusts policy.

Records

- Medical notes were in good order and information was easy to access.
- We looked at six sets of nursing and medical records which were fully completed, legible with entries timed, dated and signed for.
- Risk assessments had been carried out on all patients which included malnutrition screening, falls risks, patient manual handling assessment, wound care and communication charts. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided.
- There was documented evidence of the decision and time to admit to CCU which is in line with the National Institute of Clinical Excellence CG50 guidance.
- The nursing and medical notes were stored by the patient bedside to allow staff to quickly access them and not have to leave the patient bedside; these were stored in a folder to maintain patient confidentiality.
- Daily observation charts were used to record vital signs along with cardiac and respiratory indicators. Fluid intake and output managed records were complete, reviewed and recorded during the daily handover between shifts from nurse to nurse.
- The resuscitation status of each patient and any discussion with the families was recorded within the notes.
- We saw four Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form which were appropriately completed.
- Records were designed in a way that allowed essential information, for example allergies and medical history, to be recorded and easily viewed.
- There was evidence in the medical records of discussions with the patient and their relatives regarding progress and treatment planned. There was a purple communication sheet to document discussions with families.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff. There were posters displayed with contact details of the trusts safeguarding team.
- The nursing and medical staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- Staff had access to the trust's safeguarding team and they told us they were helpful and responsive.
- Information and relevant contact numbers for safeguarding were seen on staff noticeboards and in public areas.

- The trust reported in August 2016, 92% of medical staff and 93% of nursing staff had up to date training in both adult safeguarding and safeguarding children at levels 1 and 2. This met the trust's target of 90%.
- Although the unit admitted young people between the ages of 16 to18 years, none of the consultants working in CCU had received safeguarding children level 3 training. There were only two nurses within the unit that had safeguarding children level 3 training. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2104) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level 3 safeguarding.

Mandatory training

- The trust's training records in August 2016 showed that 92% of medical and nursing staff working in CCU had completed their mandatory training against a trust target of 90%. This was part of the trusts quality improvement plan from the last inspection.
- Mandatory training included, for example, infection control, fire, moving and handling and health and safety. Some training was delivered via face to face sessions and others were available via the e learning on line.
- There was an induction programme for all new staff and staff that had attended felt that the programme met their needs.
- Staff received emails to remind them of their current compliance level with their mandatory training.

Assessing and responding to patient risk

- On CCU, patients were closely monitored so staff could respond to any deterioration. Patients were cared for by levels of nursing staff recommended in the core standards for critical care Guidance for the Provision of intensive Care Services 2015 (GPICS 2015). Patients who were classified as needing intensive care (level three) were cared for by one nurse for each patient. Patients who needed high dependency type care (level two) were cared for by one nurse for two patients. We saw the appropriate staffing levels were maintained throughout the inspection period.
- During the last inspection it was reported that there was lack of engagement between CCU consultants and consultant physicians. However during this inspection we were told that communication had improved and we observed consultants working in other areas such as medicine and maternity having easy access to the CCU consultants. We observed good interactions and communication between the various teams.
- We spoke with three doctors who did not work in CCU who were able to accurately describe the correct referral process when needing to admit a patient to critical care in accordance with the trusts policy. Doctors explained they felt the referral process had improved and was effective.
- During the last inspection it was reported that doctors working in CCU had not received training to manage the safe transfer of patients despite this being identified in the peer review report produced by the local critical care network in July 2014. We saw evidence during this inspection that all doctors and nurses working in CCU and some staff from other areas within the hospital such as accident and emergency had received safe transfer of the patient training. Regular training sessions were held on CCU for staff to attend. Staff who had attended the training told us this was useful.
- Admission to CCU should be within four hours of the decision to admit, although the Trust was not always meeting this indicator due to the lack of beds on the wards. On occasion's patient were nursed in recovery whilst waiting for a bed on CCU.
- We observed two patients being admitted to CCU from other areas within the hospital, these were managed safely, quickly and effectively. There was good interaction and handover from ward staff to CCU staff.
- There was a critical care outreach team to provide 24 hours a day seven days a week service. At times the service was compromised due to the staff being used to work in CCU when there were staffing shortages, this was a similar situation to the last inspection. The on call anaesthetist would be used to cover outreach services when the nurses had to work on CCU.
- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were assessed and documented in the patient's records on admission and 24 hours later in line with best practice.
- The national early warning score (NEWS) was used to monitor acutely ill patients in accordance with NICE clinical guidance CG50. NEWS charts were used to identify if a patient was deteriorating. In accordance with the trust's deteriorating patient policy, staff used

the NEWS charts to record routine physiological observations, such as blood pressure, temperature and heart rate, and monitor a patient's clinical condition. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these.
- There was a trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. CCU had access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.
- Different colour printed identity wristbands were used to help alert staff to particular patient needs. For example, red ones were used for patients with allergies.

Nursing staffing

- A team of 95 whole time equivalent nurses was allocated to the CCU. There were 23% whole time equivalent nurse vacancies at the time of our inspection, for which there was ongoing recruitment. These were similar rates to the last inspection, although the unit had increased its staffing establishment.
- The hospital used agency staff and the hospital's own bank staff to ensure staffing levels remained safe. Between May 2015 and April 2016 CCU had used on average 20% bank and agency staff. Overall the trust has a higher share of bank and agency staff compared with the England average of 6.1%. During our inspection we saw one agency nurse on duty, who told us they had been inducted to the unit and their competency's had been checked prior to commencing the shift. The unit tried to book the same agency staff in advance to ensure consistency and reassurance of staff's competencies.
- We reviewed nursing staff rotas over a three month period and saw that bank and agency staff were booked in advance for vacant shifts.
- We were told that new staff had been recruited and were in the process of attending their induction programme, which would reduce the vacancy rates.
- Nursing staff levels in CCU met the Guidance for the Provision of Intensive Care Services 2015 (GPICS). Staffing related to levels of patient care was in line with core standards at all times during the inspection; that is, level three patients (intensive care) cared for on a one to one basis, whereas level two patients (high dependency) had one nurse for two patients.
- Staff levels for each shift were displayed on the entrance to CCU.
- We observed the nurses handover, each nurse had a handover at the bedside for the patient they were looking after and the senior nurse in charge had a one to one meeting with the senior nurse from the previous shift this was recorded on a standardised handover sheet. The nursing staff had a safety huddle later in the shift to give each nurse an update on the status of each patient. These were both comprehensive, effective and relevant information was shared between staff.
- We were told and we observed that the nurse in charge of CCU was always supernumerary (does not have a patient allocated to care for) leaving them free to co-ordinate the shift. This was reflected in staffing rotas and had improved since the last inspection.
- The outreach team consisted of one band 7 or one band 6 nurse allocated on the duty rota to provide a 24 hour seven day a week service for the whole hospital, however they explained there were times when they were called to work in CCU to cover staff shortages. This matter had been recorded as a risk on the risk register. The outreach nurses were supported by an on call anaesthetist who would attend requests for outreach support for deteriorating patients.
- There was a dedicated practice development nurse working in CCU that was responsible for coordinating the education, training of CCU staff as well as supporting the induction of new staff, this was in line with the GPICS 2015.
- There were dedicated physiotherapists that worked on CCU, they were directly involved in assessing and managing patient care. They could provide respiratory management and rehabilitation care as required.

Medical staffing

- Care in CCU was consultant led and delivered. There were consultants who worked in rotation and were responsible for providing senior cover within critical care. In addition there were a number of junior doctors who provided care to the patients under the supervision of the consultant. Consultants were on call weekly and an additional consultant was on call as well as at least two middle grade doctors on duty at all times.
- CCU was covered out of hours as part of the anaesthetic team rota supported with middle grade doctors on site and a consultant on call. On Saturday and Sunday during the day the consultant was on site, there was

also a consultant on call for theatre and obstetrics. This had improved since the last inspection when there was just one consultant on call to cover CCU, theatres and obstetrics and this now met the Intensive Care Society standards.

- Staff told us consultants were immediately available 24 hours a day throughout the week. They could return to the unit if required within 30 minutes of being called and there was immediate access to a doctor with advanced airway skills. The consultant covering CCU did not have other clinical commitments, other than the critical care unit at Watford Hospital.
- The consultant anaesthetist vacancy rate was 13% at the time of the inspection. Regular locum doctors were used to cover unfilled shifts, we reviewed doctor's rotas and saw these were booked up to six weeks in advance and the same locums used to ensure consistency. We were told that locum staff had an induction and support from other medical staff to orientate them to the unit.
- During the inspection the consultant to patient ratio met the GPICS 2015 standards and did not exceed a range between 1:8 to 1:15. We reviewed medical staff rotas over the previous four months which showed these levels were being consistently met. This had improved since the last inspection when the unit did not always meet these standards.
- We observed the medical staff handover was relevant and comprehensive. Ward rounds were twice daily, which was in line with national guidance. They were at the patient bed side, led by the consultant with input from other relevant staff, including junior doctors, nurses, and allied healthcare professionals.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the trust including CCU.
- Staff were aware of the policy and how to access this. Staff discussed a recent fire evacuation exercise which had taken place on CCU.

Are critical care services effective?

Good

Overall, we rated the service as good for effective because:

- CCU contributed to the Intensive Care National Audit and Research Centre (ICNARC) database and indicators were generally in line with similar units.
- Patients' care and treatment was assessed during their stay and delivered along national and best-practice guidelines, such as the National Early Warning Score (NEWS) which complied with the recommendations within NICE Guidance 50- Acutely ill patients in hospital.
- Policies and procedures were accessible, and staff were aware of the relevant information. Care was monitored to demonstrate compliance with standards.
- Patient's pain, nutrition and hydration was appropriately managed.
- Care was consultant-led, with seven day a week access to services at the weekends.
- Care bundles (evidenced based procedures) were in place for the use of ventilators and central lines.
- Patients in the unit were screened for delirium using a recognised screening tool.
- A practice development nurse was in post.
- Staff had awareness of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

However we also found:

- The microbiologist did not attend every daily ward round due to staffing issues, but telephone advice was available.
- Data provided showed that in March 2016, 69% of clinical staff within CCU had received an appraisal against a target of 90%.

Evidence-based care and treatment

- Patients' care and treatment was assessed during their stay and delivered along national and best-practice guidelines. For example, the National Early Warning Score (NEWS) with a graded response strategy to patients' deterioration complied with the recommendations within NICE Guidance 50 Acutely ill patients in hospital and the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- During the last inspection it was reported that some local CCU policies had no dates of expiry or ratification. During this inspection we found that most of these documents had been removed or replaced with trust policies, which were up to date. Local standard operating procedures were relevant and in date.
- Patients were ventilated using recognised specialist equipment and techniques. This included mechanical

invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing using masks or similar devices. All ventilated patients were reviewed and checks made and recorded hourly.

- The CCU met best practice guidance by promoting and participating in a programme of organ donation, led nationally by NHS Blood and Transplant. In the NHS, the number of patients suitable for organ donation is limited for a number of reasons. The vast majority of suitable donors will be cared for in a critical care unit. There was a link nurse for organ donation working within CCU. They directly supported the organ donation programme and worked alongside the clinical lead. The link nurse also supported a regional and community programme for promoting organ donation.
- The organ donation information from April 2015 to April 2016 showed that overall the trust achieved 90% referral to specialist organ donation during this period, which was in line with the national average.
- There was a trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. CCU had access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.
- Venous thromboembolism (VTE) assessments were recorded on the drug charts, ensuring best practice in assessment and prevention and offered treatment in accordance with NICE guidelines.
- The use of ''Fresh Eyes'' stickers had been implemented. This was a system that prompted a peer review of patient observation records. Staff swapped patients to undertake a set of routine observations and evaluate care which helped highlight changes to care where required. Staff found this to be beneficial and used this as a learning opportunity.
- The trust had specific guidance on delirium in accordance with the National Institute for Health and Care Excellence NICE CG83 guidance. We saw evidence that patients were screened on admission and this was documented on the daily observation charts.
- The CCU team were part of the East of England critical care network. We saw evidence that the network had carried out a peer review in August 2016, which showed improvement from the last peer review in 2014, such as staffing levels, staff training, readmission rates and good standards of record keeping. We saw that the staff from CCU were actively involved with the East of England critical care network and attended meetings.
- The CCU submitted data to the Intensive Care National Audit and Research Centre (ICNARC) an organisation reporting on performance and outcomes for intensive care patients nationally. There was a small dedicated team to collate this information.

Pain relief

- Pain relief was well managed. Patients' records showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. Pain management for individual patients was discussed at handovers as required.
- Pain was also managed by prophylaxis, which is to anticipate pain and provide relief in advance.
- Staff had access to the trust pain control team when required.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition.
- Staff said they monitored patient's nutritional state and, where required, would make a referral to the dietitian.
- Any feeding through tubes or intravenous lines was evaluated, prescribed and recorded. There were protocols for nursing staff to commence enteral feeding for critical care patients before discussion with dietitians.
- We saw a dietitian working on CCU and advising staff of patient dietary needs. The dietitian participated in the twice weekly multidisciplinary meeting. This was in line with the GPICS 2015.
- In all six patient records we reviewed, we observed that fluid balance charts were completed appropriately and used to monitor patients' hydration status.
- We saw an enteral feeding audit had taken place in May 2015 which included 17 patients over a two week period and showed overall 75% of patients received their nutritional requirements, which is in line with previous studies. Lessons learnt included prompt replacement of nasogastric tubes and checking the positions, additional training on placement of nasogastric tubes for staff and greater MDT working between staff.

Critical care

Patient outcomes

- Around 95% of adult, general critical care units in England, Wales and Northern Ireland participate in Intensive Care National Audit and Research Centre (ICNARC) the national clinical audit for adult critical care; the Case Mix Programme (CMP). Following rigorous data validation, all participating units received regular, quarterly comparative reports for local performance management and quality improvement. The CCU fully participated and completed a full set of data for this audit.
- The ICNARC annual report from 2015/16 showed that the unit was performing as expected (compared to other similar services) in all indicators apart from one which showed the unit had a higher than national average for delayed discharges of 14% compared to the national average of 5%. The trust was in the worst 5% of units for this element.
- During the last inspection it was reported that the trust was not meeting the standard for discharges from CCU from decision to discharge to actual discharge should not exceed four hours. During this inspection we did not see any improvement as one patient waited three days to be discharged onto a ward. The unit were continuing to audit this and report all delayed discharges as incidents and informed the trust executive team. Although this was highlighted on the CCU and trust risk register, there was no evidence within the risk register that an effective plan was in place to address this.
- The unplanned readmission rates within 48 hours was 0.5% which was better than national similar units at 1.1%.
- There was a dedicated member of staff whose role included inputting ICNARC data for CCU.
- At the previous inspection it was reported that two doctors in CCU did not have an understanding or awareness of ICNARC and its significance. During this inspection, we saw an improvement in that all staff we spoke with were aware of the ICNARC audits, its significance and told us the results were made available to staff. We saw some results displayed on the staff noticeboards.
- The unit participated in the national care bundles audits (evidenced based procedures), which formed part of the annual audit programme. This meant that the service was undertaking audit to evaluate the effectiveness of aspects of care given on critical care. We saw evidence of monthly audits in place for central venous catheter care, peripheral intravenous cannula care, urinary catheter care, enteral feeding care and ventilation-associated pneumonia. From July 2015 to June 2016 there were consistently high results between 95-100%. The results were displayed on staff noticeboards. We saw action plans in place to improve central venous catheter care which included changing the dressing type used to comply with NICE guidance and updating the trust policy.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There was a comprehensive induction for new staff. This included both a trust wide induction and local induction. We spoke with a new member of staff that would be working supernumerary for four weeks. All new staff had a dedicated mentor that they worked alongside until they were competent to work alone.
- The practice development nurse would induct new staff to the unit and familiarise them with the equipment and layout of the unit. Each new member of staff had a critical care network competency booklet to work through to ensure they gained the correct skills knowledge and competency's to work in critical care.
- We saw that over 50% of nursing staff had gained the post registration award in critical care nursing which was in line with the Guidance for the Provision of intensive Care Services 2015 (GPICS). Additional nurses were booked to attend the course in the near future.
- Staff told us they had opportunities for personal development and to enhance their skills. There was a training programme in place that included topics such as sepsis management, safe transfer of patients and tracheostomy care. These sessions were also open to other staff within the hospital.
- Some band 6 and 7 nurses had attended a local leadership programme which they felt improved their skills in managing staff and gave opportunities for personal development and career progression.
- Junior doctors all reported good supervision, they each had a specific personal development plan which they felt enhanced their training opportunities.
- Medical and nursing staff told us that they had sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely.

- Trust data for March 2016 showed that within CCU, 69% of clinical staff had received their appraisals against a target of 90%. At the time of our inspection CCU were on track to exceed the target for 2016/17.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.
- There was a dedicated critical care pharmacist who provided advice and support to clinical staff in the unit and physiotherapy staff that worked on the unit and supported patient needs daily. There was a dedicated dietitian that worked on CCU and advised staff of patient dietary needs. The pharmacist, dietitian and physiotherapist participated in the twice weekly MDT meeting. This was in line with the GPICS 2015.
- The GPICS 2015 suggest microbiology input into the daily ward rounds, but due to staffing issues a microbiologist did not always attend the ward rounds during the inspection period, however telephone advice was available.
- We observed the MDT meetings, which was led by the consultant on call, each patient was discussed and issues such as new admissions, discharges from the unit, patient dependency levels (for example level two or level three) investigation and blood tests were discussed. There was good communication between the team and all staff participated and shared information. Actions and priorities were agreed and allocated to staff.
- Staff described the multidisciplinary team as being very supportive of each other. Healthcare professionals told us they felt supported and that their contribution to overall patient care was valued.
- Staff that had received patients from CCU onto the wards told us they had a good handover and appropriate information to continue caring for the patients. They told us outreach team was very supportive and responsive to their needs.
- The critical care outreach service covered the service 24 hours seven days a week. We reviewed two patients' notes that had recently been discharged from CCU onto a ward and saw evidence that the outreach team had reviewed them within 24 hours. This was in line with NICE guidance CG83, rehabilitation after critical care.

Seven-day services

- There was a consultant on call to the service out of hours. During the last inspection it was reported that the consultant on call was not necessarily a specialist in intensive care medicine, but were general anaesthetists. During this inspection we found the consultant on call was a specialist in intensive care medicine at all times. This was in line with the GPICS 2015.
- Staff told us that at the weekend, the consultant attended the unit, carried out ward rounds and was available. We saw evidence in patient healthcare records of consultant led ward rounds being documented, including at the weekend. Overnight a critical care consultant (on-call) was available for advice and assistance. The clinical lead consultant confirmed the on call consultants could be available within 30 minutes and this formed part of the terms of the consultant's employment.
- We saw evidence that all patients admitted into the unit were assessed by a consultant within 14 hours of admission, which met the national standards.
- Critical care medical staff felt that the consultants were supportive and were available for advice, including out of hours.
- Medical staff were allocated to work in CCU 24 hours a day, so staff always had access to doctors.
- All facilities were available out of hours, this included theatres, physiotherapists, radiographers, radiologists and pharmacists who were all available at night and weekends.

Access to information

- Staff had access to relevant information to assist them to provide effective care to patients during their critical care stay. The CCU employed reception staff who coordinated the provision and requests for medical records.
- We observed the doctors' handover between shifts where patient's progress was reviewed. The nurses had a separate handover at the patient's bedside, plus the senior nurse in charge had a one to one meeting that was recorded on a standardised handover sheet. This included information about any incidents that had occurred such as medication errors, delayed discharges, how they had been responded to and a detailed evaluation of each patient's clinical status. In addition to this, accepted referrals to the CCU were documented. This meant staff were able to plan and respond appropriately to admissions to the unit.

- There were computers throughout the unit to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Staff said they had good access to patient related information and records whenever required.
- We saw a patient transferred to the unit and staff had access to all the information. Staff said they were given a handover of the patient's medical condition and ongoing care information was shared appropriately in a timely way.
- We reviewed four sets of notes of patients that had been discharged from CCU to the wards and found a comprehensive discharge summary for transfer to the ward and a rehabilitation prescription that was designed to ensure continuation of care.
- We observed on-going care information was shared appropriately at handovers.

Consent and Mental Capacity Act

- There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff could describe the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- Staff understood consent, decision making requirements and guidance.
- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with Mental Capacity Act 2005 when treating an unconscious patient, or in an emergency.
- Staff were aware of the trusts sedation protocol that took account of the potential need to use restraint if a patient became delirious, this included guidance for staff about how this was to be managed. Staff we spoke with were able to discuss the guidance advised and use of restraint that would need to be documented in the patient's medical notes, the reason communicated to relatives and reviewed daily in accordance with the trust's restraint and mental capacity act policies.
- Staff received training regarding the Mental Capacity Act 2005 as part of their mandatory training at the trust. In March 2016 92% of critical care nursing and medical staff had up to date training in all the mandatory training modules.

Are critical care services caring?

Good

Overall, we rated the service as good for caring because:

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect. Patients spoke highly of the care they had received.
- Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.
- The staff on the CCU respected confidentiality, privacy and dignity.
- Patients were kept up to date with their condition and how they were progressing.
- Information was shared with patients and their relatives and opportunities to ask questions.
- Between June 2015 and May 2016, we saw results of the trusts Friends and Family Test, which were consistently above 95 % for each month.
- The unit offered a monthly coffee, cake and chat session for relatives to meet medical, nursing and allied professionals.

Compassionate care

- Patients were treated with dignity, respect and compassion when they were receiving care and support from staff.
- Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- Due to the nature of critical care, we often cannot talk to as many patients as we might in other settings. However, patients we were able to speak to spoke highly of the care they received on the units and said staff were kind, caring and compassionate
- Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.
- We observed patients having their observations taken for example, blood pressure, temperature and respiratory rate, with care and dignity.
- Nursing staff introduced themselves appropriately and knocked on the door of side rooms before entering.
- Between June 2015 and May 2016, we saw results of the trusts Friends and Family Test, which were consistently

above 95% for each month. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Patients were given a form to complete by the outreach team when they had been discharged onto a ward. We saw August 2016 results displayed at the entrance to CCU, which showed 100% of patient, would recommend the hospital to family and friends, the response rates were not available.

- We received positive comments from the patients and relatives we spoke with about their care. Examples of their comments included "I couldn't be treated better", "I felt safe to leave my mother in the care of the team, "staff were happy and smiling" and "I've never been in hospital before and I was very impressed".

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- We observed most nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- Relatives we spoke with said they had been given time with the nurses and doctors to ask questions and this had been done in a private room if appropriate.
- We observed the dietitian give verbal information to relatives on the plan and progress of a patient and gave the family time to ask questions.
- We observed the monthly coffee, cake and chat session, where relatives of both past and present patients could attend to meet with consultants, nurses and allied professionals to ask questions about their relatives and they were offered support and advice. Relatives that attended told us they found this useful and reassuring.

Emotional support

- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required.
- There was a purple communication sheet in each patient notes to document conversation with relatives. We saw evidence that communication with the patient and their relatives was maintained throughout the patient's care.
- We observed one family being offered emotional support and privacy. The nursing and medical staff spent time with the family in a private room.
- There was a link nurse for organ donation based on CCU, to directly promote and support staff and relatives with the organ donation programme.
- The chaplaincy service provided a 24 hour service and offered support to patients and relatives, multi-faith options were available.

Are critical care services responsive?

Requires improvement

Overall, we rated the service as requires improvement for responsive because:

- The CCU was not able to respond at all times to the need to admit or discharge patients at the most appropriate time due to the unavailability of beds within the trust.
- Delayed discharges were higher than the national average at 14% compared to the national average of 5.2%. The trust was in 5% of the worst performing trusts in England. However this matter was outside the control of the CCU team and staff were continuing to audit this and report incidents to the trust executive team.
- Patients could be nursed in theatre recovery for over 10 hours whilst waiting for a bed either in CCU or on the ward. There was conflicting information over the actual number of patients this affected.
- The average length of stay for patient at this CCU was 6.2 days, which was higher than similar units at five days of average length of stay.
- Single sex accommodation was not being maintained and breaches were reported monthly.

However we also found:

- There was a CCU operational policy that described the different flows in and out of CCU.
- The unit was able to meet the individual needs of patients and provided personalised nursing care.

- There was a consultant led follow up clinic to support patients and their relatives that had been discharged from CCU
- CCU had a quiet room for relatives to have discussions in private or stay overnight if required.
- There were appropriate arrangements for meeting the needs of people who may not have English as their first language.
- People knew how to make a complaint or raise concerns.

Service planning and delivery to meet the needs of local people

- CCU admitted both elective surgical patients who required close monitoring post operatively and emergency patients. The CCU operational policy had a patient pathway which described the different patient flows into and out of CCU. This included admissions through accident and emergency, admissions from theatres and criteria for admission to CCU. Certain categories of patients who needed specialist services were transferred to appropriate units in London.
- During the last inspection it was reported that the hospital did not have a separate high dependency unit and, therefore, at busy times relied upon the respiratory ward, or the post-operative recovery room, if unwell patients needed to be cared for. During this inspection, we observed that this situation had not improved and that patients were still being nursed in recovery when the unit was busy.
- There was a theatre recovery room near to CCU and although this had equipment to safely monitor and care for critically ill patients, it was outside the main CCU and was unsuitable for anyone requiring longer term support. It was mostly used for supporting patients whilst a bed was made available for them in the main CCU. We saw evidence that patients were cared for in recovery whilst waiting for a bed on CCU or when patients were discharged from CCU and waiting for a bed in the trust. On occasions patients waited up to 10 hours before being transferred to a more suitable environment. Recovery was not a suitable environment for patients waiting to be transferred to a ward as they did not have access to toilet facilities and relatives could not always visit. Recovery staff told us that sometimes this would delay the theatre lists or result in cancelled operations.
- Between July 2015 and April 2016 there were nine incidents reported of patients who had a delayed admission to the critical care unit, patients waited between four and thirteen hours. Although we saw further evidence that additional patients had waited in recovery and there seemed to be conflicting information over the actual numbers as these were not always recorded as an incident. This was raised with senior staff during our inspection who planned to carry out an investigation.
- There was provision of facilities for visitors to the CCU. Visitors had access to a waiting room, and an area in which hot, and cold drinks were available. This was located just outside the unit for visitors to wait or to enable visitors to step away from the unit if they wanted a break. There were toilet facilities and a private room, which could be used for discussions and overnight accommodation.
- NICE guidance recommended that there should be a follow-up clinic for patients to determine if they needed further input after two to three months after discharge home. A regular clinic was in place and attended by one of the CCU consultants. This service was offered to all discharged patients.
- Visiting times were between 2pm and 8pm each day. However, they could be flexible to meet the needs of the patients and their loved ones.

Access and flow

- In the ICNARC audit 2016, the trust had four out of five metrics fall within the expected range. Delayed discharges were higher than the national average at 14% compared to the national average of 5.2%. The trust was in 5% of the worst performing trusts in England for this indicator. During our inspection one patient waited three days for a bed on the ward; this was reported as an incident and raised at the daily bed management meeting. However this matter was outside the control of the CCU team and staff were continuing to audit this and report incidents to the trust executive team.
- During the last inspection it was reported by doctors that patients waiting for discharge from the unit to the wards were not always closely observed. During this inspection staff felt that all patients received high quality of care and we observed that all patients received appropriate care.

Critical care

- Emergency admissions were required to be referred between consultants if possible. Staff confirmed consultant to consultant referrals took place. A patient requiring critical care should be admitted within four hours of the decision in order to comply with core standards for critical care (GPICS 2015). This occurred on most occasions, when the CCU had a bed available and we saw two new admissions to the unit within the four hour period.
- A consultant reviewed all new admissions to the unit within 12 hours of admission.
- Between June 2015 and May 2016 adult critical care bed occupancy was higher than the England average for all but one month. Occupancy reached 100% on seven occasions.
- In the ICNARC audit 2016, the trust had 0.7% out of hour's discharges, this was better than similar units of 1.8%.
- The average length of stay for patient at this CCU was 6.2 days, which was higher than similar units at five days of average length of stay.
- Between July 2015 and June 2016 there had been one elective patient operation cancelled due to the lack of beds on CCU. This patient was rebooked for surgery within 28 days.
- The nature of most CCUs meant there was often limited opportunity to provide single-sex wards or areas and this is not required until patients are considered ready for discharge to a ward. Staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity. Single sex breaches was reported as an incident and patients offered an explanation and if appropriate a single room. Between April 2016 and July 2016 there were on average eight single sex breaches reported each month.
- For inter hospital transfers, CCU used the East of England Critical Care Network (EECCN) standard transfer multiple copy document. The consultant would risk assess and discuss with the team the skills required to safely transfer a patient to another hospital or service.
- Between June 2016 and August 2016 transfers from critical care to a ward were all between the hours of 7am and 11pm, which was in line with national guidance.

Meeting people's individual needs

- CCU services were planned to take into account the individual needs of patients, which included both level 2 and level 3 care.
- Staff told us they had link nurses for specific areas, for example, palliative care, organ donation and infection control. The link nurses were able to support staff and share information.
- There was good access to a range of information for families and friends displayed in the visitor's room on topics such as admission and discharge and follow up clinics. There was also information about access to the patient advice liaison service (PALS) should relatives have a concern about the service.
- There was a leaflet explaining CCU was a mixed sex environment but that all efforts would be made to maintain patient's privacy and dignity. We observed the screens drawn around patients or door being closed when any patient received personal care.
- To ensure patients had sufficient rest and were not disturbed or deprived of sleep, the unit promoted an initiative called 'Silent Night'. This included reminders to staff to ensure dimming of lights by a certain hour, muting of phones to reduce noise level and for staff to wear soft soled shoes.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access these staff to discuss any concerns and to receive advice.
- There was a telephone translation services available. This could be booked through the Patients Advisory Liaison Service (PALS) if an interpreter was required.
- There was an overnight room for relatives to use and access to a quiet room, hot or cold drinks were available.
- There were information leaflets available for both patients and relative such as sedation and ventilation, discharge from critical care and a general guide to intensive care.
- Information leaflets were available in large print and different languages.
- The CCU was accessible for wheelchair users and a disabled toilet was available.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients and relatives to the PALS if they were unable to deal with their concerns directly.

- Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- Literature and posters were also displayed within CCU, advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- The trust reported three complaints relating to the critical care unit from July 2015 to July 2016. These related to poor communication, failure to listen to patients and their family and inadequate assessment of patient's condition. We saw actions taken in response to complaints included staff training and ensuring the use of the purple communications sheet.

Are critical care services well-led?

Good

Overall, we rated the service as good for well-led because:

- We saw strong leadership, commitment and support from the CCU senior team.
- The hospital participated in the ICNARC data collection.
- Staff were aware of the ICNARC data and some information was displayed on staff noticeboards.
- There were sufficient consultants on call to cover CCU, which was in line with GPICS 2015.
- Improved communication between division and joint meetings was in place.
- A strong supportive teamwork and culture was evident within the unit.
- CCU had commenced the monthly coffee, cake and chat sessions with relatives past and present.
- Staff were encouraged to share their views at their team meetings.

However we also found:

- There trusts clinical strategy 2016-2020 did not include any specific reference to critical care services.
- The trust did not have a strategy to address the capacity issues that were causing delayed discharges within CCU.
- The risk register had captured the main CCU risk that had been escalated to the trusts risk register, however there were no specific plans to reduce the number of delayed discharges.

Leadership of service

- Critical care services were under the management of the surgical, anaesthetic and oncology division. The critical are unit was led by a matron and a clinical lead consultant for critical care services, which met national guidelines for the provision of intensive care services (GPICS 2015). These leaders were visible, accessible and experienced.
- During the inspection, the nurse in charge of CCU was always supernumerary (did not have a patient allocated to care for), leaving them free to co-ordinate the shift, this met the national core standards for critical care units.
- We saw strong leadership, commitment and support from the senior team within the local team. The senior staff were responsive, accessible and available to support staff during challenging situations such as when two emergency admissions were admitted into the unit at the same time.
- Junior surgical doctors reported consultants to be supportive and encouraging. Junior doctors told us they felt well supervised by consultants and they had opportunities for development. This was an improvement from the last inspection when junior doctors reported the lack of training for example for managing patients during transfer to other services or hospitals. Specific training sessions were ongoing and available to all staff.
- The junior nursing staff on CCU were unanimous in stating that their immediate nursing support was good, and there was clear leadership from the sisters and matron.
- The leaders within CCU supported staff training and development; there was a planned training programme for staff that was also available to other staff within the trust to share learning. Staff competencies such as performance of invasive procedures were checked by the practice development nurse, matron and lead clinician.
- During the last inspection there was some criticism of lack of cohesion between some of the medical staff. Medical staff perceived that surgical patients were given priority when referring a patient for admission to CCU over medical patients. However during the inspection

we were told that communication between CCU, medical and surgical staff had improved. We saw minutes of joint meetings where discussions included admission processes, incidents and complaints.

Vision and strategy for this service

- During the last inspection it was reported there was no local strategy for critical care. We saw evidence that the trust had a clinical strategy 2016-2020, however there were no specific details relating to critical care services within this strategy. We were told there was a new local draft critical care strategy in place, this was requested but not received.
- The trusts vision was "the very best care for every patient, every day." We saw posters within the staff areas of CCU displaying the trusts vision and values and most staff were aware of these.

Governance, risk management and quality measurement

- The trust had a governance structure in place. CCU was part of the surgical division which monthly held divisional governance meetings that fed into the trust quality safety group, and trust board. The surgical divisional efficiency meetings discussed incidents, complaints, new innovations and risk management.
- Senior nurses from across the surgical, anaesthetic and oncology division attended monthly meeting with the chief nurse and consultants across the division also had joint meetings. CCU held team meetings to disseminate information to staff.
- There was a new operational policy in place for the unit with guidelines for the services, which included admission and discharge criteria.
- The CCU contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland as recommended by the faculty of intensive care core standards. This enabled the trust to show patient outcomes and other quality data benchmarked against other similar units.
- During the last inspection it was reported that the critical care risk register did not have effective plans in place to address the risks. During this inspection we saw the risk register had been updated with specific plans although the risks remained the same. The risks related to delayed discharges, breach of single sex accommodation, staffing levels, high usage of agency and medical staffing cover. Each risk had an action plan and was escalated to the trust risk register. Actions taken included continued monitoring of delayed discharges, working closely with bed managers, updates sent via email to senior managers. However, these plans were not effective as they had not reduced the incidents of delayed discharges, mixed sex breach accommodation or the high use of agency staff.
- Capacity issues within the trust were identified as the greatest contributor to delayed discharges and therefore it was difficult to reduce the numbers. The trust was in the 5% worst performing trusts within England for delayed discharges. However we saw there was more effective monitoring in place and escalation to the bed managers and the executive teams when these occurred to raise awareness. There were no specific plans to reduce the number of delayed discharges.
- During the last inspection there was no evidence that CCU staff had attended the clinical governance meeting. However during this inspection we saw evidence that senior staff from CCU attended a variety of divisional meetings, including the surgical division efficiency meeting and the divisional governance meeting.
- During the last inspection it was reported that junior medical staff were unaware of the latest ICNARC data results and the unit's participation in these audits. However during this inspection all staff we spoke with were aware of the ICNARC data and some data was displayed on the staff notice boards.
- During the last inspection it was reported that on occasion the outreach staff were used to staff the unit potentially leaving the hospital without an outreach service and that these were not reported as incidents. However during this inspection although the outreach team could still potentially be used to staff the unit the data was being reported as an incident to capture the number of times this occurred. The on call anaesthetist would be used to cover the outreach service to ensure the hospital still had access to this service.
- During the last inspection staff recruitment was a challenge and reported on the risk register. Although this was still a challenge for the trust, senior staff within CCU told us there had been a recruitment drive and positions had been offered to staff and they felt the risk had reduced. We saw evidence that new staff had been appointed.

- During the last inspection it was reported there was a shortfall in out of hour's medical staff (anaesthetists) which had been recorded on the CCU risk register in April 2014 and subsequently reviewed in January 2015. The trust had recruited additional medical staff. We reviewed the consultants' rotas and found a consultant on call for CCU and a separate consultant on call for theatre and obstetrics, which was an improvement from the last inspection and in line with the GPICS 2015.

Culture within the service

- A strong supportive teamwork and culture was evident within the unit. Staff described the unit as having a supportive, friendly atmosphere, which made it an enjoyable place to work.
- Staff were enthusiastic about working for the trust and how they were treated by them as a whole. They also felt respected and valued.
- Staff we spoke with worked well together as a team, and said they were proud to work for the trust.
- Across all disciplines staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.
- Senior managers said they were well supported and there was effective communication with the executive team. There was a culture of openness and transparency.

Public engagement

- There was no general public involvement with how the service was run, but patients and their relatives were asked to comment on their care.
- Data from the Friends and Family Test was used to monitor and influence the standards of the services provided.
- Patients and relatives were encouraged to provide feedback and information leaflets available in the relatives' room. We saw some positive comments from patients displayed on the feedback notice board.
- CCU had commenced the monthly coffee, cake and chat sessions with relatives past and present, which we observed and relatives told us they found this useful and informative.

Staff engagement

- Staff were encouraged to share their views at their team meetings for example staff had suggested implementing the nurses safety huddle which included and update on the status of each patient. There was a 'safety huddle' logo printed on the floor to indicate where this would take place. Staff told us they found this useful and informative

Innovation, improvement and sustainability

At this inspection, there had been the following improvements noted since our inspection in April 2015:

- Staff were recording incidents and receiving feedback on action plans and lessons learnt.
- There was a reduction in pressure ulcers from 18 in the previous year to five in this year.
- Disposable blood pressure cuffs were now available.
- Specific tracheostomy kit was available, which was checked daily.
- The difficult airway trolley was checked daily.
- Our observation of practice and discussion with staff confirmed that communication had improved between the various teams.
- Staff working in CCU had received training to manage the safe transfer of patients.
- There was a dedicated consultant on call for CCU as well as middle grade doctors on site.
- All policies and operating procedures where up to date.
- Staff were aware of the ICNARC audits.
- There was strong leadership, commitment and support from the CCU senior team.

There were areas highlighted where there had not been any changes since our inspection in April 2015. These included:

- The risk register had captured the main CCU risks; however there were no specific plans to reduce the number of delayed discharges. These were higher than the national average at 14% compared to the national average of 5.2%. The trust was in 5% of the worst performing trusts in England.
- Patients could be nursed in theatre recovery for over 10 hours whilst waiting for a bed either in CCU or on the ward. There was conflicting information over the actual number of patients this affected.
- The CCU was not able to respond at all times to the need to admit or discharge patient's at the most appropriate time due to the unavailability of beds within the trust.
- Single sex accommodation was not being maintained and breaches were reported monthly.

Critical care

- The average length of stay for patient at this CCU was 6.2 days, which was higher than similar units at five days of average length of stay.
- There were similar vacancy rates to the last inspection, 23% although the unit had increased its staffing establishment.
- The trust's clinical strategy 2016-2020 did not include any specific reference to critical care.
- Innovation was encouraged from all staff members across all disciplines, for example the implementation of the coffee and chat with matron to engage relatives and provide them with an opportunity to meet staff and ask questions.
- The clinical lead had designed a CCU logo for all paperwork used in CCU so this was easily identifiable.
- There was a specific purple papered communication sheet to document all communication with relatives about the patient's condition and care.
- CCU had implemented a new communication tool via a software program on mobile phones to keep staff up to date and share information.

Maternity and gynaecology

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

West Hertfordshire Hospitals NHS Trust provides maternity and gynaecology services to women living in West Hertfordshire and the surrounding areas. Outpatient maternity and gynaecology services are also provided at St Albans City Hospital and Hemel Hempstead Hospital.

The current structure for the maternity and gynaecology service includes an overall divisional director and divisional manager for women's and children's services. This team is supported by an associate medical director for obstetrics and gynaecology, separate clinical directors for each speciality, an associate director of midwifery and gynaecology nursing and matrons. The gynaecology service has been recently reconfigured, resulting in the restructure of inpatient services within the surgical division. The structure includes a divisional director, head of nursing and service manager. Gynaecology outpatient services remain under the remit of women's and children's services.

The maternity service at Watford General Hospital is one of the largest in the region and provides antenatal, labour and postnatal care for women. Outpatient services are provided at the hospital site and in conjunction with community services and GP practices. Maternity and gynaecology services are situated in the women and children's unit.

The hospital has a consultant led delivery suite with seven delivery rooms, two dedicated obstetric theatres, a three bedded recovery bay for post-operative women, one bereavement suite, one assessment admission room and a two bedded midwifery triage bay. The delivery suite also has a two bedded observation bay for women who are highly dependent and who need higher levels of care and more detailed observation than provided on a general maternity ward.

Women who have a straightforward pregnancy can have their baby at home or in the Alexandra Birth Centre (ABC) at Watford general Hospital. The ABC provides midwife led care for women with uncomplicated pregnancies and who are anticipating a normal birth. The centre has eight delivery rooms, all of which have ensuite toilet and shower facilities. It also has one sensory room and two birthing pools. There are approximately 1,000 births a year in the ABC and this unit has one of the highest water birth rates in the country.

The hospital has a 15 bedded antenatal ward (Victoria Ward), maternity day assessment unit and screening services. The hospital also has a 28 bedded postnatal ward (Katherine Ward) and an additional six bedded transitional care bay, where care is provided jointly by the maternity and neonatal service to women with babies who require more specialised neonatal care. Six amenity rooms are available to women who wish to pay for a private room.

Gynaecology inpatient services are provided on Elizabeth Ward. The ward consists of 28 beds, with four side rooms and six four-bedded bays. The hospital also has a dedicated operating theatre for gynaecology patients, a gynaecology day assessment unit, which includes an early pregnancy unit, and an ambulatory care unit.

Maternity and gynaecology

West Hertfordshire Hospitals NHS Trust provides a termination of pregnancy service for fetal abnormality only. From April 2015 to March 2016 the hospital carried out 26 medical terminations of pregnancy.

The hospital provides outpatient clinics and services, which includes uro-gynaecology, uro-dynamics, fertility, hysteroscopy, colposcopy, endometriosis service, specialist recurrent miscarriage services and a fetal medicine service.

The hospital employs community midwives, who care for women and their babies both during the antenatal and postnatal periods and provides a home birth service. From April 2015 to March 2016 the trust reported a total of 126 babies were born at home. The community midwives are aligned to local GP practices and children's centres.

The trust reported 5,208 births between January and December 2015. Of these, 54% were normal (non-assisted deliveries), which is lower than the England average (60%). Additionally, 11% were elective caesarean deliveries, which is in line with the national average and 20% were emergency caesarean deliveries, which is above the England average of 15%. The trust has seen a 5% decline in the number of births between April 2015 and March 2016, compared with April 2014 to March 2015.

The service had been previously inspected in April 2015 and was rated inadequate for safe and well-led and requires improvement for effective, caring and responsive. The service was rated inadequate overall and was required to complete a number of actions to ensure compliance with the Health and Social Care Act 2008.

We carried out an announced comprehensive inspection of Watford General Hospital from 6 to 9 September 2016. We also carried out an unannounced inspection on 27 September 2016. During our inspection, we visited all clinical areas in the service. We spoke with 15 patients and their relatives and 126 members of staff. We observed care and treatment and looked at 20 patient care records and we reviewed the trust's performance data.

Summary of findings

Overall, we rated the maternity and gynaecology service as good for effective, caring, responsive and well-led and requires improvement for safe. The service was judged to be good overall because:

- Staff were confident to report incidents and there was a robust governance and risk management framework in place to ensure incidents were investigated and reviewed in a timely way. Learning from incidents was cascaded to staff and actions were taken to minimise risks and prevent incidents from reoccurring. This was an improvement from our previous inspection in April 2015.
- Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff understood their responsibilities and were confident to raise concerns. A dedicated team of midwives had been established to provide support, care and treatment to vulnerable women.
- Medical, nurse and midwifery staffing levels and skill mix were planned, implemented and reviewed regularly. Despite high levels of midwifery staff vacancies, staffing levels were sufficient to protect people's safety. Bank and agency staff were used to ensure staffing needs were met. However, staffing levels was the most cited reason for stress and low morale amongst staff and remained the service's biggest risk. The trust were taking action to address staffing vacancies.
- Consultant cover was in line with national guidance. Access to medical support was available seven days a week throughout the service.
- The service regularly monitored and reviewed performance against locally agreed standards, which were in line with national recommendations. Actions were taken to investigate and address issues related to performance.
- We saw effective multidisciplinary working across the service.
- Feedback about the service was largely positive. Patients were treated with dignity, respect and kindness. Staff cared about the services they provided and spoke positively about improvements that had been made since our previous inspection.

Maternity and gynaecology

- The service had introduced a gynaecology ambulatory care unit, which reduced the demand for beds on the gynaecology ward.
- Perinatal mental health services had been developed to ensure women with complex mental health needs received sensitive and appropriate care. Combined obstetric and psychiatric run clinics were available and a public event was held to publicise the importance of mental health care and raise awareness in the wider local community.
- Governance arrangements were effective and there was a clearly defined strategy and governance structure in place.
- Leadership was knowledgeable about quality issues and priorities, understood the challenges and were taking action to address them. The service was well represented at board level and leadership within the service was strong, supportive and visible.

However, we also found:

- Medicines were not always managed and stored safely. Medicines in the anaesthetic room were not always stored securely, which meant there was a risk they could be removed by unauthorised persons and staff would be unaware. Patients own controlled drugs were not handled in a way to ensure they were safe and secure and there were inadequate controls in place to prevent misuse. Furthermore, the treatment rooms where medicines were stored consistently exceeded recommended temperatures. The trust was taking action to address this.
- Mandatory and midwifery specific training compliance did not meet the trust target of 95% in all topics covered, including adult basic life support and only 7% of midwifery staff were compliant with blood transfusion training. This meant there was a risk that staff did not have up-to-date knowledge in order to protect patients, visitors and staff from potential harm.
- Not all staff had received an annual performance appraisal. This was a concern we raised in our previous report.
- We were unable to determine how effective the service was in delivering care and treatment in line with national guidance because the majority of planned audits were outstanding at the time of our inspection. However, an effective framework had been established to ensure policies and guidelines were reviewed to reflect current national guidance.
- The normal (non-assisted) delivery rate was 54%, which is lower than the England average of 60%. However, the elective caesarean section rate was 11%, which is in line with the England average.
- The service did not meet the 85% standard for patients with suspected gynaecological cancer who commenced treatment within 62 days following urgent GP referral. However, the service did meet the target for patients on an incomplete pathway who waited less than 18 weeks to start treatment.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Overall, we rated the maternity and gynaecology service as requires improvement for safe because:

- Medicines were not always stored securely, which meant there was a risk they could be removed by unauthorised persons and staff would be unaware.
- The ambient room temperatures where medicines were stored regularly exceeded recommended maximum storage temperatures and initially action had not been taken to minimise this risk to patients.
- Medicines were not always administered or documented in accordance with national standards.
- Cleaning schedules were not always completed on a daily basis.
- Not all staff had completed mandatory training, particularly with regards to blood transfusion training. The service had plans in place to address this.
- Not all staff were familiar with the duty of candour regulation. However, staff did understand the importance of being open and honest with patients and relatives when something went wrong.

However, we also found:

- Safety was a priority. Incidents were reported and investigated and there was good evidence of shared learning where full investigations had taken place.
- The service had introduced the maternity safety thermometer as a means of measuring patient outcomes and improving patient care. The trust's harm free score was slightly better than the national average.
- Clinical areas were visibly clean and tidy during the inspection.
- Equipment was checked regularly and well maintained.
- Records were stored securely and were generally completed in accordance with trust policy.
- Staff understood their roles and responsibilities in the safeguarding of adults and children from abuse, harm and neglect and reflected up to date safeguarding legislation and local policy.
- Despite staff vacancies, staffing in maternity and gynaecology services was regularly reviewed and managed so that patients received safe care and treatment.
- There were generally effective systems in place for assessing and responding to patient risk.
- There was a contingency plan in place, which outlined action to be taken in the event of an abducted baby, high levels of acuity and/or staffing shortages.

Incidents

- Patients were generally protected from abuse and avoidable harm, as staff were confident to report incidents and told us that they reported incidents where it was appropriate to do so. There were processes in place to learn from incidents and implement good practice. There was an open culture to encourage focus on patient safety and risk management.
- Clinical staff we spoke with were aware of the reporting process for incidents, near misses and never events. The trust used an electronic incident reporting tool to report incidents.
- Maternity and gynaecology services had a clinical risk management strategy and framework, which identified the management arrangements and processes for the identification, assessment, treatment and monitoring of clinical risks and incidents. We saw guidance for management of clinical risk. This included the implementation of immediate safety measures, a review of all incidents at various governance meetings held daily, weekly and monthly and investigation of incidents. Root cause analysis were undertaken where appropriate, action plans were put into place, which included dissemination of feedback and support for parents and families involved.
- The trust reported one never event between July 2015 and June 2016, in the maternity service. There had been no never events reported for the gynaecological service during this period. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event (Revised Never Events

Policy and Framework, NHS England March 2015). The never event occurred in December 2015 and was classified as 'surgical/invasive procedure incident meeting serious incident (SI) criteria', where a tampon had been retained during suturing of the perineum following a vaginal delivery.

- We reviewed the root cause analysis investigation report and saw evidence of learning from this event and actions taken to mitigate future risk. Learning from this never event was shared with staff in a variety of methods including team huddles, which were held at the start of each shift, presentation to staff at the clinical governance education meeting and staff noticeboards.
- There were eight serious incidents (SIs) reported through the Strategic Executive Information System (STEIS) in the maternity and gynaecology service between August 2015 and July 2016;
- Seven of these incidents were related to maternity and one incident was related to gynaecology. Three of the SIs were classified as maternity/obstetric incident meeting SI criteria: baby only. Two were classified as maternity/obstetric incident meeting SI criteria: mother and baby. One was classified as a surgical/invasive procedure meeting SI criteria. The one gynaecology incident was classified as venous thromboembolism (VTE) meeting SI criteria.
- The majority of incidents were reported in November 2015 and March 2016, with two SIs reported in these months; however, there were no common themes to these incidents. Serious incidents associated with maternity included unexpected admission to the neonatal intensive care unit (NICU).
- The one SI related to gynaecology concerned a patient who had been readmitted to the hospital with bilateral pulmonary embolism (PE), following unilateral oophorectomy (the surgical removal of one ovary). A bilateral PE is a blockage in both the pulmonary arteries and is usually caused by a blood clot; it is potentially life-threatening because it can prevent blood from reaching the lungs. We reviewed the root cause analysis investigation report and saw evidence of learning from this SI. Staff told us that a ward clerk went through all patient records on a daily basis to check all VTE risk assessments had been completed. If a VTE risk assessment had not been completed, the ward clerk highlighted this on the handover board to alert medical staff to the patients who required VTE risk assessment. We reviewed 16 patient records and found all VTE risk assessments had been fully completed and where indicated, mechanical and/or chemical preventative measures had been prescribed to reduce the patient's risk of developing a blood clot.
- From July 2015 to August 2016 there were 1,496 incidents reported through the National Reporting and Learning System (NRLS); 1,274 were related to maternity services and 222 were related to gynaecology services. Incidents were graded from low to no harm, or moderate to severe harm. 1,463 of the 1,496 incidents (98%) were graded as low or no harm (4% and 94% respectively).
- We observed that all incidents were reviewed at the daily patient safety meeting and where necessary investigations, including root cause analyses, were carried out. Senior staff held regular meetings to identify where trends had occurred and put in place systems to prevent similar occurrences. They also monitored whether the required actions had been addressed.
- We reviewed the minutes of monthly governance meetings and saw evidence that actions were taken and lessons learnt to minimise the risk of incidents reoccurring.
- We spoke with staff about learning lessons from incidents. Staff we spoke with in the maternity and gynaecology service told us they received direct feedback regarding incidents they had been involved with. Staff also told us they received feedback about incidents that had occurred within the service. They were kept informed about incidents through team huddles, noticeboards, email and governance meetings. We observed this during our inspection. Learning folders had also been introduced to each department within the maternity service as a means of improving feedback and communication to staff. We reviewed the learning folder during our inspection and saw that it contained feedback, outcomes, recommendations and action plans from incidents, risks and complaints.
- From our previous inspection in April 2015, we reported that the service was not reviewing incidents in a timely way. The associate director of midwifery and gynaecology nursing told us that when they joined the trust in February 2016, the maternity service had a backlog of over 700 incidents that had not been actioned. Since then work had been carried out to reduce this backlog. The maternity dashboard for April to August 2016 showed that the backlog had significantly declined from 350 incidents, which had not

been progressed for April 2016, to 80 for August 2016. At the time of our inspection in September 2016, the associate director of midwifery and gynaecology nursing told us there were approximately 50 incidents outstanding. Therefore, we were assured that the service had taken action to ensure incidents were reviewed in a timely manner in order that lessons could be learned when things went wrong and improvements made to the safety of services for patients.

- The trust held monthly multidisciplinary perinatal mortality and morbidity meetings, which were attended by members of the neonatal, obstetric and midwifery team. The group aimed to ensure that the priority of the meetings was to support a culture of learning to help improve patient outcomes and experience. We reviewed the minutes of meetings held and saw that cases were presented with learning points and actions to be taken.
- The maternity service reported all premature births who did not survive the neonatal period, in line with national recommendations (MBRRACE, 2015).
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The trust had a duty of candour policy, which staff could access via the trust intranet. Staff we spoke with were aware of the importance of being open and honest with patients and relatives when something went wrong. However, not all staff were familiar with the duty of candour regulation. Some staff we spoke with were able to describe examples where the duty of candour had been applied and others were not. Therefore, we were not assured that all staff were aware of their roles and responsibilities in relation to duty of candour. We reviewed the investigation of four serious incidents and saw they had been managed in line with the duty of candour. This also included the completion of 'Being Open'; a document which detailed each contact made with the patient and/or family member to discuss the progress and findings of the investigation and any actions required.

Safety thermometer

- The maternity safety thermometer was launched by the NHS in October 2014 and was designed to support and measure local improvements to patient care and experience. It allowed maternity teams to take a 'temperature check' on harm and records the number of mothers who have experienced harm free care. It also records the number of harm(s) associated with maternity care. The maternity safety thermometer measures harm from perineal trauma, abdominal wound (following caesarean section or any other surgery), post-partum haemorrhage (excessive blood loss of more than 500mls following delivery), infection and women's psychological perception of safety. It also records babies with an Apgar score of six or less at five minutes and babies who were admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a new born infant based on a rating of 0, 1 or 2 for each of the five characteristics of colour, heart rate, response to stimulation, muscle tone and respiration, with 10 being the optimum score.
- Since our previous inspection in April 2015, the trust had introduced the maternity safety thermometer to the service in June 2016. We saw the results displayed publically on the postnatal ward. In July 2016, the trust's combined harm free score was slightly better than the national average at 76%, compared with the national average of 70%.
- The maternity service also took part in the national maternity dashboard, as recommended by the Royal College of Obstetricians and Gynaecologists (RCOG, 2008). The maternity dashboard serves as a clinical performance and governance score card and may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality, safe maternity care.
- The dashboard data was compared with safety-related targets on a monthly basis. The maternity dashboard results were displayed publically and staff were aware of the outcome measures and performance. We saw evidence that action was taken to improve safety performance when indicated.
- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls and urine infections (in patients with a catheter) and venous thromboembolism (VTE).

- We saw that on the whole 'harm free' care was provided in the gynaecology service. From August 2015 to August 2016 the gynaecology ward reported a total of six harms; one pressure ulcer, one fall, three VTE's and one catheter associated urine infection. Staff we spoke with gave us examples of actions that had been taken to improve safety performance. For example, teaching sessions on the recognition and prevention of pressure ulcers had been carried out on the gynaecology ward.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and tidy during our inspection.
- There was a service level agreement in place between the trust and an external provider who cleaned patient and public areas, with daily and weekly cleaning schedules. Each patient area displayed the up to date cleaning schedule, which confirmed areas had been cleaned. However, we observed that the cleaning schedules were not always completed. For example, on the gynaecology ward we reviewed 11 weeks of cleaning schedules and found only three weeks of cleaning schedules had been fully completed on a daily basis. Similarly, on the postnatal ward we found nine occasions when the cleaning schedules had not been completed on a daily basis during the period from 5 to 25 September 2016.
- The external provider carried out an annual audit of services within maternity and gynaecology based on national standards for infection prevention. The audits were carried out in May 2016 and the average compliance rate for the service was 98%; no area scored less than 96% compliance.
- Midwifery and nursing staff were responsible for cleaning the equipment and we saw that stickers were placed on items of equipment stating when they had last been cleaned. In all areas we visited we observed that the equipment which was not in use had been cleaned that day or the previous day. The equipment we saw during our inspection was clean and ready for use.
- Hand sanitising gel dispensers were available for staff, patients and relatives to use at the entrance to each of the wards. We saw infection control notice boards displayed in waiting areas and the wards, which included the results of cleanliness and hand hygiene audits. The antenatal clinic waiting area displayed infection control advice for parents to be.
- Staff complied with infection prevention and control policies. All clinical staff adhered to the trusts 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of infection. There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons, in all areas of maternity and gynaecology.
- Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Bins were not overfilled. We saw all clinical areas had appropriate facilities for the disposal of clinical waste and sharps. All sharps bins we observed were clean, dated and not overfilled. However, not all temporary closures were in place; temporary closures are recommended to prevent accidental spillage of sharps if the bin is knocked over and to minimise the risk of needle stick injury.
- Staff had access to infection control policies and knew how to access them on the hospital intranet. We saw that they were accessible on the hospital intranet.
- The maternity and gynaecology risk register detailed two risks (out of a total of 25 identified risks), which concerned cleanliness, infection control and hygiene. One risk identified concerned the recurrent blocking of the patient toilet on delivery suite, above the new born hearing screening room, which had caused overflowing and flooding of this room with sewage and contaminated water. The service and estates department had taken appropriate action to address this risk, such as the replacement of the floor above the new born hearing screening room and had re-designated the toilet on delivery suite as a facility for birthing partners, to reduce the usage and inappropriate disposal of sanitary products. Staff we spoke with told us there had been no further issues with the flooding of the new born hearing screening room.
- The second risk related to cleanliness, infection control and hygiene, concerned the poor condition of the sluice on the postnatal ward. The risk identified that the old style sink and flooring was difficult to clean to a high standard. In addition, due to a lack of appropriate storage on the ward meant that clean stock was being stored in the dirty utility room. We saw evidence that the service had implemented controls to minimise the risks identified, such as the daily cleaning of the dirty utility room, the storage of clean stock in closed cupboards and had developed a business case for the

refurbishment of the dirty utility room. During our inspection we observed that the dirty utility room appeared clean and tidy and that some refurbishment had been undertaken. For example, the flooring had been replaced and additional cupboards had been installed for the storage of clean stock. Funding to replace the sink had been applied for and it was anticipated that this work would be carried out in the next financial year. The external audit of infection prevention standards for the postnatal ward showed compliance of 100% for October 2016.

- Trust data for March 2016 showed completed infection control and hand hygiene training did not meet the trust target of 95% compliance. In maternity, 87% of midwifery staff and 80% of healthcare assistants and housekeeping staff had completed infection control training; 83% and 80% had completed hand hygiene training respectively. In gynaecology, 79% of nursing staff and 85% of healthcare assistants and domestic staff had completed infection control training; 67% and 85% had completed hand hygiene training respectively. Compliance rates for medical staff were 81% for infection control and 79% for hand hygiene training. During our inspection we reviewed the maternity training statistics for July 2016 and the service compliance rate for infection control training had improved to 91%. Hand hygiene training compliance remained at a similar figure, with 83% of staff compliant. The service had developed an action plan to address non-compliance with mandatory training, which included hand hygiene training. Actions identified included the monthly review and reporting of staff training compliance and the follow up of all non-compliant staff by their line manager.
- The maternity department participated in monthly hand hygiene audits in line with the trust's infection prevention programme. From December 2015 to May 2016 hand hygiene compliance on maternity inpatient wards was 100% for midwifery staff, with the exception of March 2016 when midwifery staff on the postnatal ward scored 90% compliance.
- The maternity department undertook audits of the cleaning and decontamination of clinic equipment, in accordance with national recommendations (Department of Health 2010, Saving Lives: High Impact Intervention No 8). The average compliance percentage for inpatient maternity wards for the period February to June 2016 was 97%.
- Side rooms were available in each ward area, which could be used to admit patients with a known and/or suspected infection, as required.
- Staff we spoke with could describe what they would do if a patient required isolation due to infection. For example, PPE would be stored outside the patient's room to ensure clinical staff took appropriate precautions before they entered, in order to reduce the spread of infection. We observed this during our inspection on the gynaecology ward.
- The maternity service reported no cases of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections from December 2015 to May 2016. Patients who were booked for elective caesarean section and elective gynaecology surgery were screened for MRSA during their pre-operative assessment appointment. We saw evidence of this in the records we reviewed during our inspection. Staff we spoke with told us that any patients who were admitted to the gynaecology ward as an emergency were screened for MRSA at the point of admission, such as the gynaecology day assessment unit (GDAU) or emergency department (ED).
- The gynaecology service reported no cases of hospital acquired MRSA and one case of Clostridium difficile infection from August 2015 to August 2016. The infection prevention control team informed the ward of the result and ensured that 2105actions were taken to treat and reduce the spread of infection, which included appropriate isolation of the patient.
- Staff we spoke with were able to describe the process for cleaning birthing pools; this information was included in the department's water birth guideline. Each birthing pool was cleaned daily and following every patient use. The estates department also carried out a daily thermal disinfection and a weekly chemical disinfection.
- Patients we spoke with said they found the patient areas to be clean and we heard staff asking patients if they would like their bedding changed.
- In the 2015 CQC maternity survey, the service scored 'about the same' for the cleanliness of toilets and bathrooms; this was an improvement from the 2013 CQC maternity survey. The service also scored 'about the same' for the cleanliness of the hospital room or ward.

- Women were offered screening for infectious diseases such as rubella and hepatitis B. Women were also offered flu and whooping cough vaccination in pregnancy. This was in line with national guidance.

Environment and equipment

- Generally, the design, maintenance and use of facilities and premises kept people safe.
- The delivery suite, obstetric theatres and neonatal unit were all situated on the third floor, which enabled timely transfer when required. The Alexandra Birthing Centre (ABC) was situated on the second floor and a dedicated patient lift was available to transfer women and/or babies when required.
- The delivery suite, antenatal, postnatal and gynaecology wards had restricted access. Access was by means of swipe card or an intercom and buzzer system to gain entry to the wards. This meant that staff could identify visitors and ensure women and their babies were kept safe. We saw no visitors gain unauthorised entry to the ward.
- We saw that a defunct external fire door on the antenatal ward, within the room where medicines and equipment were stored, was open. This meant that unauthorised persons could potentially access this store room and the ward. We raised this concern immediately with staff and were told that the door was usually closed but sometimes a draught caused it to open. The trust took immediate action to address this risk and when we revisited this ward the following day we saw that the door had been sealed shut.
- Emergency clinical equipment, such as defibrillator (device that gives a high energy electric shock to the heart through the chest wall to someone who is in cardiac arrest), oxygen and suction were available in all patient areas for use at short notice. The obstetrics and gynaecology theatres had emergency equipment for both adult and neonatal resuscitation when required. The equipment was checked each day to ensure it was in working order. We saw checklists completed to confirm this. This was an improvement from our previous inspection in April 2015, when we reported that daily checks of the maternal resuscitation equipment had not been carried out and compliance with these checks against trust policy had not been monitored.
- Resuscitaires (used to support new born babies who may need resuscitation after delivery) were available in all maternity inpatient areas. These were also checked daily to ensure they were in working order and equipment was fully stocked. We reviewed the checklists for seven Resuscitaires on delivery suite from the 1 July to 7 September 2016 and found 11 occasions when Resuscitaires had not been checked; this equated to 2% of checklists not completed for this time period. The two Resuscitaires on the ABC had been checked daily, with the exception of five occasions from 1 June to 31 August 2016.
- Cardiotocography (CTG) machines were available on the maternity day assessment unit (MDAU), antenatal ward, delivery suite and the ABC for women who required continuous electronic fetal heart monitoring. A CTG machine is used to record both the fetal heart and uterine contractions during pregnancy and labour. Its purpose is to monitor fetal wellbeing and allow early detection of fetal distress. Fetal blood gas analysers were available on delivery suite and the neonatal unit, in accordance with national recommendations (Safer Childbirth, 2007).
- Maternity staff were required to undertake annual training updates on the safe and correct use of medical devices, such as infusion and epidural patient controlled analgesia pumps. However, according to data provided by the trust as of July 2016 only 32% of staff were compliant with this training; the trust target for compliance was 95%. We saw evidence that an action plan had been developed to address non-compliance.
- There was a dedicated secure fridge for blood and blood products situated on the third floor, in close proximity to delivery suite and obstetrics and gynaecology theatres. Laboratory facilities with blood and blood products were also available at the hospital.
- During our inspection we saw stickers on equipment with service dates recorded. All equipment was found to have been safety tested and conformed to safety standards; with the exception of one hoist on the gynaecology ward.
- We saw that cleaning equipment was generally stored appropriately throughout the service. However, we found a storage cupboard on the postnatal ward was left open, despite having secure key code access. This meant that unauthorised persons could potentially access hazardous cleaning materials.
- The delivery suite did not meet the Department of Health's recommendation that all birthing rooms should include ensuite sanitary facilities (Children, young people and maternity services. Health Building Note

09-02: Maternity care facilities, 2013). The building where maternity services were located pre-dated this guidance and it was observed on inspection that there was insufficient space available to enable ensuite facilities to be provided in all birthing rooms on delivery suite. The birthing rooms on the ABC all had ensuite facilities.

- The trust participated in patient led assessments of the care environment (PLACE). Each year members of the public undertake unannounced visits to assess how the environment supports; patient's privacy, dignity and wellbeing, food, cleanliness, general building maintenance, dementia and disability. In April/May 2016 the Alexandra Birth Centre (ABC) and postnatal ward were assessed. The results showed that the assessors were "very confident" that the ABC supported good care and were "confident" that the postnatal ward supported good care. We saw evidence that the service had developed an action plan in response to the assessment and that the majority of issues had been addressed.

Medicines

- We were not assured that medicines were always stored, recorded and administered in line with trust policies and national standards.
- We observed that medication was stored in lockable cupboards within clinical areas. However, during our inspection the anaesthetic room was open and we were able to enter unchallenged. We found that the fridge and cupboards, where medicines were stored, were all unlocked. This meant there was a risk that medicines could be removed by unauthorised persons and staff would be unaware. We raised this concern immediately with staff and were told that the door should have been closed but the cupboards were kept unlocked when a patient was in theatre, so that medicines could be accessed quickly in the event of an emergency. We revisited this area during our inspection and found the door was locked. However, when we revisited this area on our unannounced inspection we found the anaesthetic room was again left open and the fridge and cupboards, where medicines were stored, were unlocked. We raised this concern immediately with staff who promptly ensured the door to the anaesthetic room was closed and could not be accessed by unauthorised persons.
- Trust policy stated that the ambient and fridge temperatures should be checked daily to ensure medicines stored were safe for patient use. We reviewed the records for Victoria Ward and found 16 occasions between 1 June and 7 September 2016 when temperatures had not been recorded. For the same period, the records for the ABC showed there was one occasion when a temperature had not been recorded. The records for delivery suite showed there were three occasions between 1 August and 7 September 2016 when temperatures had not been recorded.
- We saw that ambient room temperatures were consistently above the recommended maximum storage temperature of 25°C. For example, the records for Victoria Ward showed that the ambient room temperature exceeded 25°C every day in August 2016 and had reached 31°C most days. The records for delivery suite showed 14 occasions in August 2016 when the maximum temperature had been exceeded. Staff told us that this had been reported to pharmacy. Medicines requiring cold storage were maintained within the recommended temperature range.
- We were told that the expiry dates for medicines stored where temperatures exceeded the maximum range should be reduced to ensure they were safe for patient use. However, we saw no evidence that expiry dates had been reduced. Therefore, the service had not adhered to trust policy and we were not assured that action had been taken to minimise the risk to patients.
- We reviewed the controlled drug register in the anaesthetic room and found one entry where diamorphine (a powerful opioid used to treat severe pain) had been signed to show it had been given, but the patient who had received it had not been recorded. This is not in accordance with legislation and national standards governing controlled medicines (controlled medicines require extra checks and special storage arrangements because of their potential for misuse). We raised this concern with staff at the time and the patient's name was added to the register.
- Controlled medicines were stored correctly within wall mounted locked cupboards and staff regularly checked the physical stock held against the stock level recorded in the register. We reviewed the controlled drug registers within the service between 1 June and 8 September 2016 and found they were reconciled daily, in line with trust policy; for the majority of days we reviewed the controlled medicines had been reconciled twice daily. However, controlled medicines brought in by patients were not handled in a way to ensure they were safe and secure and there were inadequate controls in place to

prevent misuse. Controlled medicines were put into designated envelopes by nurses on receipt and the contents were not rechecked or recounted until the patient was discharged or the medicine was no longer required. Staff were sometimes using plain white envelopes rather than the designated stationery.

- Controlled medicines were not disposed of in line with Home Office advice and the Department of Health Safer Management of Controlled Drugs: a guide to good practice in secondary care 2007. Staff told us that controlled medicines not used or partially used were not denatured (rendered irretrievable) at ward level before being placed into pharmaceutical waste containers. There were no suitable controlled drug destruction kits available on the wards.
- FP10 prescriptions were stored securely. We saw that monitoring systems were in place to ensure all prescriptions were accounted for.
- Medicine incidents were reported via the electronic incident reporting system. Between July 2015 and August 2016 the maternity and gynaecology service reported a total of 58 medication incidents (this equates to 4% of total incidents reported); 27 incidents were related to maternity and 31 were related to gynaecology. Two incidents were graded as having caused moderate harm; the remaining 56 incidents were graded as having caused no or low harm. Common themes included the administration of contra-indicated medicines, incomplete documentation, wrong frequency and missed and/or delayed administration. We saw evidence that actions had been taken and learning from incidents was cascaded to staff. For example, staff on the gynaecology ward operated a system of 'check and challenge' at each shift handover. Staff checked the prescription records for any missed doses and rectified any omissions immediately. Staff we spoke with told us this had resulted in less missed doses of medicines.
- We reviewed the prescription records of 16 patients on the gynaecology and postnatal wards and found each patient's allergy status had been clearly documented. However, we found one omission on the prescription record of a patient admitted to the postnatal ward; the patient had been prescribed anticoagulant medicine, which was to be administered once a day at 8pm. We reviewed the prescription record around 9.15pm and asked staff why this medicine had not been given at the prescribed time. We were told that it been given to the patient and the member of staff who had administered the medicine then proceeded to sign the prescription record in front of us. This practice is not in accordance with national standards, which state that 'you must make a clear, accurate and immediate record of all medicine administered' (NMC Standards for medicines management, 2007).
- Prescription records were designed so that courses of antibiotics should be reviewed by the medical team at appropriate intervals, usually 72 hours. However, compliance with this varied. From the 16 prescription records we looked at, three courses of antibiotics had not been reviewed. Nursing staff we spoke with corroborated our findings and told us that antibiotic courses were not always reviewed in line with trust guidance. Ward staff were supported by a clinical pharmacist during weekdays. The pharmacist monitored the prescribing of medicines and was available to provide advice to patients and/or staff, as required.
- Patients that attended a pre-operative assessment clinic prior to having planned surgery were reviewed by a pharmacist to ensure they were prescribed the correct medicines upon admission to hospital. The pharmacist also advised patients on which medicines they should stop taking ahead of surgery, as necessary.
- We raised our concerns regarding the exceeded room temperatures where fluids and medicines were stored and the management of patients own controlled drugs with the trust, following our inspection. The trust provided evidence of immediate action they had taken to address our concerns. The trust had amended its policy with regards to the handling of patients' own controlled drugs. Staff were told that all controlled drugs brought in by patients must be stored in the controlled drug cupboard until the patient was discharged, transferred or alternatively, sent to pharmacy for destruction, if no longer required. Furthermore, the policy directed that two registered members of staff must reconcile the balance of all patients own controlled drugs and sign the controlled drugs register to confirm this had been done on a daily basis. The trust had amended the temperature record for all fridge and ambient medicines storage. Staff were told they must report (via the electronic reporting system) each day the temperature of the room and/or fridge was out of the accepted range and the incident number must be documented on the temperature

record. The trust had added the subcategory under medicines of "incorrect storage environment" to the incident reporting system. All incidents would be reviewed by pharmacy and estates, who would advise ward staff of any actions that should be taken with regards to the environment and how they should handle the medicines.

Records

- Patient records were stored securely in trolleys. The trolleys were secured by means of a lock and staff had to enter a key code in order to remove patient records as required. We did not find any trolleys unsecured during our inspection.
- The patient information board on the postnatal ward was positioned on the wall, in the main corridor. Staff were aware of this risk to patient confidentiality and we were told a screen had been ordered so that patient names could be covered from public view. Interim measures had been taken to protect patient confidentiality. The patient's first name and initial of surname were listed and clinical information was coded (such as type of delivery). This had been risk assessed by the information governance team to ensure all measures to protect patient confidentiality had been taken.
- The maternity service used the Perinatal Institute's national maternity notes to record labour and postnatal care and had recently introduced the pregnancy notes to record antenatal care.
- Women carried their own pregnancy records, which they were advised to bring to each antenatal appointment and any occasions when they attended the hospital. These handheld records were supported by hospital-held information to ensure staff had access to essential patient information and could make informed judgements on patients care, management and treatment.
- We reviewed five sets of antenatal, labour and postnatal records on the postnatal ward. We saw evidence in the handheld antenatal records of regular clinical assessment and test results were clearly documented, such as blood pressure, urine analysis and symphysis-fundal height measurement. This was in accordance with the National Institute for Health and Care Excellence (NICE) recommendations (NICE Antenatal care, 2012). Relevant previous and current clinical information was completed and risk assessments were evident, with detailed information of actions taken where appropriate.
- The labour and postnatal notes were generally completed to a satisfactory standard. There was evidence that detailed recordings were made regarding the assessment of babies shortly after birth. Entries made in the records were dated, timed and signed, with the name identified. However, we did find some omissions. For example, the named midwife and/or consultant was not always clearly documented on the cover sheet and the patient's name and hospital/NHS number was not recorded on every page, where indicated.
- Venous thromboembolism (VTE) assessments (used to determine a patient's risk of developing a blood clot) were completed.
- The personal child health record (also known as the 'red book') was given to mothers on discharge for each new born baby. The red book is a national standard health and development record and is used to monitor growth and development and includes a record of vaccinations.
- We reviewed four sets of records on the gynaecology ward and found they were well maintained, comprehensive and fully completed. All entries were legible and were dated, timed and signed, with the name identified. We did not find any omissions in the records we reviewed.

Safeguarding

- There were processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- We were told by senior staff that all midwives, medical staff and maternity care assistants had access to level three safeguarding children training; this is in line with national recommendations (Working together to safeguard children, 2015; Intercollegiate Document, Safeguarding children and young people: roles and competences for health care staff, March 2014). Updates were provided annually on the third (out of four) mandatory maternity one stop study day. We saw evidence that training covered all aspects of safeguarding children and included professional

responsibilities, categories of abuse, safeguarding processes and child protection. The study day also included guidance and responsibilities regarding domestic violence, child sexual exploitation, parental drug and alcohol misuse, perinatal mental health and female genital mutilation (FGM).

- Training data provided by the trust showed that, as of July 2016, 97% of staff within the maternity service had completed safeguarding children level three training and 91% had completed safeguarding adults level two training. This was slightly below the trust target of 95%.
- Since our previous inspection in April 2015, the maternity service had established a designated team of midwives (known as the Lavender team) who provided care, support and treatment for vulnerable women, such as those who had misused substances, perinatal mental health concerns, teenagers and asylum seekers. A member of the Lavender team was on call from Monday to Friday, 8am to 6pm to provide advice and support to vulnerable women, as required. We saw the on call rotas from 13 June to 8 July 2016 which confirmed this. A secure email and voicemail service was available out of these hours; this was checked daily. Staff could also contact the Lavender team if they needed advice and support with any safeguarding issues. The team had established a secure database of all women with safeguarding concerns under their care. The information on the database was reviewed regularly and updated as required. Each woman was graded as low, medium or high risk. The database provided midwifery and medical staff with up-to-date details of the care plan for each woman, so that if they were admitted and/or discharged from the hospital, appropriate actions were taken by staff to protect these women and/or their babies. The database also included a record of all known women with FGM; none of which were under the age of 18 years. At the time of inspection, the team were in the process of setting up a de-infibulation clinic for women with FGM.
- The majority of referrals to the Lavender team were made by community midwives, following the initial 'booking' appointment, but the team would accept referrals at any point of care. Women were also able to self-refer to the team.
- We saw evidence that learning from serious case reviews were shared at multidisciplinary clinical governance meetings and the mandatory maternity one stop study day. Senior staff told us that learning from an incident, which related to a woman with a history of domestic violence and mental health concerns, had resulted in all vulnerable women receiving follow-up care for 28 days in the postnatal period.
- Staff we spoke with were confident in talking about the types of concerns that would prompt them to make a safeguarding referral as well as the referral process.
- A security guard manned the main reception desk (situated by the entrance of the Women and Children's unit) from 8pm to 8am, seven days a week. Ward staff would inform the security guard of any visitors who were not allowed access to the unit.
- Following a simulated abduction of a baby from the postnatal ward, the service had introduced stricter measures and controls to minimise the risk of a baby being abducted from the unit. We saw a flowchart displayed behind the reception desk of the postnatal ward, which listed all the actions to be taken if a baby went missing. Staff we spoke with told us they were much more aware of security risks following the simulated abduction and were able to describe the actions they would take if a baby went missing from the ward. The service had also introduced discharge cards, which stated "I have been discharged home by my midwife". These cards were issued to women prior to discharge and they then had to present them to a member of staff before they were allowed to leave the ward with their baby. We were told that all babies who required treatment on the neonatal intensive care unit were escorted by a member of staff.
- A baby identity tagging system was in use to ensure the safety of babies in the maternity unit. Every baby had an identity tag applied to each ankle shortly after birth and included the baby's name, date of birth and mother's name. The identity tags were checked on admission to the postnatal ward following transfer from delivery suite and on a daily basis, as part of the routine postnatal check. Staff told us if they found a baby with only one tag they would apply a second. If both tags were missing staff would report it via the electronic incident reporting system and all babies in the unit would be checked to confirm their identity. We checked six babies during our inspection and all had two identity tags secured to their ankles.
- The gynaecology service did provide care and treatment for young people between the ages of 16 and 18 years old. The trust required all clinical staff who had contact with children, young people and/or their parents and

carers to be trained in safeguarding children to level two, as defined by national guidance (Intercollegiate Document, Safeguarding children and young people: roles and competences for health care staff, March 2014). This level of safeguarding children training had been agreed by the trust safeguarding panel and the designated nurse for safeguarding children in Hertfordshire.

- The training data, as of March 2016, showed that gynaecology nursing staff and healthcare assistants were 95% compliant with safeguarding adults at level two training and 94% compliant with safeguarding children at level two training. This was against a trust target of 95%.
- Posters regarding domestic violence and how to seek help were displayed in patient and public toilets throughout the unit.
- The trust only performed termination of pregnancy for fetal abnormality. In 2016 to date (January to October inclusive), no patients under the age of 18 years had a termination of pregnancy for fetal abnormality.

Mandatory training

- Staff compliance with trust mandatory training was varied across the maternity and gynaecology service and the trust target of 95% compliance had not been met for topics covered. Furthermore, compliance with maternity specific training was below the trust target and we were not assured that all maternity staff had up-to-date knowledge and skills to protect patients, particularly with regards to the management of blood transfusion.
- Mandatory training covered a range of topics and included health and safety, manual handling, infection control, hand hygiene, conflict resolution, equality and diversity, information governance and adult basic life support. Staff within the maternity and gynaecology service were aware of the need to attend mandatory training.
- Training was completed as e-learning modules and/or face-to-face sessions. Staff could access e-learning courses at work or home. As of July 2016, the maternity service was slightly below the trust target of 95% compliance for conflict resolution training (91%). However, the service did not meet the trust target for fire and evacuation (79%), patient moving and handling (81%), equality and diversity (87%), information governance (81%) and adult basic life support training (74%).
- As of August 2016, only 7% of midwifery staff were compliant with blood transfusion training. The National Patient Safety Agency recommends that registered practitioners undertake an assessment in the blood administration process every three years to ensure they are competent to take, collect and administer blood products. This concern had been recognised and an action plan had been developed to address non-compliance, which included three members of the practice development team undergoing additional training so they could undertake blood transfusion training and assess staff competency within the department. According to the action plan, the service planned to achieve 95% compliance with blood transfusion training by December 2016.
- Maternity staff were required to complete annual cardiotocography (CTG) training. The service used the K2 perinatal training programme. As of July 2016, 100% of medical staff and 83% of midwifery staff were compliant with CTG training; the trust target was 95%. Two 'CTG Masterclass' study day's had also been held at the hospital and were delivered by a leading expert in CTG interpretation. The study day was offered to all midwives and obstetricians. According to the attendance lists we saw, 54 attended in November 2015 and 45 attended in July 2016.
- Maternity staff were required to attend an additional four 'one stop study days' a year. Study day one was focused on antenatal health promotion and included; antenatal screening, health promotion, smoking in pregnancy, perinatal mental health, promotion of normality, infant feeding and medicines management. Study day three was focused on supervision of midwives and safeguarding and included; midwives responsibilities and accountability, record keeping, revalidation and reflection, safeguarding children level three, female genital mutilation, child sexual exploitation and domestic violence. Study day four was focused on medical devices and mentorship and included; epidural anaesthetic training and update, infusion pump training and update for all registered mentors of student midwives. According to data provided by the trust, as of July 2016, the training compliance for study day one was 79%, study day three

was 75% and study day four was 32%. According to the September issue of the women's services staff magazine, medical devices training (study day 4) had improved from 44% to 87% in August 2016. This information only related to midwives on the postnatal ward; figures for staff in other areas were not published as that edition of the magazine featured the postnatal ward.

- Study day two was multidisciplinary and covered 'core skills and drills' training, in line with national guidance (Safer Childbirth, 2007). A PROMPT style approach was used for maternity staff to maintain their skills in obstetric emergencies, including; sepsis and maternal collapse, major obstetric haemorrhage, shoulder dystocia, eclampsia, cord prolapse and neonatal resuscitation. PROMPT (Practical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proved to improve knowledge, clinical skills and team working. As of July 2016, the training compliance for study day two was 82%; the trust target was 95%.
- Operational pressures were cited as reasons why staff were unable to attend mandatory training. Staff told us they would be pulled from study days to cover shortages on clinical shifts.
- Since our previous inspection in April 2015, the maternity service had established a practice development team. We saw evidence that the team had full oversight of the training needs within the service and of current training compliance rates.
- Training data was reported to the associate director for women's services on a monthly and quarterly basis. We saw evidence that the practice development team had identified actions to address training compliance within the service. For example, the team had identified all midwives who were non-compliant and training had been booked; training compliance was reported monthly and reviewed at the senior management team meeting; staff who did not attend were identified and managed in accordance with trust policy; additional 'skills and drills' study days had been arranged for September and October 2016, and; the team planned to undertake the BLS trainer's course so they would be able to train staff within the service in a timelier manner.
- We saw evidence that the maternity specific study days reflected on incidents that had taken place within the service.
- Trust data for March 2016 showed completed mandatory training rates varied across the gynaecology service. For example, nursing staff in colposcopy and early pregnancy assessment unit (EPAU) were 100% compliant with patient moving and handling, health and safety, equality and diversity and conflict resolution training. EPAU staff were also 100% compliant with information governance training. However, the trust target of 95% compliance for mandatory training was not met by nursing staff on the gynaecology ward. For example, 56% of staff were compliant with patient moving and handling, 61% were compliant with fire evacuation and 67% were compliant with conflict resolution.
- The compliance rate for adult basic life support training was also below the trust target; 76% of nursing staff within the gynaecology service had completed this training.

Assessing and responding to patient risk

- We reviewed five sets of records and saw evidence that comprehensive risk assessments were carried out at the booking appointment and were reviewed at each patient contact, including medical, social and mental health assessments. Women who were identified as unsuitable for midwifery led care were referred to the obstetric team for review and management.
- NHS England's 'Saving babies lives' care bundle (2016) for reducing stillbirth recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour. The maternity service did not use customised fetal growth charts to help identify babies who were not growing as expected. We were told that the service planned to introduce customised growth charts in September 2016. We saw evidence that symphysis-fundal height measurement was routinely performed from 24 weeks gestation, in line with national guidance.
- Women with high risk pregnancies due to pre-eclampsia, diabetes, obstetric cholestasis, intrauterine growth retardation, for example, were regularly monitored and reviewed on the MDAU by midwives, who could refer to an obstetrician for medical advice and review as required.

Maternity and gynaecology

- There was a designated three-bedded triage area where women with urgent health issues, such as pain, vaginal bleeding or suspected broken waters, could be assessed and reviewed. Triage is the process of determining the priority of a pregnant woman's treatment based on the severity of their needs. Women were provided with the telephone number for the unit and could access it directly if they had any concerns.
- The delivery suite also had a two-bedded observation bay for women who required high dependency care. We were told that this was staffed by senior midwives and/or midwives who had completed training in obstetric high dependency care. We observed this during our inspection. The critical outreach team were also available to support midwives with the care and management of women who were highly dependent. Critically ill women were transferred to the general intensive therapy unit (ITU). Staff we spoke with told us if an ITU bed was unavailable the critical outreach team would attend to support staff with appropriate care and management. We saw prompt admission of two critically ill patients to ITU during our inspection.
- The maternity service used the modified obstetric early warning score (MEOWS), designed to allow early recognition and deterioration in pregnant and postnatal women by monitoring physical parameters, such as blood pressure, heart rate and temperature. MEOWS charts were completed for all admitted patients. We reviewed five MEOWS charts and found one had not been completed fully and appropriate action had not been taken once deterioration had been recognised. According to the patient's blood pressure recordings and reported symptoms, a doctor should have been called to review the patient within 30 minutes and a management plan should have been documented. A doctor did not review the patient until more than 12 hours after potential physical deterioration had first been recognised. We also observed that physiological observations were not checked as frequently as dictated by the patient's condition; this was not in line with trust policy. We raised this with senior staff during the inspection. When we revisited the service on our unannounced inspection we saw evidence that staff had been reminded to complete MEOWS charts and to promptly escalate all patients with abnormal observations. This information had been cascaded to staff at handover, via email and the learning folders.
- Senior midwives on duty provided a CTG review referred to as 'fresh eyes'. This was in accordance with national guidance (NHS England Saving Babies' Lives: A care bundle for reducing stillbirth, 2016). It involved a second midwife checking the CTG recording of fetal heart and uterine contractions during labour, to ensure it was within normal parameters. We saw evidence that 'fresh eye' reviews were carried out.
- There was a guideline and pathway for the management of sepsis. Staff we spoke with were able to describe what actions should be taken when a patient was admitted with suspected and/or known sepsis and what treatment should be initiated, in line with national guidance. We observed information regarding sepsis was displayed on boards in the maternity unit and treatment rooms, to remind staff of actions and treatment required.
- A pre-operative assessment clinic was held weekly for all women who were booked for an elective caesarean section. We saw evidence that appropriate risk assessments were carried out, including MRSA screening, blood tests, anaesthetic review and venous thromboembolism (VTE). A VTE assessment is used to determine a patient's risk of developing a blood clot. This is recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) to reduce avoidable harm and death from VTE. Those at risk of developing a blood clot can be given preventative treatment. The RCOG recommends that VTE assessments are carried out at booking, each hospital admission, if other problems develop and following delivery (RCOG Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium, 2015). We saw completed VTE assessments in the patient records we reviewed. Data provided by the trust showed a compliance rate of 94% for the completion of VTE assessments, from June to August 2016.
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures, in accordance with national recommendations. This included completion of the World Health Organisation's (WHO) surgical safety checklist. The WHO checklists were regularly monitored for completion against 26 measures. Data provided by the trust showed that from 17 July 2015 to 29 April 2016, compliance generally exceeded 95%. The only measure that was consistently below target concerned whether

the patient had a pre-operative temperature recorded. Compliance against this measure ranged from 40% to 71%. There was no evidence to show if any actions had been taken to address this.

- NHS Safety Alert 1229: Reducing the risk of retained swabs after vaginal birth and perineal suturing states that swabs should be counted whenever they are used. The service reported a never event in December 2015, when a patient retained a tampon following perineal suturing. Swabs and tampons used for vaginal birth and/or perineal suturing were counted for completeness by two members of staff. This was confirmed in records we reviewed.
- Staff we spoke with told us that the consultant obstetrician on call was contacted prior to any emergency caesarean section. We saw evidence of this in the records we reviewed. This is in accordance with national recommendations (Safer Childbirth, 2007).
- We observed that the SBAR (Situation, Background, Assessment, and Recommendation) handover tool was used by staff and we saw evidence of this in the records we reviewed. SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety.
- We saw evidence that staff carried out comprehensive risk assessments on patient's admitted to the gynaecology ward. Assessments included the malnutrition universal screening tool (MUST), Waterlow score (which is used to determine a patient's risk of developing a pressure sore), falls risk and continence assessment. These were fully completed and actions were taken to minimise risks to patients, when indicated.
- There was an effective system in place to ensure all patients had a VTE assessment and were prescribed preventative treatment to reduce the risk of developing a blood clot whilst in hospital. We reviewed four VTE assessments and all had been fully completed by a doctor within 24 hours of admission to the gynaecology ward. The National Early Warning Score (NEWS) was used to identify escalating patient risk. NEWS is a standardised physiological assessment tool, designed to alert the clinical team to any medical deterioration and trigger a timely clinical response. We reviewed four NEWS charts and all had been fully completed.
- The maternity department had a local agreement with the ambulance service for attendance at emergencies, such as babies born unexpectedly at home and when transfer to or from the hospital was required.
- The trust had up to date policies in place for transfer arrangements to ensure women and/or their babies received care and treatment in the most appropriate location. These included transfer to delivery suite or the midwifery-led birthing unit, from a home birth, transfer from the emergency department to delivery suite and transfer to another hospital.

Midwifery staffing

- When we inspected the maternity service in April 2015 we found there were substantial and frequent staff shortages. Vacancy levels were at 25% and had been at high levels for a significant period of time. Whilst vacancy rates were still high across the maternity service we saw that improvements had been made and action taken to address staff vacancies.
- The service risk register detailed high midwifery vacancies as a major risk and was recognised as one of the top three risks within the service. A rolling recruitment programme was ongoing and the trust had agreed to over recruit staff in order to stabilise the workforce and increase retention. Staff we spoke with told us staffing was still an issue but had improved since our previous inspection.
- There were five incidents reported to NRLS for the period July 2015 to August 2016 regarding midwifery shortages; all were graded as no harm. This equated to 0.3% of all incidents reported for this period. Staff sickness and high levels of activity on delivery suite were the common themes. We saw evidence that appropriate action was taken and staff were redeployed to ensure safe patient care was provided.
- We saw that staffing levels and skill mix were planned and reviewed daily so that patients received safe care and treatment. The maternity service used a traffic light system to rate and flag up any staffing issues. A green rating indicated staffing levels were as planned and/or were safe, given the workload and patient acuity. An amber rating indicated staffing levels were as planned but additional staff were required given workload and acuity and/ or staffing levels were not as planned and adjustments were needed to meet workload and acuity. A red rating indicated staffing levels were inadequate to cope with workload and patient acuity. We reviewed the

duty rosters for August 2016. On average, 60% of shifts were green rated and 40% were amber rated. There were no red rated shifts. The percentage of actual shifts filled by midwives versus planned was 77% of day shifts and 98% of night shifts. The figures were less for healthcare assistants, with 55% of day shifts filled and 66% of night shifts. We saw evidence that action was taken to mitigate risks when indicated, such as the redeployment of staff.

- There was a staff escalation plan in place to address staffing issues. A midwifery manager was on call 24 hours a day, seven days a week. They were the point of escalation for staffing concerns and would take appropriate action as needed.
- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment on the days of our inspection. We observed that bank and agency staff were used to ensure establishment was met.
- We spoke with agency and bank staff during our inspection and were told they had received an induction and orientation to the ward before they commenced duties. We saw evidence that checklists for agency staff were completed.
- All areas were reporting planned and actual staffing levels using safe staffing protocols and the daily shift cover of midwives, nurses and healthcare assistants was on display in each area we visited.
- According to the maternity dashboard data provided by the trust, the whole time equivalent (WTE) planned establishment for midwifery staff was 229. As of July 2016 the WTE vacancy rate for midwifery staff was 36.5, which equated to a vacancy rate of 16%. We were told that 25 WTE midwives had been recruited with confirmed dates for commencement of employment, which would reduce the vacancy rate to 5%. For the same period, 27.9 WTE bank midwives and 29.5 WTE agency midwives were employed by the service.
- The maternity service used Birth Rate Plus and NICE Safe Midwifery Staffing to assess and monitor acuity and midwifery staffing levels. Birth Rate Plus is a national tool available for calculating midwifery staffing levels by working with individual trusts to understand their activity, case mix and demographics to calculate an individual ratio of clinical midwives to births for maternity services.
- According to Birth Rate Plus, the midwife to birth ratio required to ensure sufficient staff were available to provide safe care was 1:28. According to data provided by the trust, the midwife to birth ratio (including bank/agency staff) was 1:26 from April to July 2016. This was an improvement since our previous inspection, when we reported the midwife to birth ratio was on average 1:29.
- The service promoted one-to-one care in active labour. Data from the maternity dashboard showed that 100% of women received one-to-one care in labour from April to August 2016. We were told that during periods of high activity and/or lack of available staff, midwives would be deployed from other areas in order to support delivery suite and ensure patients' needs were met appropriately. This was an improvement since our previous inspection, when we reported that one-to-one care was achieved 87 to 90% of the time.
- Midwifery handover took place at the change of each shift. Handover included a review of all women on the wards and allocation of workloads. Handover also included a 'safety huddle' where information regarding incidents, practice and guidelines was shared with staff. For example, we observed staff were reminded to check all instrument and swab counts, ensure blood samples were labelled and countersigned and were asked to read the updated induction of labour policy, as changes had been made to practice. Formal multidisciplinary handovers were carried out three times a day on the delivery suite and were attended by medical staff (including the anaesthetic team) and the labour ward coordinator. We observed the morning handover, which included structured discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to appropriate medical staff.
- The delivery suite coordinator was mostly supernumerary and coordinated the activity on the ward. This enabled them to have constant oversight of ward activity and meant they were available to provide support and assistance to staff as required. We were told that during periods of high activity the coordinator may have to allocate themselves patients. When this occurred they would oversee patients who required minimal intervention, such as those who were stable and awaiting transfer to the postnatal ward.

- The service employed one WTE consultant midwife, in accordance with national recommendations (Safer Childbirth, 2007). A further consultant midwife had been recruited and commenced post the week of our inspection,
- Additional midwives had also been recruited to specialist roles since our previous inspection in April 2015. This included six practice development midwives (with a further two due to commence employment in October 2016), lead midwife for bereavement and lead midwife for vulnerable women.
- The gynaecology service used the safer nursing care tool (SNCT), a recognised patient acuity tool, to determine levels of nursing staff required on the ward. According to the SNCT, which was completed in February 2016, the ward should have had a minimum of 28.28 WTE nursing staff. The trust had exceeded this with a budgeted establishment of 33.11 WTE nursing staff. Senior staff we spoke with told us there were no nursing vacancies on the gynaecology ward at the time of our inspection.
- Planned and actual staffing levels for the gynaecology ward were displayed and the establishment was met during the days of our inspection. Four nursing staff and three health care assistants staffed the ward in the day. A senior nurse was also on duty to supervise and coordinate ward activity. Three nursing staff and two health care assistants staffed the ward during the night. Actual planned staffing levels were comparable to planned levels. For example, in August 2016 96% of planned nursing staff requirements were met.
- There were two incidents reported to NRLS for the period July 2015 to August 2016 regarding a shortage of sonography staff; both were graded as no harm. We saw evidence that attempts had been made to source assistance but agency staff were not available. Additional scanning slots had been allocated to the consultant and the gynaecology day assessment unit nurse also provided additional support, to ensure patients were scanned.

Medical staffing

- Medical staffing was appropriate and there was generally an effective level of cover to support service needs.
- The level of consultants was above the England average as 44% of medical staff were consultants compared with 40% for the England average. The percentage of middle grade doctors was 5%, which was below the England average of 8%. Middle grade doctors had at least three years' experience at senior house level or a higher grade within their chosen speciality. 49% of medical staff were registrars, which is above the England average of 46% and 2% were classified as junior doctors, who have one to two years' experience, which was lower than the England average of 6%. Therefore, we were assured medical staffing was sufficient to keep people safe.
- During inspection we saw medical cover had been managed to meet the complexity and needs of patients within the service.
- Data provided by the trust for the period between December 2014 and June 2016 showed the average number of hours per week of consultant obstetric cover on the labour ward was 98 hours per week; this was for all months in this period. This is in line with the number of hours recommended by Safer Childbirth guidelines for units with more than 5,000 deliveries per year (2007).
- There were 17 WTE consultants in post at the time of our inspection. According to data provided by the trust, the vacancy rate from June 2015 to May 2016 was; 0.4 WTE (2%) for consultant grades and 4.3 WTE (46.2%) for senior house officer grades. There were no vacancies at specialist registrar grade. From May 2015 to April 2016 the average locum use was; 0.53 WTE (3%) for consultant grades, 1.69 WTE (10%) for specialist registrar grades and 0.95 WTE (11%) for senior house officer grades.
- Information provided by the trust and staff we spoke with confirmed that the obstetric consultants provided on-site cover (consultant presence) from 8am to 10pm, seven days a week. After 10pm and until 8am first and second consultants were on-call from home.
- The gynaecology consultant provided on-site cover from 8am to 5pm Monday to Friday and 9am to 1pm at weekends. Out of these hours consultant cover was provided by the first and/or second on-call consultant.
- From 8am to 1pm Monday to Friday there was a consultant delivered elective caesarean section list.
- On-call arrangements were in place and worked well. Staff we spoke with did not have any concerns about contacting the on-call consultant.
- There were three multidisciplinary ward rounds per day on delivery suite and a dedicated consultant ward round of all other wards once a day, seven days a week.
- Anaesthetic cover was available 24 hours a day, seven days a week. From 8am to 5pm Monday to Friday two

consultant anaesthetists were dedicated to the maternity service. From 6pm to 8am one anaesthetist was available on-site; they were supported by one operating department practitioner.
- Staff we spoke with told us that senior medical staff responded when their presence was requested.
- There were five incidents reported to NRLS for the period July 2015 to August 2016 regarding a shortage of medical staff and/or delay to patients being reviewed by medical staff; three were related to maternity and two were related to gynaecology, all were graded as no harm. This equates to 0.3% of all incidents reported for this period.
- Staff we spoke to on the gynaecology ward told us a medicine locum attended the ward five days a week and a medicine consultant attended a minimum of three days per week. This was to ensure any medical outliers were reviewed by the appropriate medical team. On-call assistance was also available if required.

Major incident awareness and training

- The trust had contingency plans for maternity services, which covered staffing, closure of the unit, abandoned baby and abducted baby. Senior staff we spoke with were aware of these plans. Data provided by the trust showed that from December 2014 to June 2016 the maternity unit was closed for two days (46 hours) in May 2015. We were told this was due to no beds being available on the neonatal unit.
- We saw evidence that regular impromptu emergency scenarios were held to maintain and improve the skills needed in the event of an emergency. For example, the service had carried out the fake abduction of a baby from the postnatal ward. We saw evidence that stricter measures and controls had been implemented following the abduction scenario.
- The trust had a major incident policy and staff were able to tell us where this was located on the trust intranet. Staff we spoke with understood their roles and responsibilities with regards to major incidents.

Are maternity and gynaecology services effective?

Good

Overall, we rated the maternity and gynaecology service as good for effective because:

- There was an effective system in place to ensure policies and guidelines were reviewed to reflect current national guidance.
- The service was working towards stage one baby friendly accreditation. However, this had not been attained at the time of our inspection.
- Adequate arrangements were in place to ensure women and their babies received nutrition and hydration.
- There were systems in place to monitor, investigate and address issues related to clinical performance indicators.
- Staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.
- The supervisor of midwives to midwives ratio met with national recommendations.
- Staff worked collaboratively to meet the needs of women and there was evidence of effective multidisciplinary team meetings.
- Access to medical support was available seven days a week throughout the service.
- Information needed to deliver effective care and treatment was available.
- Staff understood their role and responsibility regarding consent and were aware of how to obtain consent from patients.
- Completion of certificate for termination of pregnancy was in line with legislation.

However, we also found:

- The service had recently updated the majority of policies and guidelines, however, there was limited evidence to demonstrate that practice was effective and delivered in line with national recommendations.
- Pain relief was provided as required. However, the majority of women waited longer than the recommended wait time to receive epidural anaesthesia.

- The normal (non-assisted) delivery was lower than the England average. However, the elective caesarean section rate was in line with the England average.
- Whilst there had been some improvement in the number of staff who had received an annual performance appraisal from our previous inspection, the trust target had still not been met across the maternity and gynaecology service.

Evidence-based care and treatment

- On our previous inspection in April 2015, we reported there was no effective system in place to ensure policies and guidelines were reviewed to reflect current national guidance. During this inspection we reviewed 22 guidelines on the intranet and found they had all been reviewed in 2015 or 2016.
- On our previous inspection, we reported that the service risk register indicated there was no forum to review and update clinical and operational policies. We found this risk had been addressed and had been removed from the risk register. A forum was held monthly for the review of all maternity and gynaecology guidelines, which was led by a consultant and consultant midwife. Guidelines were then ratified at the monthly quality and safety group (QSG) meeting; this was confirmed from minutes we reviewed. All doctors, midwives and nursing staff within the service were invited to comment on all updated guidelines before the contents were agreed and ratified.
- Guidelines and policies we reviewed were based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). However, as the majority of guidelines had been reviewed and updated in 2016, there was limited evidence to demonstrate that practice and outcomes had been audited against guidelines. Therefore, at the time of our inspection we were unable to determine whether care and treatment was effective and delivered in line with evidence-based guidance.
- There were clearly defined audit plans for the maternity and gynaecology service. From December 2015 to November 2016 the service were undertaking 13 obstetric audits and 12 gynaecology audits. They were designed to audit current practice and outcomes against national recommendations and outcomes such as caesarean section, antenatal and postnatal health, surgical management of ectopic pregnancy and outpatient hysteroscopy. Staff told us there was a programme in place to ensure they were continuously improving their patient care, which was informed by national guidance, patterns of incidents and clinical data. However, staff we spoke with told us that audits were not always completed within agreed timescales due to work pressures. We saw evidence that the majority of audits were outstanding at the time of our inspection.
- We found from our discussion and from observation that antepartum, intrapartum and postnatal care was provided in line with NICE quality standards.
- The service provided a birth options clinic. The clinic provided an opportunity for women who have previously had a caesarean section and/or traumatic birth to explore the birth choices for their current pregnancy. This was in line with national guidance (NICE Caesarean section, 2013; RCOG Birth After Previous Caesarean Birth, 2015).
- Women with a breech presentation were offered external cephalic version (ECV) around 36 weeks gestation, in line with national guidance (NICE Antenatal care, 2012). ECV is a process by which a breech baby can sometimes be turned from buttocks or foot first to head first position. It is a manual procedure that is recommended by national guidelines for breech presentation singleton pregnancy, in order to enable vaginal delivery.
- Staff told us that women assessed as high risk for venous thromboembolism (VTE) at booking were referred to a haematologist for specialist advice and appropriate management. This was in line with national guidance (RCOG Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium, 2015).
- We saw evidence that fetal growth was monitored from 24 weeks gestation, in line with national recommendations (NHS England Saving Babies' Lives: A care bundle for reducing stillbirth, 2016). Fundal height measurements were documented in patient's handheld maternity records. If a woman was found to measure three centimetres less or more than expected, they would be referred to the maternity day assessment unit (MDAU) or triage that day for further assessment of fetal wellbeing and obstetric review.
- All women were given the 'count the kicks' leaflet from 28 weeks gestation. Women were advised to contact the maternity day assessment unit (MDAU) or maternity

triage unit if they were concerned about their baby's movements and would be invited to attend for further monitoring to assess fetal wellbeing. We saw evidence that women were routinely asked about their baby's movements.

- Management plans for patients who had gestational diabetes were developed and in place. The maternity service provided combined consultant led endocrine and obstetric clinics for women with diabetes. This was in line with national guidance (NICE Diabetes in pregnancy: management from preconception to the postnatal period, 2015).
- The care of women with multiple pregnancies was planned and provided in accordance with NICE quality standards. For example, women with multiple pregnancies were offered ultrasound between 11 weeks and 13 weeks six days to determine the chorionicity and amnionicity of their pregnancy (NICE quality statement one: Determining chorionicity and amnionicity, 2013).
- The service had policies and management plans in place to ensure that medical termination of pregnancy for fetal abnormality was carried out in line with RCOG guidance.
- The Kirkup report was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital. The report made recommendations for the trust and wider NHS, aimed at ensuring that any failings in a service were properly recognised and acted upon. We saw documentary evidence the service had monitored its performance against the recommendations of the report. We saw evidence of a formal action plan, which was monitored by the trust leadership committee. All actions identified had been achieved.

Pain relief

- Pain relief was readily available for maternity patients and included 'gas and air' (a ready-to-use medical gas made up of half oxygen and half nitrous oxide, which is used when pain relief that worked quickly and was excreted from the body quickly was required), opioids (such as pethidine and oral morphine) and epidural anaesthesia (an injection into the back that numbs the lower half of the body and can provide continuous pain relief in labour).
- An audit undertaken in August and September 2016 showed the average wait time for women requesting an epidural for pain relief in established labour was 53 minutes. National guidelines recommend that the time from which a woman requested an epidural to the time they are ready to receive one should not normally exceed 30 minutes; this period should only exceed one hour in exceptional circumstances. The wait times ranged from 20 minutes to one hour and 43 minutes. Out of a total 16 records audited, six women had their epidural sited within 30 minutes of request (38%) and 10 within an hour (62%). Of the remaining ten women, six waited longer than an hour (60%) due to delay in transfer to delivery suite, waiting for the fourth on call anaesthetist to arrive or because of other midwifery care prior to the procedure. The audit findings also noted that 13 of the women (81%) were seen by the anaesthetist within the hour and were given advice and prepared prior to the epidural anaesthesia. The audit did not identify any actions that had been taken to improve the time women waited for epidural analgesia.
- Non-pharmacological methods of pain relief were also available. The Alexandra Birth Centre (ABC) had two birthing pools, which were available for women to use in labour and/or birth. Entonox and opioid analgesia was available for patients on the ABC as required; patients who required epidural analgesia were transferred to the delivery suite. An average of 11% of patients were transferred from the ABC to delivery suite for epidural analgesia from January to July 2016.
- Regular analgesia was prescribed for post-operative women, including opioids and non-steroidal anti-inflammatory drugs (NSAIDs).
- Women were routinely given local anaesthetic analgesia prior to perineal suturing and were offered NSAIDs per rectum following perineal suturing, unless contra-indicated. This is in accordance with national recommendations (NICE Intrapartum care: care of healthy women and their babies during childbirth, 2014).
- Patients, who had undergone surgery including caesarean section, were given pain relief when they were discharged from the hospital for use at home.
- Women who were found to of miscarried in early pregnancy were prescribed pain relief for use at home.
- We reviewed four patient records on the gynaecology ward and saw pain levels were assessed by use of a recognised pain score.
- Patients we spoke with told us they received pain relief in a timely manner.

Maternity and gynaecology

Nutrition and hydration

- Women received support and advice for breastfeeding their babies. The uptake of breastfeeding was monitored quarterly. For March to May 2016, breastfeeding at the point of discharge was 76%, which was comparable to the national average of 77%.
- The maternity service had recently applied for stage one baby friendly accreditation. The baby friendly initiative awards are based on a set of interlinking, evidence-based standards for maternity, health visiting, neonatal and children's centre services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways, which will support optimum health and development. Facilities implement the standards in three stages over a number of years. At each stage, they are externally assessed by UNICEF UK. When all the stages are passed, they are accredited as Baby Friendly.
- Infant formula was only provided for babies when it was clinically indicated, such as concerns about the baby's weight and hypoglycaemia, (low blood sugar) and had been prescribed by a doctor.
- Infant formula was not provided to mothers who had made the decision not to breastfeed their baby. Mothers were informed they would need to bring their own supply of formula feed and equipment, such as bottles and teats, with them.
- Women with hyperemesis gravidarum (a complication of pregnancy that is characterised by severe nausea and vomiting such that weight loss and dehydration occur) were treated with intravenous fluid therapy to correct dehydration.
- Women with gestational diabetes were assessed by a dietitian and given advice on diet, including foods with a low glycaemic index and weight gain control. A dietitian was present at the joint diabetes and antenatal clinics, which were held twice a week. This is in line with national guidance (NICE Diabetes in pregnancy: management from preconception to the postnatal period, 2015).
- We saw fluid balance charts were completed to monitor patient's intake and output, where appropriate, in the nine sets of maternity and gynaecology records we reviewed.
- Dietetic support was available for patients on the gynaecology ward as needed. Referrals were made to the dietetic team via the bleep system. We were told dietetic support was accessible.

Patient outcomes

- The proportion of deliveries by recorded delivery method between January and December 2015 reported were:
  - Normal (non-assisted) delivery was 54%; which is below the England average of 60%
  - Elective caesarean delivery was 11%; which is in line with the England average
  - Emergency caesarean delivery was 20%; which is higher than then England average of 15%
  - Low forceps cephalic delivery was 2%; which is slightly below the England average of 3%
  - Other forceps delivery was 6%; which is higher than the England average of 4%
  - Ventouse (vacuum delivery) was 7%; which is slightly higher than the England average of 6%
  - Breech vaginal delivery was 0.3%; which is in line with the England average of 0.4%
- The maternity and gynaecology service each maintained a quality and performance dashboard, which reported on activity and clinical outcomes.
- In maternity, performance was monitored for a range of outcomes including normal vaginal deliveries, instrumental deliveries, caesarean sections, unexpected maternal and neonatal admissions to intensive care and the number of third and fourth-degree tears.
- The trust's maternity dashboard parameters had been set in agreement with the clinical commissioning group (CCG). The dashboard tracked performance against locally agreed standards, in line with RCOG recommendations (2008). A total of 48 performance measures were detailed on the trust's maternity dashboard, covering birth activity, workforce and clinical indicators. A traffic light system was used to flag performance against agreed thresholds. A 'red flag' indicated areas that required action, in order to maintain safety and restore quality.
- According to the maternity dashboard for April to August 2016, the service met the threshold for the number of women who had an induction of labour, with an average of 26% for this period. There were no reported maternal deaths, post-partum hysterectomies, shoulder

dystocia's resulting in neonatal injury and late neonatal deaths during this period. The service also met the threshold for postnatal neonatal readmissions and early neonatal deaths during this period.

- The service generally met the threshold for the number of women who sustained a third or fourth-degree perineal tear, with the exception of June 2016, where it scored amber on the dashboard; with a rate of 5.7%. The locally agreed standard for third and/or fourth degree tears was an occurrence of less than 9% per month. However, as a result of the increase reported in June, this exception was audited in July 2016. We reviewed the audit findings and saw an action plan had been developed to address documentation, perineal trauma assessment, patient information, follow up care and physiotherapy support.
- Activity indicators where the service scored a red flag included the total rate (planned and unscheduled) of caesarean sections. The service scored red throughout May, June, July and August 2016 with an average caesarean section rate of 29%; this was against a threshold of 26% or below. The trust had introduced measures to try and reduce the number of caesarean sections performed. The multidisciplinary team reviewed every emergency caesarean section performed at the daily patient safety meeting to identify any instances where a caesarean section could have been avoided. Learning from these reviews was cascaded to staff. Women who requested elective caesarean section due to fear of childbirth were offered therapeutic counselling to address their fears and concerns. A vaginal birth after caesarean section clinic was also established.
- Clinical indicators where the service scored a red flag during April to August 2016 included:
  - One incident of major obstetric haemorrhage of five litres or more (against a threshold of zero per month)
  - 29 incidents of major obstetric haemorrhage of more than two litres and less than five litres; 13 in July and 16 in August (against a threshold of 10 per month)
  - One incident of eclampsia (against a threshold of zero per month)
  - One incident of meconium aspiration (against a threshold of zero per month)
  - Four women were transferred to the intensive care unit (ITU); one in May, two in June and one in August (against a threshold of zero per month)
  - One incident of intrapartum stillbirth (against a threshold of zero per month)
  - Six incidents of antepartum stillbirth; two in April, two in July and two in August (against a threshold of one per month)
  - 24 incidents of postnatal readmission; 17 in June and seven in August (against a target threshold of two per month.)
- There is no national threshold for clinical maternity indicators; these are set locally, in agreement with the CCG. We saw evidence that the service had actions in place to monitor, investigate and address any issues related to the clinical indicators, such as daily multidisciplinary case review and audits of practice. The maternity dashboard included hyperlinks to audits that had been undertaken in response to patterns of incidents and clinical data. For example, the maternity dashboard for August 2016 showed two completed audits were available to review. These were in response to an increase in July 2016 of third and fourth-degree tears and an increase from May to August 2016 of postnatal readmissions. A further audit was in progress following an increase in July and August 2016 of major obstetric haemorrhage (this is blood loss of more than 2 litres).
- The service actively participated in national audits including the National Screening Committee antenatal and new born screening annual report. We reviewed a copy of the report for the trust for April 2015 to March 2016. The report had been produced to assist the service by providing a benchmark for future service planning and quality improvement initiatives. We saw evidence that actions had been taken to improve performance where indicated.
- The trust participated in the National Neonatal Audit Programme (NNAP), which measures service provision against five standards/benchmarks. The trust met the two standards related to maternity care provision (the remaining three standards were related to neonatal care provision). These were:
  - Do all babies at 28+6 weeks gestation have their temperature taken within the first hour after birth? The NNAP standard was 98-100%; the trust achieved 100%.
  - Are all mothers who deliver babies between 24+0 and 34+6 weeks gestation given any doses of antenatal steroids? The NNAP standard was 85%; the trust achieved 85%.

- According to data provided by the trust there were 683 unexpected admissions to the neonatal unit from April 2015 to March 2016; 376 of these were full term babies (babies born from 37 weeks gestation). During this same period the trust reported a total of 5,211 deliveries. Therefore, unexpected admissions to the neonatal unit equated to 13% of all deliveries, 7% of which were full term babies. We currently do not have national data to compare these figures with. Therefore, we are unable to determine whether unexpected admissions to the neonatal unit were worse or better than the England average.
- We attended the weekly clinical incident review panel meeting, where the results of an audit were presented to members of the multidisciplinary team; this meeting was open to all staff. The audit had been undertaken following four recent incidents of hypoxic-ischaemic encephalopathy (a type of brain damage that occurs when a baby does not receive enough oxygen and blood). We observed clear objectives, results and conclusions were defined.
- The maternity service reported 24 stillbirths for the period April 2015 to March 2016. All stillbirths were reviewed at the daily clinical incident review panel meeting to ensure early identification of issues and subsequent learning and the monthly perinatal mortality and morbidity meeting. We saw evidence that changes had been made to practice as a result of reviews undertaken, in order to reduce the number of avoidable stillbirths.
- There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. The trust had audited compliance with the completion of HSA1 forms and reported that all had been fully completed and signed by two registered medical practitioners.
- The Local Supervising Authority (LSA) audit was undertaken in May 2016 and reported that the service had made improvements over the last year, particularly with regards to the interface between supervision and clinical risk.
- The gynaecology ward had an enhanced recovery programme for patients who underwent hysterectomy or vaginal repair. The aim of the programme was to get patients back to full health as soon as possible after surgery. According to data for August 2016, patients on the enhanced recovery programme had all been discharged home after an average stay in hospital of 2.4 days; this was better than the trust target of 3 days.

Competent staff

- Following our previous inspection in April 2015, we reported the majority of staff in the maternity and gynaecology service had not had a performance appraisal in the preceding 12 months. During this inspection we found that compliance rates varied across the maternity and gynaecology service. As of September 2016, the compliance rate for midwifery staff on the ABC was 88%, antenatal clinic was 89%, delivery suite was 76%, postnatal ward was 100% and antenatal ward was 89%. For gynaecology, the compliance rate for nursing and/or midwifery staff was; 100% for colposcopy, 68% for the gynaecology ward and 100% for the early pregnancy unit (EPU) / gynaecology day assessment unit (GDAU). The trust target was 95%.We saw evidence that action had been taken to address appraisal compliance rates. Staff who had not completed an appraisal in the last 12 months were advised to arrange an appraisal as soon as possible. The appraisal compliance rate for medical staff was 100%.
- Midwifery and nursing staff were supported with revalidation. Revalidation was introduced by the Nursing and Midwifery Council (NMC) in April 2016 and is the process that all nurses and midwives must follow every three years to maintain their registration. A session on revalidation was included in maternity mandatory training and information was also provided in the September 2016 issue of the Women's Services magazine.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. According to the maternity dashboard for April to August 2016, the SoM to midwives ratio was 1:15; this is in accordance with national recommendations (NMC, 2012). This was an

improvement from our previous inspection where we reported that the SoM to midwives ratio was significantly higher than the trust target. The improved ratio was, in part, due to the appointment of a fulltime SoM, whose caseload was 1:50, which was appropriate for the number of hours they were assigned for supervision duties. This meant that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.

- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.
- Midwives are required to meet annually with their SoM to review their practice and development needs. As of March 2016, 90% of midwives had undertaken a formal supervision review. Formal supervision included discussion on any practice issues and identified any learning needs.
- Since our previous inspection, the maternity service had established a practice development team who were responsible for ensuring all educational and clinical objectives were met within the service. Any trends in incident reporting were used to assist in the identification of training needs. The team would also provide individual training for staff that required support to attain additional competencies, such as perineal suturing.
- A comprehensive induction programme for newly appointed staff was tailored to their roles. This included a range of mandatory training courses and role specific training courses, such as intravenous drug therapy, venepuncture and cannulation.
- We spoke with agency staff who told us they had received a good induction before they commenced clinical duties.
- There was a 12 month preceptorship programme for newly qualified midwives from which they would be promoted to band six upon completion of relevant competencies. Each preceptor was given a booklet to record assessment of their competencies, which was submitted to the practice development team. Competency assessments included antenatal booking, safeguarding, intrapartum fetal monitoring, neonatal resuscitation, perineal repair and new born screening. This was observed during our inspection.
- Preceptor midwives were rotated to work in all areas of the maternity service during their 12 month programme including community, delivery suite, antenatal and postnatal wards. The first two shifts they worked in each area were in a supernumerary role.
- Maternity staff were required to complete annual cardiotocography (CTG) training. The service used the K2 perinatal training programme. All staff were required to complete the acid base and fetal physiology and cardiotocography interpretation chapters as a minimum. Staff were also required to attend a minimum of two CTG meetings per year. CTG meetings were held once a week and included individual case reviews and associated CTG interpretation. As of July 2016, 100% of medical staff and 83% of midwifery staff were compliant with CTG training.
- We saw evidence that regular impromptu emergency scenarios were held to maintain and improve the skills needed in the event of an emergency. We reviewed evaluation records of three simulated emergencies carried out in June, July and September 2016. Areas of good practice, areas for improvement and learning from the incident were detailed and shared within the service.
- Midwifery and medical staff were required to attend annual 'skills and drills' training to ensure they had the necessary knowledge and skills to manage obstetric emergencies including sepsis and maternal collapse, major obstetric haemorrhage and neonatal resuscitation. As of July 2016, 82% of staff had completed this training; the trust target was 95%.
- Staff had access to additional training courses including the new born and infant physical examination (NIPE) and obstetric high dependency care training.
- Junior medical staff we spoke with told us there was adequate support with training.
- Nursing revalidation was supported by the trust and nursing staff were given assistance and support to complete the appropriate reflective accounts, and training to complete this.
- Nursing staff we spoke with in the EPAU and GDAU were trained in ultrasound sonography; a mandatory counselling module was included in this training. Staff told us that patients who required therapeutic counselling would be referred to their GP.

- Senior staff told us that newly qualified nurses were supported by a mentor and worked supernumerary for the first month. They received a formal review at three and six months in post to monitor progress and identify any additional learning needs.

Multidisciplinary working

- The staff we spoke with reported improved multidisciplinary (MDT) working since our previous inspection in April 2015.
- A multidisciplinary handover took place three times a day on delivery suite and included an overview of all maternity and gynaecology patients. We observed one medical handover where patient care was discussed and prioritised according to clinical need. This handover was attended by anaesthetists and the labour ward coordinator.
- Potentially high-risk patients, such as those with a body mass index (BMI) greater than 35, were referred for anaesthetic review.
- Medical staff within the maternity and gynaecology service reported excellent working relationships with the intensive treatment unit (ITU) and other specialities, such as haematology and psychiatry.
- Patients identified as high-risk for venous thromboembolism (VTE) were referred to a haematologist for specialist review and management. A haematologist is a doctor who specialises in the diagnosis, treatment and prevention of blood diseases.
- We observed good MDT attendance at safety, quality and governance meetings and saw evidence of regular MDT meetings being held within the maternity service. These included labour ward forum, patient safety meeting, clinical incident review panel and perinatal and morbidity meeting.
- Communication with community maternity teams was efficient. The teams worked closely together and the community team provided cover for the hospital during peaks in activity.
- Staff we spoke with told us that community midwives and GPs were informed when a woman had suffered a pregnancy loss, including termination of pregnancy for fetal abnormality. Community midwives we spoke with confirmed this happened.
- Women with multiple pregnancies were cared for by a multidisciplinary core team, which included fetal medicine specialist obstetricians, specialist fetal medicine midwives and ultrasonographers. Women could also be referred to perinatal mental health professionals, women's health physiotherapists, the infant feeding specialist and dietitian as needed. Women who needed higher levels of care would be referred to neighbouring trusts with tertiary fetal medicine centres. This is in line with NICE quality standards (NICE quality statement three: Composition of the multidisciplinary core team, 2013).

Seven-day services

- Access to medical support was available seven days a week. Consultant cover was provided seven days a week, with on-call arrangements out of hours.
- Community midwives were on call over a 24 hour period to facilitate home births.
- Anaesthetic cover was available for emergencies on delivery suite and/or within the maternity service, 24 hours a day, seven days a week. This was in line with national recommendations (AAGBI Obstetric Anaesthetic Guidance, 2013).
- A supervisor of midwives was available 24 hours a day, seven days a week for women who required advice about their care and treatment.
- The maternity day assessment unit was open from 8am to 5.30pm, Monday to Friday.
- The maternity triage unit was available for women to telephone over a 24 hour period. Staff told us that they often received calls from mothers that required support and advice during the night.
- Local diagnostic services were available daily with out of hours facilities for emergency procedures such as x-ray, computerised tomography (CT), ultrasound sonography and pathology.
- The gynaecology day assessment unit was open from 8am to 5pm, Monday to Friday.

Access to information

- Information needed to deliver effective care and treatment was generally available to relevant staff in a timely and accessible way.
- The trust intranet and e-mail systems were available to staff, which enabled them to keep pace with changes and developments elsewhere in the trust and access guidelines, policies and procedures to assist them in their specific role.

- Discharge summaries were sent to community midwives, health visitors and GPs. They contained information about the patient's pregnancy, labour and postnatal care and any ongoing risks and/or needs. A copy was also given to the woman.
- Women used handheld notes for the duration of their pregnancy, which included detailed risk assessments, clinical observations (such as blood pressure, urinalysis and symphysis-fundal height measurement) and discussions from all antenatal appointments attended. Women were also discharged home with handheld postnatal notes, which detailed all observations and care provided for the woman and baby during the postnatal period. The use of handheld notes ensured continuity of care was facilitated.
- Clinical staff had access to patient's test results, such as blood tests and diagnostic imaging results, to support them to care for patients safely. These were available via the trust's electronic recording system.
- The gynaecology ward sent care summaries to the patient's GP on discharge to ensure information on the patient's condition was received by the GP in a timely manner. The patient also received a copy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had up to date policies regarding consent (which included the use of Fraser guidelines and Gillick competency), the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff could access these via the trust intranet.
- Staff we spoke with were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected.
- According to data provided by the trust, as of July 2016 the majority of staff within the maternity and gynaecology service were compliant with MCA and DoLS training. Compliance figures showed that 100% of gynaecology nursing staff and 99% of midwifery staff had completed this training. Compliance rates for medical staff were also generally high; 100% for senior house officers and 94% for specialist registrars. However, consultants were only 65% compliant with MCA and DoLS training.
- Midwifery, nursing and medical staff understood their responsibility regarding consent and were aware of how to obtain consent from patients. We saw evidence that consent was obtained prior to surgical procedures, which was good practice. Patient records we reviewed included completed consent forms.
- The trust had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure, one for children and another for procedures not under a general anaesthetic. The women and children's directorate also had specific consent forms, which contained additional information regarding potential risks associated with specific procedures, such as endometrial ablation, hysteroscopy and vaginal hysterectomy.
- We saw evidence that two doctors had authorised terminations of pregnancies in line with the Abortion Act 1967.

Are maternity and gynaecology services caring?

Good

We rated maternity and gynaecology services as good for caring because:

- All women we spoke with were positive about the care and treatment they had received.
- In the 2015 CQC survey of Women's Experiences of Maternity Services, the trust scored 'about the same as other trusts' for 18 out of the 19 questions.
- Staff were kind and caring towards patients.
- Patients, partners and relatives felt involved in their care and were happy that they had received sufficient information to make informed decisions about their care.
- Women's privacy and dignity were protected.

However:

- The maternity NHS Friends and Family Test (FFT) results between June 2015 and May 2016 were worse than the England average for antenatal, postnatal and birthing care.
- The gynaecology inpatients FFT results between June 2015 and May 2016 were also worse than the England average.

Maternity and gynaecology

Compassionate care

- Women we spoke with were positive about the care they had received on both the maternity and gynaecology wards.
- An expectant mother told us they had chosen a different trust in their birthing plan however based on the care she had received on the antenatal ward, she had amended her birthing plan and planned to labour at Watford General Hospital.
- We observed caring and compassionate interactions between staff members and patients.
- Women's privacy and dignity was protected. We observed staff knocking on doors and standing outside curtains before they entered. We also observed staff drawing curtains around women when they wanted to feed their baby to give them more privacy. One woman told us she was particularly impressed by the way staff members covered her with blankets when she was taken in a wheelchair to the ultrasound room.
- Women we spoke with said they generally felt there was enough staff to meet their individual needs. We were told that when staff were particularly busy they were still very pleasant towards patients they were caring for.
- The NHS Friends and Family Test (FFT) results between June 2015 and May 2016 were:
  - Antenatal: the trust scored lower than the England average for eight of the 12 months. The latest percentage, May 2016 was 97% which was just above the England average of 96%.
  - Birth: the trust scored below the England average for all 12 months. May 2016 percentage was 95% versus the England average of 97%.
  - Postnatal Ward: the trust scored below the England average for all 12 months. May 2016 percentage was 78% versus the England average of 94%.
  - Postnatal Community: The trust only submitted results for March 2016 to May 2016, only April 2016 scored higher than the England average. May 2016 percentage was 93% versus the England average of 98%.
  - Gynaecology inpatients: the trust scored lower than the England average for all of the 12 months. The latest percentage, May 2016 was 92% versus the England average of 95%.
- In the 2015 CQC survey of Women's Experiences of Maternity Services, the trust scored about the same as other trusts for 18 out of the 19 questions. The remaining question relating to patients feeling involved in decisions relating to their care scored 'worse than other trusts'.

Understanding and involvement of patients and those close to them

- Women told us that they felt well-informed and able to ask staff questions if they were unsure of anything. A gynaecology patient told us that staff had provided information verbally and sourced information leaflets so that the patient could read the information in more detail when she felt better.
- Women we spoke with said they had been given choices about birth and where they wished to give birth.
- Women's partners told us they felt well-informed and involved during discussions with staff. A patient's partner told us they were always invited to the ultrasound room and had been engaged in discussions with consultants.
- Patients could request a chaperone to be present during consultations and examinations and there were signs displayed to inform patients that this support was available.
- Women reported to us that communication with staff was good throughout the duration of their stay.
- We observed a discussion about treatment options between a patient and a consultant. Pros and cons of each option were discussed thoroughly and the patient told us they felt able to make an informed decision following the discussion.
- Patients were kept informed of clinic waiting times. We saw up to date clinic delay waiting times on the whiteboards in outpatient clinics.

Emotional support

- The women we spoke with said they felt staff acknowledged their emotional needs. One woman said: 'They (nurses) know when you are happy and sad, and they go out of their way to make you feel better".
- Women's birthing partners were able to stay with them to provide additional support throughout labour and following delivery.
- Midwives observed women for anxiety and depression levels.
- There was a dedicated bereavement lead midwife. The bereavement lead midwife supported women after a pregnancy loss.

Maternity and gynaecology

- Staff we spoke with told us they referred patients on to services that provided counselling, advice and support to assist women and their partners in coming to terms with their condition and circumstances, when necessary. For example, they used services such as SANDS (stillbirth and neonatal death charity) and the Down's Syndrome Association.
- Women and those close to them had access to the trust chaplaincy service, which provided spiritual care and religious support for patients, carers and relatives.

Are maternity and gynaecology services responsive?

Good

Overall, we rated the maternity and gynaecology service as good for responsive because:

- The maternity service was flexible and provided choice and continuity of care.
- Women were supported to make a choice about the place they wished to give birth.
- Despite high numbers of medical outliers admitted to the gynaecology ward, at the time of our inspection this did not impact on the response the service gave to gynaecology patients.
- A gynaecology ambulatory care unit had been commissioned to reduce the number of unnecessary admissions to the gynaecology ward.
- Translation services were available to patients.
- Effective arrangements were in place to support women who had complex needs.
- The service had a bereavement midwife to provide care and support to women and families who had suffered a pregnancy loss.
- Feedback from complaints was provided to staff and we saw evidence of improvements to service provision in response to complaints received.

However, we also found:

- The trust did not meet the referral to treatment target for patients with suspected gynaecological cancer. However, patients were generally able to access care and treatment in a timely way.
- We observed that the dedicated bereavement room was untidy and used to store equipment.
- Patients who attended triage waited an average of three times longer to be seen by a doctor at night, than in the day. However, we also found that the majority of patients were seen promptly by a midwife, day or night.
- There were occasions when gynaecology patients were cancelled on the day of their elective surgery because of capacity and staffing issues.

Service planning and delivery to meet the needs of local people

- Services were generally planned and delivered to meet the needs of local people. The maternity service engaged with the local maternity services liaison committee MSLC). The MLSC provided a forum for people who used services, health professionals and the clinical commissioning group to work in partnership to plan, monitor and improve maternity services in the local area. For example, minutes from the meeting in May 2016 discussed the setting up of focus groups with women who had recently used the service, in order to improve communication and continuity of care in antenatal clinics and community midwifery.
- Senior staff told us the service had recently joined the East of England's Maternity, New born, Children and Young People's Clinical Strategic Network. The forum brings together those who use, provide and commission services to make improvements in outcomes for patients.
- Women could access maternity services via their GP, local Children's Centre or by contacting the community midwives directly. A self-referral form was available on the trust's public website, which patients could complete to access care.
- Women were given an informed choice about where to give birth, in conjunction with consideration of their potential risk. Low risk women were encouraged to have a home birth or delivery at the Alexandra Birth Centre (ABC), which was midwifery led. Women who had an existing medical condition, complication of pregnancy or had experienced a previous complication in pregnancy were advised to have their baby on delivery suite, which was obstetric led.
- A birth options clinic was also available for women who did not meet the criteria for low risk birth but who wished to consider alternative options for delivery. The

clinic was run jointly by a consultant obstetrician and consultant midwife. Women were also advised to contact a supervisor of midwives (SoM) if they wished to discuss their choice and options for birth.
- Community midwives offered an on call service to support women who were planning to have a home birth.
- Postnatal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- Partners were able to stay overnight in the hospital if they wished. However, we observed that there were limited facilities for them to be able to rest comfortably.
- The trust public website contained information on choosing a place of birth. This information was also available in large print, braille and audio for patients with a sight or hearing disability. Patients could also request this information in another language. Other information on the public website included the schedule for antenatal care, health during pregnancy, information on screening tests offered during and after pregnancy for women and their babies and pain relief during labour. Patients were directed to other websites for screening information and pain relief options, where this information could be downloaded in other languages.
- The early pregnancy unit had leaflets produced by the Miscarriage Association; these were available in seven different languages.

Access and flow

- Patients were generally able to access care and treatment in a timely way.
- From April to August 2016, an average of 94% of women had booked for antenatal care by 12 weeks and six days. The National Institute for Health and Care Excellence (NICE) recommends that women should ideally be able to access antenatal care by 10 weeks (2012), so that early screening for Downs's syndrome, which must be completed by 13 weeks and six days of pregnancy, can be arranged in a timely manner. The trust were unable to provide us with the percentage of women who had accessed antenatal care by 10 weeks.
- The maternity service scheduled routine antenatal care appointments in line with NICE guidance (2012).
- The antenatal clinic (ANC) was staffed from 8am to 6pm, Monday to Friday. There was a white board, which midwifery staff updated with clinic waiting times. Staff we spoke with told us they updated the board every 30 minutes. When we visited the ANC during our inspection the clinic was running to time. However, information displayed for August 2016 showed the average waiting time for patients to be seen was 60 minutes.
- There was a policy in place to ensure women who did not attend appointments were followed up.
- Women with high-risk pregnancies were regularly monitored and reviewed on the maternity day assessment unit (MDAU). Women could also self-refer to the MDAU if, for example, they were concerned about their baby's movements. The MDAU was open from 8am to 5.30pm, Monday to Friday. Staff with spoke with told us that the unit operated a 'drop in' service, with no appointment system. Whilst this meant women could access the service at a time that was convenient for them, it also meant they may have to wait a long time to be seen if the unit was busy. We reviewed the attendance record and saw that the majority of women were seen and discharged within two hours. Out of 86 patients who attended the MDAU in September 2016, only six were in the unit for longer than two hours.
- Patients who were booked for an elective caesarean section were admitted to delivery suite between 7.45am and 8am of the morning of their planned section. Elective caesarean section lists ran five times a week, Monday to Friday, with generally three operations scheduled per list. The service had a dedicated team to carry out the elective caesarean section list. Staff told us that the list could be delayed or cancelled due to high levels of activity and/or complications on delivery suite. The trust did not audit the number of women who had their elective caesarean section delayed; therefore we were unable to determine whether this occurred regularly.
- The service risk register identified that the ground floor location of the maternity triage unit was a moderate risk to patients because during periods of high activity there was a delay in the pathway for women being assessed, reviewed or admitted. The service had addressed this risk by relocating the triage unit to the third floor, within delivery suite. A traffic light system had also been introduced, to ensure women were assessed and reviewed in a timely way, using Red, Amber and Green (RAG) ratings. An audit of waiting times was carried out

in October 2016, following our inspection. The results showed that the majority of women were seen by a midwife within ten minutes of arrival; this was generally the same for women who attended the triage unit in the day or at night. However, the length of time women waited to be seen by a doctor was varied, particularly at night. For example, women waited an average of 40 minutes to be seen by a doctor during the day and an average of 130 minutes to be seen by a doctor at night. The audit concluded that there was not equity of service provision between the day and night. This was because a doctor was allocated to triage during the day, whilst at night triage was covered by the delivery suite medical team. Following the results of this audit an action plan had been developed. This included the presentation of the audit findings at the clinical governance education meeting, so that a collaborative plan to reduce patient waiting times at night could be developed. As the action plan was outstanding, we were unable to determine whether any actions taken by the service were effective at reducing the length of time patients in triage waited to be seen by a doctor, particularly at night.

- We saw evidence that the maternity service had recently developed an audit tool to record all delayed inductions of labour and elective caesarean sections. All delays would be discussed at the daily patient safety meetings. However, this had not been implemented at the time of our inspection. Therefore, we were unable to determine how many women had their planned induction or caesarean section delayed and whether the service had taken appropriate action to minimise any delays.
- On our previous inspection in April 2015, we reported the gynaecology ward took a high number of outlier patients from other specialities, which impacted on the response the service gave to gynaecology patients. Nurses we spoke with told us that elective patients often had to wait for several hours in a 'holding' area for a bed to become available.
- During this inspection, we saw that the service risk register identified that the use of gynaecology ward beds for medical outliers meant gynaecology patients who required elective or emergency surgery were cancelled or had their admission delayed. The service had taken action to address this risk. In order to release beds on the gynaecology ward a gynaecology ambulatory care unit had been commissioned. The unit provided facilities for up to six women who were suitable for day case treatment, such as intravenous fluid hydration for women with hyperemesis gravidarum or surgery for the management of ectopic pregnancy. The ambulatory care unit had only opened the week of our inspection; therefore there was no data available to demonstrate the unit's effect on access and flow within the gynaecology service. During our unannounced inspection, staff we spoke with told us that out of 10 patients seen within the unit during the previous week, six had not required admission to the gynaecology ward.
- Staff we spoke with told us that access and flow within the gynaecology service had improved since the service was restructured under the surgical division. Dedicated emergency theatre slots had been allocated to minimise disruption to patients who were booked for elective surgery. Senior staff told us that very few elective surgery cases had been cancelled since the restructure.
- When we visited the gynaecology ward during our announced inspection, 10 patients on the 28-bedded ward were medical outliers. We were told that no gynaecology patients admitted for surgery had been delayed or cancelled that day due to medical outliers.
- A standard operating procedure regarding the cancellation of elective surgery on the day for non-medical reasons had been produced. Since then, senior staff told us that no elective patients for gynaecology surgery had been cancelled on the day for non-medical reasons. However, information provided by the trust following our inspection showed that 16 patients were cancelled on the day of their elective surgery for non-clinical reasons, from August to October 2016. Two patients were cancelled due to estate issues, seven because surgery lists overran, one because there was no bed available and six because staff were not available. Out of the total 16 patients, four waited between one and 12 days for their elective surgery to be rescheduled, six waited between 13 and 22 days, four waited 23 to 40 days and two patients were still waiting for a date.
- The service had a gynaecology day assessment unit (GDAU), which was consultant led and offered appointments between 9am and 5pm, Monday to Friday. The service accepted referrals from GPs, the emergency department (ED) and other consultants / wards. Patients who required admission would be transferred to the gynaecology ward.
- A midwifery-led early pregnancy assessment unit (EPAU) offered appointments between 8.30am and 4.30pm,

Monday to Friday and 10am to 4pm on Saturday. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from GPs and ED. There was access to scans each morning and afternoon and medical opinion was accessible from the on call registrar and senior house officer. If they were unavailable and a patient required urgent review, staff would bleep the on call consultant.

- Between June 2015 and June 2016, 94.7% of patients on a non-admitted pathway waited less than 18 weeks from referral to treatment for gynaecology; this was slightly below the England average of 96.1%. For the same period, 96.6% of patients on an incomplete pathway (patients waiting to start treatment) waited less than 18 weeks; this was above the England average of 93.8%.
- Data published in the August 2016 integrated performance report, showed the trust had not met the referral to treatment target of 85% for patients with suspected gynaecological cancer. For example:
  - 82.5% of patients commenced treatment within 62 days following urgent GP referral for the period April to June 2016
  - 83.3% of patients commenced treatment within 62 days following urgent GP referral for the period July to September 2016
- Women who had undergone termination of pregnancy for fetal abnormality were given telephone numbers to access 24 hour help if required. Women were advised to contact either the gynaecology day assessment unit between the hours of 8am to 8pm and/or the gynaecology ward, where staff were available to provide advice and support 24 hours a day.

Meeting people's individual needs

- The maternity service had arrangements in place to support women who had complex needs, with access to clinical specialists and medical expertise.
- Booking appointments were generally held at children centres within the local community but alternative arrangements could be made to meet women's individual needs, such as home visits.
- We saw evidence of women being offered information so they could make an informed choice about where to give birth depending on clinical need. The maternity service offered home birth, midwifery led care in the Alexandra Birth Centre or obstetric led care on delivery suite. Two birthing pools were available for women who wished to use water immersion for pain relief in labour.
- We saw that there were effective processes for screening for fetal abnormality. Women identified with a high risk of fetal abnormality, such as Down's syndrome (a genetic condition that typically causes some level of learning disability and characteristic physical features) were invited to attend the fetal medicine service. This service provided a range of prenatal diagnostic and fetal therapeutic services in collaboration with other specialist providers.
- The service provided a birth options clinic. The clinic provided an opportunity for women who have previously had a caesarean section or traumatic birth to explore the birth choices for their current pregnancy.
- Women who requested a caesarean section because of anxiety about childbirth were referred to a specialist counselling service, in line with national recommendations (NICE, 2012).
- The service ran a combined endocrinology and obstetric clinic for women with diabetes.
- Since our previous inspection in April 2015, the maternity service had established a designated team of midwives (known as the Lavender team) who provided care, support and treatment for vulnerable women, such as those with a learning disability, substance misuse, perinatal mental health concerns, teenagers and asylum seekers.
- Combined obstetric and psychiatric run clinics were available for women with complex perinatal mental health needs.
- At the time of our inspection, a consultant with special interest in perinatal mental health held an open evening for GPs within the local community to publicise services offered at the hospital. GPs were able to refer women with complex needs directly to the Lavender team to ensure they received timely support, advice and treatment.
- There was a six-bedded transitional care unit, where care was provided jointly by the maternity and neonatal service, for women with babies who required more specialised neonatal care, such as phototherapy treatment for jaundice.
- Since our previous inspection, a substantive bereavement midwife had been employed by the trust, whose role was to develop the service, provide support

for parents and training and education for staff. Memory boxes were made up for parents who had suffered a pregnancy loss. Parents were supported in making funeral arrangements.

- We were told that parents who had experienced a stillbirth, neonatal death or termination of pregnancy for fetal abnormality were offered a post-mortem examination in order to improve future pregnancy counselling.
- The delivery suite had a dedicated bereavement room to ensure bereaved parents had personal time with their baby. The room had been appropriately decorated and had a sofa bed and ensuite facilities. There was a cold cot available, which meant that babies could stay longer with their parents. However, we were told that the ensuite bathroom was often used to store equipment and during our inspection we saw a commode and empty photograph frames were left there, which made it look untidy and did not create an appropriate environment for bereaved parents. Furthermore, there were no facilities in the room for parents or visitors to make themselves hot drinks.
- Interpreter services were available and could be booked through the patient advisory liaison service (PALS). An interpreter could be booked to attend appointments or inpatient services when required; a telephone service was also available. We saw information about the translator services available displayed through the service. We observed an interpreter attend an antenatal clinic appointment with a woman during our inspection.
- Antenatal education classes were available for parents to attend.
- Partners were able to stay overnight if they wished. Friends and relatives could visit at fixed times. This enabled new parents to spend protected time with their babies.
- Staff provided women who had undergone termination of pregnancy with information regarding the disposal of pregnancy remains and women were asked their preferred option. This ensured women were given the opportunity of making an informed choice with regards to the disposal of pregnancy remains and is in accordance with national recommendations (Department of Health, 2014).
- The maternity and gynaecology service was accessible to wheelchair users.
- Women had a choice of meals with took account of their individual preferences, respecting cultural and personal choice.
- The women we spoke with told us their fluid and dietary needs had been met and they were provided with fresh jugs of water regularly.
- Mealtimes were protected, yet there was flexibility to obtain meals for women who were admitted outside of set mealtimes.
- Women and those close to them had access to the chaplaincy service and a multi-faith room.

Learning from complaints and concerns

- We discussed the complaints procedure and learning from complaints with the management team who told us that, where possible, complaints were resolved locally and at the time of the complaint. The service had introduced 'quality rounds', where the ward manager or shift co-ordinator would ask all patients on the ward if they had any concerns or complaints regarding the care they had received.
- Complaints were handled in line with trust policy. All complaints received by the trust were sent to the divisional leads within the service and were allocated to a senior member of staff to investigate and action. A weekly complaints meeting was held with divisional leads and the trust complaints team, where the progress of complaints was monitored and any trends identified. All complaints received were acknowledged by the trust within 72 hours of receipt. According to the maternity dashboard figures for April to August 2016, 100% of complaints received had been acknowledged within 72 hours of receipt.
- Patients were offered a local resolution meeting to discuss any aspects of care they were not happy with. The associate director of midwifery and gynaecology nursing requested to meet any patients and/or their relatives who would not recommend the service to their friends and/or family.
- Information from the trust showed there had been a total of 105 complaints received for women's services during the period of July 2015 to July 2016. Delivery suite had received the most complaints (24%), followed by the gynaecology ward (15%). The least number of complaints were received by the GDAU (0.9%). The most

common themes for complaint regarded communication/information to patients (written and oral) (30%), attitude of staff (27%) and clinical treatment (26%).
- Learning from complaints was integrated in the governance framework. Complaints were reviewed and discussed at the monthly quality and safety group and clinical governance education meetings. Learning was also shared with staff via emails, the "message of the week" bulletin and at daily staff huddles. We also observed noticeboards throughout the unit, which included details of the top three themes of complaints received and corresponding actions to be taken by staff to minimise further complaints.
- The antenatal clinic had information leaflets regarding the hospital's patient advisory liaison service (PALS). PALS provided advice and support to patients (and those close to them) who wished to raise a concern or complaint.
- Two complaints were referred to the Parliamentary Health Service Ombudsman; one was related to maternity and the other to gynaecology services.

Are maternity and gynaecology services well-led?

Good

Overall, we rated the maternity and gynaecology service as good for being well-led because:

- Senior leadership had been established and staff felt the management team were visible and approachable.
- The service was focused on providing quality care and had a clear vision, values and strategy to support its aims.
- There was a robust governance and risk management framework in place. Meetings were well documented, actions were taken to address patient safety and quality issues and lessons learned were cascaded to staff.
- The risk register was current and reviewed regularly. Staff were aware of risks within the service.
- Staff cared about the service they provided and were generally proud to work at the hospital.
- Staff had agreed a charter for standards of behaviour, which were focused on commitment, care and quality.
- There were some processes in place to engage and involve people who used the service, the public and staff in the planning and delivery of care. Actions had been taken to improve the service as a result of feedback received.
- Some specialities were developing services to improve patient care.

However, we also found:

- Staffing levels was the most commonly cited reason for stress and low morale amongst staff. The service was taking action to address this. However, staff morale had improved since our previous inspection.
- There was a clearly defined audit plan in place to monitor and improve patient care. However, audits were not always completed within agreed timescales.

Leadership of service

- During our previous inspection in April 2015, we identified issues with the management of the service and reported there was a lack of overall direction and leadership. We found that the service had taken action to address our concerns and improvements had been made.
- The trust had employed senior medical and midwifery staff to support the leadership of the service since our previous inspection. This included the medical director for obstetrics and gynaecology and associate director of midwifery and gynaecology nursing. They had made changes to how the service was managed, which included additions to the staffing structure, and had established an effective governance and risk management framework. All staff we spoke with told us the changes were well received and had improved service provision and staff morale.
- The associate director of midwifery and gynaecology nursing had access to the trust board and attended monthly trust quality and safety group meetings. Issues affecting women's services were presented at this forum every other month. Maternity services were represented by a non-executive and executive director at board level.
- The delivery suite was co-ordinated by an experienced senior midwife who, wherever possible, was supernumerary to the staffing numbers required for one-to-one care.
- All midwives had a named supervisor of midwives (SoM). The ratio of SoMs to midwives was 1 to 15, which is in line with national guidance.

- The unit had two consultant clinical leads; one for obstetrics and one for gynaecology. The unit also had two consultant midwives and a delivery suite manager.
- There were consultant leads for specific services, such as perinatal mental health, diabetes, audit and clinical risk.
- Specialist roles within midwifery had also been developed since our previous inspection, including the addition of a bereavement midwife, practice development team, consultant midwife for public health and the Lavender team, who provided care, support and treatment for vulnerable women.
- Staff we spoke with told us the management team were visible and approachable.
- We saw evidence that actions were taken in response to national reports and audits. The service had developed its strategy in line with recommendations made by the National Maternity Review (2016).

Vision and strategy for this service

- The service had implemented a clear vision and set of values, which were focused on providing quality care. The vision for the maternity service was: "We are positive staff always working towards providing positive women's experiences, everyday". The values included; caring and compassionate, open and transparent, responsive, quality, safety, accountability and responsibility, effective leadership and learning culture. We saw the vision and values publicly displayed throughout areas of the service, including the entrance to the women and children's unit.
- The service told us that it had been developed through a process of engagement with staff and people who used the services. Staff we spoke with were aware of the vision, values and strategy and told us they had been involved in its development.
- The vision for the service had been translated into a three to five year strategic plan, which encompassed the national maternity strategy. Priorities for maternity included strengthening core services, such as; improving continuity of care, promoting midwifery led care and normal childbirth and working towards 24-hour, seven day consultant cover, with an increased presence on labour ward, in line with Royal Colleges recommendations (Safer Childbirth , 2007). The service also aimed to develop specialist services, such as perinatal mental health, fetal medicine and local female genital mutilation (FGM) services.
- This was an improvement from our previous inspection in April 2015, when we reported that the service did not have a clear vision, set of values and defined strategy in place that staff could describe.

Governance, risk management and quality measurement

- The previous inspection in April 2015 had identified several issues relating to governance, risk management and quality measurements. We reported that the service did not have an effective governance framework to support the delivery of good quality care. There were not effective arrangements in place for identifying, recording and managing risks and the risk register was not current or reflective of the level of risks in the service. On this inspection we saw evidence that improvements had been made to the governance framework and management of risk.
- The service had established an effective governance and risk management framework to support the delivery of good quality care.
- All incidents reported via the electronic incident reporting tool were reviewed daily, Monday to Friday, at the patient safety meeting. The management team told us that the premise of the patient safety meeting was to ensure the service was safe and whether any immediate actions were required to address any safety concerns. We attended a patient safety meeting during our inspection and observed the multidisciplinary team review the patient records related to incidents and emergency caesarean sections that had occurred the previous day. Any potential serious incidents were then reviewed in more depth at the daily clinical incident review group (CIRG) and were escalated to the trust serious incident panel.
- The serious incident panel met three times a week to review all potential serious incidents and ensure there was consistency in the escalation of reporting. If an incident was declared as a serious incident the panel would appoint an appropriate senior member of staff to lead the investigation and conduct a root cause analysis. The divisional leads informed us that the group assisted with identifying which incidents required internal investigation and notified clinicians of findings.

- The clinical incident review panel met weekly to review incidents within the division and the risk register. The minutes we reviewed were detailed and contained copies of relevant reports, action plans and lessons learned.
- Monthly governance, quality and safety group (QSG) meetings were held, which reported to the divisional quality and safety group, who in turn reported to the trust quality and safety group. The minutes confirmed that incidents and complaints were reviewed in detail, actions were identified and learning was cascaded to staff.
- During our inspection we attended the monthly clinical governance education meeting and observed reports on clinical effectiveness, the presentation of audits and learning from serious incident investigations.
- The service had a risk register, which identified each risk in detail alongside a description of the mitigation and assurances in place. An assessment of the likelihood of the risk materialising and its possible impact had been included. We saw that risks were reviewed regularly and updated with any changes or details of mitigation. The service had identified 25 risks at the time of our inspection.
- Staff we spoke with were aware of risks within the service. The top three risks within the service were displayed on notice boards throughout the unit and included high midwifery vacancies and lack of interface between the computer systems used by the trust.
- There was a clearly defined audit plan within the maternity and gynaecology service for 2015/16 and 2016/17. The service told us there was a programme in place for women's services to ensure they were continuously improving their patient care, which was informed by national guidance, patterns of incidents and clinical data outcomes. Findings from these audits were shared with staff through a variety of means, which included clinical governance meetings, daily team huddles, staff noticeboards and learning folders. However, we saw that audits were not always completed within agreed timescales.
- The RCOG Good Practice No.7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The maternity dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. The maternity service dashboard was clearly displayed throughout the unit and was used to help identify patient safety and quality issues. We saw evidence that timely and appropriate actions were taken to address any areas where locally agreed performance standards had not been met.
- Staff told us that they recieved feedback in various ways, such as the daily team huddle and learning folder. Performance issues were taken up with the individual staff member and were managed through statutory supervisory processes and in line with trust policies.
- The service had a risk management strategy and policy, which identified local arrangements for maternity service's integrated governance approach. Management arrangements and processes for the identification, assessment, treatment and monitoring of clinical risks was detailed.

Culture within the service

- During our previous inspection in April 2015, we identified issues with staff morale and reported that staff did not feel engaged to help shape the service with a focus on care and quality. We found that the service had taken action to address our concerns and improvements had been made.
- The maternity service held three team building days in June and July 2016 to address concerns highlighted in our previous report. The team building days were facilitated by an external psychologist. We saw evidence that staff were encouraged to develop a vision for the service and initiatives to improve service provision, such as reducing the caesarean section rate.
- The team building days also led to the development of a charter for standards of behaviour, which all members of staff were required to adhere to. The behaviour standards incorporated the trust's vision and values and were focused on commitment, care and quality. A code of conduct for consultants was also agreed, in order to address historical issues of conflict within the team and senior management.
- Senior staff told us that actions were taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. For example, consultants were required to demonstrate they had reflected on clinical incidents, in line with the Royal College of Obstetricians and Gynaecologists reflective practice template.

- Staff told us that there was generally a good working relationship between medical staff and midwives.
- All staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and spoke positively about improvements that had been made since our previous inspection.
- During our inspection we observed that staff worked collaboratively to ensure good quality care was provided.
- Staff were confident with both raising concerns with their managers and that they would be acted on.

Public engagement

- Following our previous inspection in April 2015, we reported that patient's views and experiences were not effectively gathered and acted on to shape and improve the services and culture. During this inspection we saw that improvements had been made to engage and involve people who used the service and the public.
- Information from the Friends and Family Test and complaints were used to monitor and shape services provided. We saw: 'You said, we did' posters, displayed on wards throughout the women and children's unit, which listed actions they had taken in response to feedback and complaints received. Examples included the employment of more nursery nurses to provide parent education on the postnatal ward and partners being able to stay overnight on the antenatal and postnatal wards. However, it was noted that the response rate from the Friends and Family Test was low and it was not clear if the service had taken any action to address the low response rate.
- The service participated in the Maternity Services Liaison Committee. The group met monthly and provided a forum for parents, health professionals and the local clinical commissioning group to work in partnership to plan, monitor and improve maternity services in the local area.
- In July 2016 the service held an open evening to promote perinatal mental health services. The event was called: 'The importance of mental health care during pregnancy and beyond,' and aimed to raise awareness and reduce the stigma around mental health conditions during pregnancy, childbirth and the postnatal period. Mothers who had lived through mental illness were involved in the event and were invited to talk about their personal experiences. The event was well attended by approximately 80 members of the public. We were told that a perinatal mental health focus group was being developed, which planned to enlist people who used the service to help shape and improve service provision. This had not yet been established at the time of our inspection.

Staff engagement

- Following our previous inspection in April 2015, we reported that staff did not feel actively engaged in the planning and delivering of services and in shaping the culture. During this inspection we saw that improvements had been made to engage and involve staff in service provision.
- We saw evidence that staff were actively involved and engaged in the development of the vision, values and strategy for the maternity service.
- The service introduced quarterly 'temperature checks' to encourage staff engagement and the improvement of women's services. Staff were asked to answer nine questions using a six point scale, which ranged from 'strongly disagree' to 'strongly agree'. Questions included whether the staff member felt happy and supported working within women's services, whether they felt the service provided high quality care to patients and whether they felt able to make changes, however small, to drive improvement in their area of work. At the time of our inspection, three temperature checks had been undertaken in November 2015, February and July 2016. We reviewed the results and saw there was an increase in positive feedback for all questions from the temperature check taken in July 2016 compared with November 2015. The questions which received the most positive feedback were; "over the last month I feel we have provided high quality care to our patients", which 88% of respondents agreed with and "I feel proud to work for West Herts NHS Trust", which 80% of respondents agreed with. The questions which received the lowest positive feedback were; "over the last month I have felt that day to day issues which cause frustration and get in the way of me doing my job are resolved", which 60% of respondents agreed with and "over the last month I have felt happy and supported working within the women's division", which 69% of staff agreed with.
- The question which received the greatest increase in positive feedback of 16% was; "over the last month I feel that communication within the division has worked

well", which rose from 59% in November 2015 to 75% in July 2016. During our inspection we saw that the service had introduced initiatives to improve communication within the division, such as message of the week, newsletters, managers walking the floor, more team meetings and safety huddles. The staff newsletter, for example, was introduced in June 2016 and published quarterly. We reviewed the newsletters for June and September and saw they provided staff with information on actions taken to address concerns raised by the Care Quality Commission (CQC) following our previous inspection in April 2015. Information on staff recruitment, study days, training compliance and specialist midwifery roles was also included, as well as celebrating successes within the service, such as 'star of the month' and staff who had successfully completed additional training courses.

- Staff were also invited to add comments on the temperature check questionnaires and examples of these included; "thank you for bringing us together as one team" and "there has been a marked improvement in communication and support and although there are still issues, the team is excellent and has done a very good job so far". The majority of negative comments were due to staffing and included; "stress levels increased due to staffing levels" and "a lot of these issues would be solved with more staff, desperately need more staff".
- We saw evidence that the service was working to improve upon these results. For example, a recruitment plan was in place and the service had employed a further 25 whole time equivalent midwives with confirmed dates for commencement of employment. The trust had also agreed to over recruit staff in order to stabilise the workforce, increase retention and provide resilience when staff resigned or retired. Furthermore, the role of operational matron had been introduced to support staff with resolving day to day issues that cause frustration.

Innovation, improvement and sustainability

- Following our previous inspection in April 2015, we reported there was a lack of innovation and sustained, continual improvement across the service. During this inspection we saw evidence that the service had introduced performance measures, such as the maternity safety thermometer and dashboard, and a robust governance and risk management strategy that were focused on the continuous improvement of services.
- The trust had agreed to fund the recruitment of midwifery staff above the recommended midwifery establishment, in order to provide stability within the workforce and resilience when staff resigned or retired.
- We saw some improvements to service provision since our April 2015 inspection. These included the introduction of the Lavender team, the relocation of triage from the ground floor to within delivery suite and the gynaecology ambulatory care unit. There was also evidence that specialties within maternity and gynaecology were developing services in order to meet the needs of people within the local community, such as the setting up of a de-infibulation clinic for women with female genital mutilation.
- We saw evidence that the supervisors of midwives worked with the service to improve services where required, particularly with regards to governance and clinical risk management.

Services for children and young people

Safe	Requires improvement
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Children's inpatient service operates two wards, both based at Watford General Hospital within the women and children's block. The service cares for children up to the age of 16. Young people aged 17 and 18 are cared for in the adult services.

The service is led by an overall divisional director for women and children's services. In addition, there is a clinical director for the children's service. There are clinical leads for the neonatal service and the children's emergency department. There is a Head of nursing for children's services. There is a matron for neonatal services and a matron for children's services. In non-clinical roles there is a divisional and an assistant divisional manager of children's services.

Starfish is a 20 bedded general paediatric ward caring for children up to the age of 16 years. The ward cares for children with both medical and surgical conditions and includes two high dependency beds.

The Safari Day Unit has 10 beds and provides day care for children up to the age of 16 years. The unit provides care for children requiring day surgery and carries out treatments such as chemotherapy and administration of intravenous antibiotics. Investigations for chronic conditions are carried out there. Investigations include endoscopies and allergy tests.

The neonatal unit is a level two neonatal unit. It provides care for infants born from 28 weeks gestation who require short term intensive care, high dependency care and special care to premature and sick infants. There are three intensive therapy cots, five high dependency cots, 16 special care cots and six transitional care cots. The transitional care cots are based on the postnatal ward within the maternity department. At times, this service is expanded into the general postnatal ward, if additional cots are required.

Watford General Hospital also provides outpatients services to children from birth to 16 years of age. There are daily general paediatric clinics and other special clinics for conditions such as diabetes and cystic fibrosis. There are dedicated oncology and gastroenterology clinics. The hospital provides surgery for children in several specialities, including ear nose and throat (ENT), gastroenterology, general surgery, dental and urology. Staff told us that they provide trauma surgery for patients who are suitable for day care if theatre time allows.

Services for children and young people

Summary of findings

Overall we rated the services for children and young people as requires improvement because:

- Incidents were reported inconsistently. The service did not ensure that staff complied with the policy and procedure for reporting incidents.
- Not all staff were involved in debriefing session outcomes.
- Information flows were not always robust.
- Feedback was mixed from staff as to whether incident reporting was encouraged. Whilst some doctors and nurses saw the value of raising concerns, some were afraid or discouraged from raising concerns and felt they may be blamed when reporting incidents.
- The service cancelled some governance meetings. Staff who could not attend did not always receive minutes from these meetings.
- There was a significant division of staff concerning opinion and practice within the neonatal unit. Some staff felt this might have had an impact on patient care. An external thematic review of this had been commissioned by the service.
- There were gaps in management and support arrangements for staff, such as appraisal and professional development. Not all nursing staff were up to date with their appraisals.
- Not all nursing and medical staff were up to date with mandatory training.
- Patients who showed signs of deterioration were not always escalated to a senior nurse or doctor as recommended in the trust guidelines.
- There was not a paediatric safety thermometer in use.
- There were high numbers of cancellations of outpatient appointments for children especially in epilepsy and cardiology.
- The neonatal unit lacked sufficient space to operate in accordance with current guidelines.

However, we also found:

- Staff provided skilled and competent patient centred care.
- Staff treated all patients with kindness, dignity and respect. All patients and their carers that we spoke with told us that staff were kind, caring and included them in the planning of care and treatment.
- A carer support team was in place that supported carers and patients' families. Regular activities were arranged for patients. Play therapists were an important part of the ward team ensuring that nervous patients or those with additional needs received the support required.
- Staff regularly went 'above and beyond' to provide individualised care for patients. In feedback from patients and carers, we saw that consultants: "Always listen well, explain difficult information clearly and care very professionally".
- Nurse leaders and matrons were highly visible, approachable and fully engaged with providing patient centred, excellent care.
- Staff knew how to report safeguarding concerns.
- Nursing staff knew how to report incidents and understood their responsibilities in reporting incidents and near misses.
- Nursing staff shared lessons learned in a variety of ways. Individual nurses were sensitively supported with their learning, skills and development where required, following incidents.
- Staff understood about risk and risk assessments, which were generally thorough and updated frequently. Discussions about risk at multi-disciplinary team meetings were detailed and individualised.
- Patients had their care assessed, planned and delivered in a clear and consistent way. Patient records we checked were accurate and up to date. Nursing staff had completed care plans and assessments. There was regular and well documented monitoring of symptoms and pain in patients.
- Information technology was used to access results and x-rays. Safeguarding information was available to the specialist safeguarding nurses via a community based electronic records system.

Services for children and young people

- The environment and equipment were visibly clean, well maintained and serviced. Environmental checks were done regularly. Beds and side rooms were thoroughly checked, cleaned and stocked between every patient.
- Doctors and nurses were all compliant with "arms bare below the elbow" policy and hand hygiene. There were adequate places to wash hands and apply hand gel.
- Starfish and Safari wards shared a playroom and adolescents' room, which were attractively designed and well equipped.
- Staffing levels were safe for the number and acuity of patients. There were effective measures in place to ensure that when there was increased activity staff numbers increased. Medical staff had the relevant experience, skills and qualifications to care for and treat patients. There were practice development nurses in post to identify and deliver individual and service wide training needs.
- Medicines and drugs were stored, prescribed and administered safely. There was a paediatric pharmacist in post.
- Staff received specialist and mandatory training to enable them to fulfil their roles effectively.
- There was effective multidisciplinary team (MDT) working. This included pharmacists, mental health services, dietitians, safeguarding services, physiotherapists and occupational therapists. MDT working was effective both internally and with partners in other trusts and organisations.
- Patients moving from children's services to adult services were prepared in advance for the transition by individual specialist consultants and nurses.
- The service was planning development of specialist services including diabetes, epilepsy, oncology and gynaecology.
- There was a clear governance structure in place; detailed responsibilities were documented in the governance policies that covered both the trust and the service.
- There was participation in both local and national audit. Audit was routinely used to monitor, inform and develop practice.

Are services for children and young people safe?

Requires improvement

Overall we rated the services for children and young people as requires improvement because:

- Reporting and investigation of incidents was inconsistently done amongst the medical staff.
- Minutes of meetings relating to safety and lessons learnt were not always shared with staff.
- There was no safety thermometer in use on Starfish ward. This is contrary to the guidelines issued by the NHS.
- Not all staff were aware of the Duty of Candour.
- There was insufficient space, which did not reflect current guidelines, in the neonatal unit.
- During our inspection, staff did not always follow the correct security procedures for entering and exiting the Neonatal unit, Starfish Ward and Safari Ward.
- Patients were moved from the inpatient wards to the operating theatre along a corridor that was not fit for that purpose.
- Operating theatre and recovery arrangements did not consider adequately the specific needs of children.
- Although all staff who were working within the children's departments were trained to level three in safeguarding, not all staff who were assessing, planning or treating children and young people throughout the trust were trained to this level.
- Recording of actions taken with regards to escalation, when a child deteriorated were not always recorded.
- Some medical notes had gaps between entries. We saw that doctors had sometimes used the term "written retrospectively" up to 12 hours after an event.

However we also found that

- There had been no never events reported between September 2015 and August 2016. All nursing staff we spoke with understood the requirements of reporting incidents and what constituted an incident. They could clearly explain to us how to report an incident using the online incident reporting system.
- The service had recently implemented a safety round to discuss any incidents that may have happened over night and discuss further management.

- There was evidence of improved patient care and practice. For example in sepsis treatment and pain management.
- Nursing staff carried out regular observations of temperature, pulse and respirations to ensure patients were continually assessed.
- There was a strong safeguarding team in place. Each paediatric nurse had access to learning and supervision.
- Nurse and medical staffing levels were appropriate to the activity and dependency of the patients prior to and during the inspection.
- Wards and departments were visibly clean and infection control measures were in place and audited regularly.
- All staff were trained in infection control annually.
- Resuscitation equipment was checked and stored safely.
- Equipment used to monitor and treat children was clean, serviced and electronically tested.
- Medicines were stored, prescribed and administered safely.
- A new "druggle" round had been introduced weekly on the wards to improve learning for staff and to ensure they were aware of any safety issues around drugs and medicines.
- There were specific areas for play and relaxation on the wards that were well equipped, clean and safe.
- Records were up to date, legible and had clear plans in place for each patient. Records were stored securely on the ward in locked cabinets.

Incidents

- We found that the incident reporting culture was variable. The service did not ensure that staff complied with the policy and procedure for reporting incidents.
- All staff had access to the electronic incident reporting system which meant that there should have been no delay in reporting incidents in usual circumstances.
- There were 245 incidents reported by the children services in the period September 2015 to August 2016. No incidents had been classified as safeguarding incidents. 218 were classified as no harm incidents, 20 as low harm, six as moderate harm and one as causing severe harm.
- One serious incident had been reported to STEIS. The incident involved the resuscitation of a new born baby.
- There were no never events reported between September 2015 and August 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Within the neonatal unit, some junior doctors reported that they felt anxious about reporting incidents or near misses. They told us they were not supported through the reporting and investigation process and would feel blamed and punished when an incident involving them was investigated.
- During the unannounced visit to the service we reviewed further 35 patient records, six serious incident decision templates, (these are documents that support the process of deciding whether an incident should be categorised as a serious incident and therefore have a root cause analysis investigation completed) and three root cause analysis reports. Of the six serious incident decision templates, four were correctly completed and escalated as required. One was incomplete and it was unclear what the final decision was regarding escalation. One serious incident decision template had three versions recorded by different individuals. None of these staff had fully completed the template. The staff using the templates failed to identify adequately whether this was a wholly unpreventable event or whether there may have been contributory factors with the medical care. The incident identified may have required escalation to a root cause analysis.
- We found that out of the patient's notes we reviewed, 26 patients had been transferred out of the neonatal unit since July 2015. Of the 26, 14 did not require an electronic report about their transfer because the transfer out was an expected event. Two were correctly reported, as the transfer was an unexpected event. Six did not have an electronic report and should have done, and four were reported on the mother's record. Within the nursing staff, there was a strong desire to continue to develop a culture of learning through review and reflection of incidents and near misses.
- From November 2014, NHS providers were required to apply the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and

requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Some nursing and medical staff we spoke with knew what this meant and how to apply it. However, we found one senior nurse and one junior nurse who did not know what this meant.

- There was a trust policy called: "Being open". This policy provided guidance for staff to ensure that all processes and procedures were recorded and reported correctly and patients were communicated with openly and in a timely fashion, about their care and treatment.
- Learning from incidents was shared through staff information boards, newsletters, individual supervision and reflection, and governance meetings where information was forwarded to service leaders and consultants.
- Nursing and medical staff attended monthly morbidity and mortality reviews and service governance meetings where incidents and near misses were reviewed. However, we were told by some doctors that they had not received minutes from the divisional morbidity and mortality meetings after they had been held. This meant that if a person was absent from the meetings lessons learned were not shared fully.
- A newsletter was distributed quarterly by email from the paediatric service matron informing all staff about safety incidents that had occurred within children's services and lessons learned.
- Nursing staff shared learning in a variety of ways, which included discussion at handover, during team meetings or ad-hoc conversations. The team also used a communication book which shared key information. Staff were expected to read the communication book and sign as proof of reading. Notice boards had lessons learned and key practice points displayed.
- During inspection, the service commenced a safety round on the neonatal unit. This had been planned previously. The safety round was used to discuss any incidents that had happened overnight, decide what action to take and any lessons that could be learned.
- Daily safety meetings took place on Starfish ward in which the clinical team discussed incidents that had been reported over the previous 24 hours and worked together to resolve any incidents. These meetings were recorded by a risk governance administrator. Action points were produced for individuals. Senior nurses told us of medicine errors which had been reported and appropriate measures and training had taken place to help prevent future similar errors.

Safety thermometer

- On Starfish ward and Safari ward there was no safety thermometer in use. The NHS children and young people's safety thermometer was designed to measure local improvement over time. It is a way of recording and monitoring risks to patient safety, to inform and improve practice and performance and therefore reduce the risk to patients.
- We did not see evidence of monitoring of incidence of intravenous line infection or monitoring of venous thromboembolism (VTE or blood clots) assessment. This meant that we were not sure how well these assessments were being carried out. However, we did see audit results of monitoring of paediatric early warning scores. From November 2015 to July 2016, there had been monthly audits of the use of the paediatric early warning scores. Of the notes audited 98% had a full set of observations of the child's pulse, respirations and temperature, completed twice a day. The remaining information gathered was inconsistent over the period. This means that we could not tell if the information was useful to the service.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and mostly clutter free with cleaning schedules in place. We saw that these were up to date and completed in each clinical area.
- Staff followed the "arms bare below the elbow" policy. We observed staff regularly cleaning their hands with gel or washing their hands as required, according to trust policy.
- Hand hygiene, environmental cleanliness, documentation, and compliance with patients wearing identification and allergy warning bracelets were audited. The data produced was used to highlight areas for improvement. Audits carried out from December 2015 to May 2016 showed 100% compliance in hand hygiene on the neonatal unit, Safari ward, Starfish ward and the children's emergency department. However, one audit showed that there personal protective equipment was used 85% of the time in the neonatal unit.

- Across all areas there was a rate of 96% compliance with hygiene policy for high impact procedures.
- There were no reported cases of Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile for children's and young people's services between July 2015 and June 2016.
- On the trust's website and on notice boards in the children's department there was information for parents about good hygiene practices.
- There was a trust wide infection prevention and control lead. We saw that there was divisional and departmental link nurses with responsibility for infection control and prevention. All staff undertook mandatory training in infection control and prevention. All staff we spoke with knew who their infection control link nurse was and how to contact them.
- All areas we visited had designated housekeeping staff. On Safari and Starfish wards there was a system in place for ensuring that ward areas and bed spaces were kept clean. All the bed spaces we saw had been prepared, cleaned and checked for the next patient.
- There was appropriate and sufficient personal protective equipment available, such as gloves and aprons.
- On entering each area, we were asked by staff to use hand gel, and by a recorded message in Starfish ward, as well as by visual signs.
- All machinery and equipment we saw was labelled with a date and signature when it had been cleaned confirming it was safe to use.
- On Starfish ward, where children might be isolated for prevention of cross infection, there was preparation room between the ward and the room. However, on the neonatal unit the isolation rooms did not have a preparation room.
- When a child had been transferred from another hospital or if a child was at risk of carrying MRSA, they were isolated until they were proven to be free from MRSA infection.

Environment and equipment

- On Starfish ward there was a playroom and adolescent room. There was a parents' room where carers could relax, store food or make a hot drink. There was a small milk kitchen and a general ward kitchen for the preparation of food for the patients. There were clean and dirty utility rooms. There was a room specifically for treating a child in an emergency where appropriate equipment was stored.
- High locks were in place on the doors to the clinical rooms as well as the main kitchen and the parents' kitchen to prevent children from gaining entry.
- All areas where children were treated as inpatients were secured with entry systems and video surveillance. There were clear signs instructing staff and visitors not to "tailgate" through the doorways. To exit either Starfish Ward, Safari Ward or the neonatal unit, it was possible to open a door and leave without being challenged by staff. On one occasion, a student nurse held a door open for us without challenging who we were, before we entered the area immediately before Starfish ward. This meant that there was a risk that a child could be removed from the ward without permission from staff or parents.
- In the observation bay in the children's emergency department (CED), we saw an area which was prone to flooding with sewage. This had at times led to contamination and closure of the area. This was an item on the trust's risk register. The staff in the department had repeatedly raised the issue. However, we did not see that the trust estates department had a plan in place to address the problem. This could have had a significant impact on the health of staff and patients and the capacity to care for patients in the CED.
- There was adequate and appropriate equipment for delivery of treatments to patients. This included machines to monitor blood pressure, equipment to deliver intravenous medicines and equipment for the care of the complex needs of babies in the neonatal unit.
- Resuscitation equipment throughout the children's wards were mostly checked daily and adequately stocked for emergencies. They included all the appropriate equipment for resuscitation of children including defibrillators. We found one resuscitation trolley which had had one daily check missed within the four weeks prior to our visit.
- All equipment used for treating children that we saw was labelled to state that it had been electrically tested to make sure it was safe to use. A maintenance programme was in place for all equipment used within the service.

- Bins for the disposal of sharp items and needles were labelled correctly, however we found three boxes on Starfish Ward that had not been signed or dated when assembled. We raised this with the nurse in charge who immediately rectified the issue.
- Powdered milk available for babies' feeds was stored in large containers in an unsecure milk kitchen. The containers could have been used by multiple people. There was a risk that the powdered milk could be contaminated due to the unsecure method of containment and storage. We raised this with the nurse in charge who noted our concerns and told us that she would investigate further in order to find a solution to minimise this risk. When we returned to complete an unannounced visit three weeks later, the same nurse told us that the powdered milk was now stored in a locked cupboard to which only staff had access.
- The ward housekeeper safely stored all substances hazardous to health in the cleaning store. This was in line with Control of Substances Hazardous to Health Regulations 2002.
- Clinical waste was segregated and disposed of safely.
- We were told that the neonatal unit had recently been refurbished, which included painting the walls and replacement of the plumbing system due to water contamination. The new plumbing had reduced the risk of infection by contaminated water. However, the refurbishment that the service had requested which included redesigning of the entire space to aid with safe staffing, had not taken place. The floor area of the neonatal unit, especially where the sickest babies were treated was very limited. It did not meet the criteria of the British Association of Perinatal Medicine's (BAPM) 2004 service specification on designing a neonatal unit, nor the more recent document Health Building Note 09-03 2013 from the Department of Health – Neonatal Units. This document recommends the layout and minimum specifications for each baby's incubator or cot. In particular access to the incubator or cot in an emergency. This meant that due to limited bed space, if there was a clinical emergency, doctors or nurses may have had difficulty easily accessing the patient. There was also insufficient space to accommodate a parent on a chair by the cot side or in a hospital bed if required.
- In the neonatal unit there was no room for computers in the intensive care area, therefore staff were unable to see or enter information easily as they were unable to leave their patients alone.
- On Starfish ward, there were four small rooms for babies in cots. There was a fold out bed available for parents to use when staying in hospital overnight. These rooms did not provide enough space for the required staff to be able to treat a patient in an emergency. However, there was a large, well equipped resuscitation room in Starfish Ward, to which a patient could be quickly taken if necessary. This was also used for storage of some portable equipment which could have impeded access to emergency equipment if needed.
- A multi-point electrical extension unit was on the floor of the resuscitation room. This was connected to the electricity supply. We raised this concern with the nurse in charge who took immediate action to rectify the issue.
- A dedicated children's outpatient department was a child friendly area where other members of the multidisciplinary team such as dietitians and physiotherapists reviewed and treated children.
- The main outpatients department saw children in some adult clinics, particularly in sub surgical specialities such as dermatology, ear nose and throat (ENT) and orthopaedics. The children's waiting area was an area absorbed into the general outpatients waiting area. This was an unsecured, open seating area with seating similar to the rest of the department with three toys available.
- We tracked a patient through their surgery from the ward and back. We saw the operating theatres where children had surgery and the recovery area. The journey to the operating theatres from the children's wards included going down in a lift, which was shared to move waste, to an underground utility corridor. This corridor had been painted in attractive murals. However, there were doors left open to expose storage and waste disposal areas. There was also evidence of water leaks running down the walls. There was no temperature control in this corridor. This corridor presented a safety risk to children.
- In the operating department there was no specialist paediatric theatre or recovery area. Children were treated within the same clinical areas as adults. There was limited segregation and screening throughout the patient's stay in the operating department. The environment had not been designed to consider the needs of children. The area that had been screened in recovery to treat children was cluttered and used for

storage of equipment. This means that when a child awoke from an anaesthetic they were not in a child friendly environment and were at risk of hearing distressing scenes.
- On Starfish ward there was a well-equipped, bright and attractive playroom for younger children. There was also an adolescent's room that had age appropriate murals on the walls, games consoles and books. All children were able to access the trust wide Wi-Fi network so that they could use social media.

Medicines

- A named nurse cared for each patient on each shift. The nurse was responsible for administering prescribed medication to their allocated patients.
- On discharge, the nurse would organise any medication that the patient needed to take home. It could take several hours for a patient to receive the medication they needed to take home. Whilst the nurses were able to arrange the prescriptions, we were told that often there would be delays receiving the medicines from pharmacy. We were told that on the day prior to our inspection a patient had to wait eight hours for their medication.
- A named pharmacist for the children's service worked Monday to Friday with the ward staff. Out of hours provision was by the on call pharmacist.
- Drugs and medicines were mostly stored safely and securely in locked cupboards. We found some intravenous fluids used on the neonatal unit were not stored carefully by segregating different strengths of fluids. We alerted a senior nurse who rectified this.
- A system was introduced by the children's services on Starfish ward in June 2016 called a "druggle". This was a weekly safety meeting concerning drugs and medicines. The most recent meeting included reminders about safe prescribing based on age or weight, depending on the medication. The druggle included the ward pharmacist, doctors and nurses with the aim of reducing medicine errors and continuous learning.
- We looked at prescription records of 17 patients and saw that the methods of prescribing and administering medicines to children were safe and recorded on the medicine administration chart. Patient information was clearly documented, including any allergies and the patient's weight.
- Temperature sensitive medicines were stored appropriately and fridge temperatures were monitored and recorded daily. A process was in place to ensure that medicines would be safely disposed if a fridge temperature was found to be out of the safe range for storing medicines.
- Controlled drugs were stored correctly and appropriate and accurate records were kept.
- Antibiotics were prescribed and administered according to the trust's policy on use of antimicrobials.

Records

- Records were clear, accurate and legible. We looked at the medical and nursing records of 17 patients across all inpatient areas including Starfish and Safari wards and the neonatal unit. During our unannounced visit, three weeks later, we looked at a further 35 records.
- Some notes made by medical staff had gaps between entries. This meant that additional entries could have been made later. When reviewing neonatal records, we saw that doctors had sometimes used the term, "written retrospectively" up to 12 hours after an event.
- Records were stored securely on the wards in locked cabinets with security code locks.
- Nursing assessments were made on admission to hospital and care given was recorded, mostly in a timely manner. The assessments were designed based on evidence and guidelines from the Royal College of Nursing Standards for assessing, measuring and monitoring vital signs in infants, children and young people 2013.
- The safeguarding team were able to access the computerised community records of children in their care. Nurses, responsible for safeguarding were able to see if a child was subject to a child protection plan. The system gave safeguarding staff 24 hour access to safeguarding information about the children and young people in their care. The record detailed some GP visits and interactions with health visitors, occupational therapists, children's community nursing, speech and language therapists and physiotherapists.

Safeguarding

- There was a clear structure in place for safeguarding children responsibilities within the trust. The trust safeguarding policies reflected relevant legislation and local requirements for safeguarding children and young people that all staff we spoke with were aware of. All staff we spoke with knew who the safeguarding children link nurse was and how to contact them if necessary.

- A team of safeguarding nurses within the hospital and local safeguarding link nurses for all areas were responsible for identifying children subject to a safeguarding plan. These children would then be alerted to the ward staff. The children would have an identifying symbol on the ward board and on their records.
- One senior nurse told us about a child with complex social problems who was well known by the ward staff. The nurse described how the ward staff worked together with the safeguarding team and family to protect he child.
- There was 90% compliance rate in level 1 safeguarding training, a 100% compliance rate in level 2 safeguarding training and a 99% compliance rate amongst staff in the children's service trained to level 3 in safeguarding. The Intercollegiate Document (March 2014) states that: "Any clinician who is responsible for planning or assessing the needs of children who may be vulnerable or at risk of harm, require level 3 safeguarding training." This included clinicians whether a doctor, nurse, or allied health professional. Therefore, level 3 safeguarding training is the expected level for people caring for and assessing the needs of children and young people.
- In safeguarding adults training, there was an 88% compliance rate in level 1 and a 94% compliance rate in level 2 against a trust target of 90%.
- Staff in working in both the paediatric and neonatal departments were issued with a safeguarding passport booklet that was completed with all safeguarding training and supervision sessions that they had attended. The passport also contained relevant information about female genital mutilation and child sexual exploitation. It also explained how to make referrals. This was a valuable record and supported staff with their personal revalidation.
- There was an overall compliance rate of 96% with safeguarding supervision within the service of all staff trained in levels 1 to level 4 of safeguarding.

Mandatory training

- A structured corporate induction programme was in place for permanent staff when they started at the trust. This included the following; adult basic life support; conflict resolution; equality and diversity; fire evacuation for clinical staff; fire evacuation for non-clinical staff; hand hygiene; health and safety; infection control; information governance; non-patient moving handling and patient moving handling.
- In the children's service 70.7% of nursing and midwifery staff were up to date with this training and 84.8% of medical and dental staff. This was against a trust target of 90%.
- Training in the use of the sepsis proforma (a method of screening, identifying and treating suspected blood infections promptly) had been introduced and emphasised through a range of training and presentations since October 2015 following a serious incident. The service did not provide us with the uptake rate of sepsis training.

Assessing and responding to patient risk

- Comprehensive assessments were completed by nursing and medical staff when assessing a patient's suitability for treatment. Patients were assessed in terms of their health, care and individual needs on admission to Starfish ward and in a pre-admission appointment to Safari ward.
- Risks were assessed on an individual basis. This included health, nutrition and hydration, mental health, special educational and disability needs.
- If an individual risk was identified, a plan of care was put in place, risks mitigated and actions taken to provide whatever additional support may be required. For example, if a child or young person's mental health posed a risk to themselves or anyone else, a registered nurse (mental health) would be arranged to support the child and the staff in caring for them. Or if a child's nutritional status was at risk a referral would be made to a dietitian.
- Paediatric early warning scores (PEWS) were used to detect any changes in a patient's condition and recognise if they were deteriorating. These were adapted for use in the paediatric wards and the neonatal unit. The "test your care" team audited compliance with the use of the PEWS scores from January to July 2016 on Starfish ward and found that 100% of patients had PEWS scores completed. We found that in most cases observations were completed accurately and legibly with evidence that patients were appropriately escalated to either the nurse in charge or a doctor, which ever was indicated. However, from January to May 2016, only 50% of children who needed

their care to be escalated to a doctor or senior nurse had been. Also in January 2016 33% of children who needed to have their scores rechecked within 30 minutes had been. This meant that although the ward used the PEWS charts with all patients, when the score indicated escalation it was not always carried out as required in line with trust policy.

- There were assessments carried out for children at higher risk of developing a venous thromboembolism (VTE). This is where a blood clot can move around the body with a potentially fatal effect. There was also a nursing assessment prior to the admission of patient's undergoing ear nose and throat surgery that took into account specific risks for this type of surgery.
- On the wards we saw that the service used a pre-operative checklist for all children undergoing surgery incorporating recommendations from world health organisation and the National Institute of Health and Care Excellence (NICE). In the records we saw the checklist was used in preparation for surgery at ward level.
- Staff working in the outpatient department told us that there was not a member of staff trained in paediatric advanced life support. However, we were told within children's services as a whole, there is always at least one member of nursing staff on duty who held the advanced paediatric life support (APLS) qualification and cover was provided from the children's emergency department when required. Staff rotas we saw confirmed this.
- A seriously ill child who required transfer to another hospital would be cared for by suitably qualified staff until transport could be arranged. This was provided by the special transfer service that operated throughout a network of local hospitals. This included critically ill children and neonates. While awaiting transport, there was a service level agreement which ensured arrangements to care for the patient were in place.
- A policy was in place detailing measures to be taken if a child went missing from a ward. This was available on the intranet.

Nursing staffing

- Nursing staffing levels across the service were appropriate to deliver safe care to patients. We were provided with data that showed that over the period from February 2016 to May 2016 there was a 90% fill rate of planned versus actual staff. There was always a band 7 senior sister, on duty in all areas. However, we were told that some band 6 junior sisters were being trained to be able to take responsibility for a shift.
- Matrons used the escalation policy for guidance when staffing levels were insufficient for the patients' needs. They would follow this policy if the service needed to be closed to admissions.
- Senior nurses told us that nurse staffing levels were benchmarked against the Royal College of Nursing (RCN) Children's Nursing recommendations. With nurse to patient ratios as; one nurse to two patients for high dependency patients (HDU), one nurse for three patients for children under two years and one nurse for four patients over two years old.
- Senior nurses monitored staffing levels daily in line with trust policy. Staff were used flexibly to achieve this. For example, if the ward was full with the HDU beds occupied, the ward would work with other areas such as paediatric outpatients to move staff to the areas where they were most needed.
- In the neonatal unit, the British Association of Perinatal Medicine (BAPM) 2003 guidance, and East of England Network guidance recommendations were followed for nursing staffing levels. These guidelines provided specific guidance for staffing of a neonatal unit.
- In all areas, from February to May 2016 there was an average of 80% of qualified staff to 20% unregistered staff which is higher than trust planned 70% qualified staff to 30% unregistered staff ratio.
- On Starfish ward we saw that there were no nursing vacancies. Whilst there was a full complement of staff, there were times when bank or agency staff were required to fill gaps in staffing due to sickness or holidays. The children's service used an in house bank staff provider whenever possible. Agency staff were used when required using agencies known to the trust.
- On the neonatal unit we were told that there were five whole time equivalent (WTE) junior registered nurse vacancies. There were also 2.5 WTE senior nurses posts vacant and an advanced neonatal practitioner post vacant. The service was preparing for an open day to attract more nurses to the speciality. We were told that a business case had been prepared to increase the numbers of neonatal nurses. We were not provided with

the information of what the numbers were being increased from or to. The service also had actively recruited nurses from overseas who were due to commence in the service in 2017.

- On Safari ward there were 1.7 WTE posts vacant, one WTE equivalent was on a secondment to the diabetes team and was due to return in January 2017. The 0.7 WTE post had been recruited to and was due to start in November 2016.
- An average of 2.5 WTE posts were provided by agency staff across the service from April to August 2016.
- A patient with acute mental health needs had recently had their admission delayed because there was no appropriately trained member of staff available to care for them. However, as soon as a specialist nurse was allocated, the patient was admitted.
- There had been one occasion since January 2016 that the neonatal unit had been closed to admissions. The unit had to seek support from another local neonatal unit as there were insufficient levels of suitably trained nurses available.
- Nursing staff handed over twice a day. Nurses were allocated patients with whom they would care for though out their shift.
- We observed a handover on the neonatal unit from the night to day shift between consultants and junior doctors. This was well structured, using an electronic board which was updated with actions to be completed in real time. We also observed a board round on Starfish ward with both medical and nursing staff present. This was thorough and used the situation, background, assessment and recommendations (SBAR) model to ensure all patients' details were handed over.
- On Starfish wards there were two allocated high dependency beds that were staffed in accordance with the RCN and 2015 Paediatric Intensives Care Standards.
- A policy for induction of bank and agency staff was in place. However, we were unable to speak with any agency staff during our visit to see whether the service complied with this.

Medical staffing

- Consultant grade staff made up 35% of medical staff versus the England average of 39%. There were 3% middle career staff (senior registrars) versus the England average of 7%. Doctors in training posts made up 54% of medical staff versus the England average of 47%. This meant that there was a higher number of the most junior doctors compared to other England trusts and consultants had to supervise higher numbers of junior doctors than average.
- Five of the paediatricians had a special interest in neonatology. These were doctors who treat very young babies. There were eight more paediatricians in post, all with areas of special interests such as oncology, neurology including epilepsy, allergies, constipation, respiratory disorders, diabetes, nephrology (kidney disease) and gastroenterology. There were also three paediatric doctors employed in the children's emergency department.
- There was not a specialist paediatric anaesthetist; however, we were told that all anaesthetists were trained in basic paediatric anaesthesia. Higher paediatric training competencies were offered to registrar level trainees on an individual basis. Evidence of competence was provided by the deanery in order that that the hospital were assured a satisfactory assessment of these skills had taken place.
- The paediatric consultants had an on call rota. A consultant was on call for four days of the week, Tuesday to Friday. Saturday, Sunday and Monday were divided between 10 paediatric consultants. These consultants would cover Starfish ward and Safari ward.
- Both the consultant and junior doctor's rotas were compliant with European working time directives. On the wards and neonatal unit there was consultant cover from 8.30am to 8pm. At night there was a consultant on call during the week. At weekends consultants worked from 8.30am until 2pm and were on call from 2pm until 8.30am the next day. When a consultant was on call, they may not have been present in the hospital but were contactable by telephone.
- The children's doctors were mostly general paediatricians with special interests in particular conditions. Paediatricians who were not on call and who had a particular special interest would not necessarily have been available for immediate telephone advice for acute problems in their specialty. However, there was a dedicated neonatal and general paediatric consultant rota, with immediate availability to return to the hospital. This meant that two consultant paediatricians were available quickly. In addition, there was frequent informal contact between consultants who

made themselves available even when not on call. For emergencies that required expertise outside the service, there was the ability to communicate with multiple specialist tertiary (secondary referral) services.
- In the children's emergency department, there was a different schedule for summer and winter, in order that the usual increase in winter respiratory viruses could be dealt with effectively. In summer, there was medical cover during the day from 10am until 7pm Monday to Friday and an emergency department consultant on call from 7pm to 10am. In the winter there was a consultant in the department from 10am to 10pm with consultant cover provided by the general paediatricians who were on call and available by telephone overnight and at weekends.
- Medical staff rotas demonstrated that junior doctors were covering all in patient areas 24 hours a day seven a days a week.
- From May 2015 to April 2016 the average overall use of locum paediatricians was 10%. Following a recruitment programme, from February 2016 no locums were required and none were used in February, March and April 2016.
- Senior paediatricians told us that cover was provided by the team when a colleague was either off or on leave.
- There were at least two handovers in 24 hours from consultant to consultant. This was done at the beginning and end of the working day. There was a third board round done on Safari ward at 4pm to report any changes. A board round was carried out with the consultant and their teams. On the neonatal unit a handover was done in a seminar room with an electronic board, followed by a bedside round.
- Children were admitted to hospital via children's emergency department which also functioned as a Paediatric Assessment Unit (PAU). The GP could refer them to the department; they could attend directly with their parents or carers, or arrive by ambulance. There was no separate PAU. All of these patients were subject to the national four hour wait emergency department target. However, this was not audited and therefore the department could not confirm that all children were seen within the target time by a middle grade doctor. In addition, although the service told us that most children were seen by a consultant paediatrician within 14 hours of admission, they were unable to verify this as the information was not audited.

Major incident awareness and training

- The trust had a major incident plan, which was located on the intranet. Nursing staff demonstrated that they were able to access this. None of the nurses we spoke with told us that they had been involved in a major incident exercise, or had undergone major incident training.
- Service leaders told us that there was a plan being progressed to develop the number of high dependency beds on Starfish ward from two to four. This was partly in response to winter pressures which include included an increase in bronchiolitis. (An acute lung condition in babies and young children).

Are services for children and young people effective?

Good

Overall we rated the service as good for effective because;

- Assessment, care and treatment were mostly based on up to date evidence and guidelines and were recorded accordingly.
- The service contributed to national audit programmes and compared their own data with national data to drive improvement.
- Practice development nurses supported on going learning and professional development amongst all nursing staff.
- The readmission rate was lower than the national average.
- Staff had access to community information systems.
- An effective pain relief tool in place.
- The service worked with other multidisciplinary services to cater for patients with special and complex needs. This included collaborative working with community teams and mental health services.
- Transition from children's to adult services was managed well.
- In patients and the children's emergency department had access to seven day diagnostic services.

However we also found that:

- Some guidelines were due to be reviewed and updated.
- The information technology and computer system was out dated which caused staff difficulties accessing

information, patient records and results. There were too few terminals for staff in some areas and access was very limited in the intensive care area of the neonatal unit.
- Not all nursing staff had up to date appraisals completed.
- Staff did not routinely ask parents to share their parent held records with them.

Evidence-based care and treatment

- Patients had their needs assessed and their care planned and delivered in line with evidence based guidance, standards and best practice.
- Policies and procedures were based on appropriate guidelines form the National Institute of Health and Care Excellence (NICE), the British Association of Perinatal Medicine BAPM as well as the Royal College of Paediatric and Child Health (RCPCH). However, some were out of date and overdue for review. We reviewed seven guidelines in total, three were out of date. These were Neonatal Hypo 8 that was due for revision in 2016, no month was specified. However, this was awaiting the outcome of a clinical trial and department of health recommendations prior to revision. The postnatal care guideline, which was a joint guideline with maternity, was due for revision in 2015. The guideline for correction of metabolic acidosis was due for revision in October 2015. There were written policies available in the neonatal unit for staff to follow. All staff in all areas were able to access the electronic system that held the service and trust wide policies.
- On line links were available for all National Institute for Health and Care Excellence (NICE) guidelines.
- A work plan for 2016 for the diabetes service was in place. This showed that guidelines had been reviewed and updated in August 2016. This was in line with new East of England Network (EEN) guidelines on newly diagnosed patients and the care of young children and people with diabetic ketoacidosis. There was an annual review of local policy in line with EEN guidelines around support for children in education. Furthermore, there were additional annual review clinics planned for assessment of psychological need, dietetic assessment and screening of children and young people with diabetes.
- An internal audit programme was led by a consultant and mostly carried out by junior doctors. This included a regional audit of high dependency units (HDU), acute management of childhood wheeze in the children's emergency department, prospective hypothermia audit, documentation audit (neonates resuscitation), paediatric outpatient quality improvement plan audit, an audit on CT scans of the head and subsequent MRI of the head in the children's emergency department (CED).
- The service had signed up to various accreditation schemes. For example, the trust had registered their intent to work toward accreditation in the UNICEF baby friendly scheme, in order to improve breastfeeding rates in women. One senior nurse told us the women and children's service was being supported with this by the local community trust that had already achieved "baby friendly" status.
- The service was also committed to "Sign up to Safety" a national patient safety campaign launched by the Secretary of State for Health in June 2014. It aimed to make the NHS the safest healthcare system in the world by creating a health system devoted to continuous learning and improvement. As a response to this we saw that there was a "SAFE" project within the service. This aimed to raise awareness of the key messages that were highlighted during regular safety audits.
- Data was contributed to national audits including; Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries, National Paediatric Diabetes Audit and the National Neonatal Audit programme (NNAP). This means that the service can compare its outcomes with those of similar services across the country.
- Data taken from recording blood specimens taken from babies was better than average. The England average for completing and recording of blood specimens was 85% the neonatal unit was 97%. No babies had an infection from a central line (this is a tube inserted into a central vein, rather than a vein in a limb). Following a baby's admission to the neonatal unit, 90% of parents were consulted by a paediatrician within 24 hours. This was above the national average, where 88% of parents had the first consultation within 24 hours of admission.
- Prior to October 2015 there had been no sepsis screening for children and young people. A proforma and accompanying stickers were introduced to ensure screening took place. Following introduction, four audits had taken place, which showed increasing compliance with sepsis screening and modifications to the tools used. In addition there were action plans to

increase compliance. At the time of the inspection, 90% of children and young people who had one or more triggers which may have indicated they had sepsis, were being screened.

Pain relief

- Pain was assessed and managed appropriately in all patients with whom we spoke.
- A paediatric pain assessment tool was in place which helped staff to assess the level of pain and provide the appropriate pain relief required. Following an incident regarding monitoring pain in patients, steps were taken to revise the way pain was monitored, assessed and treated across the service. Pain charts were completed and we saw that children received pain relief promptly.
- We observed a nurse assessing a distressed child who was too young to tell staff about any pain or discomfort. The nurse discussed the child with senior colleagues and requested a pain relief prescription from a doctor. The medication was administered immediately.
- Play therapists were available to support in distracting patients from any pain they may be experiencing.
- There was a trust pain team which provide support and advice to the children and young people's service upon request. There was not a dedicated children's pain team.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed either in their pre-admission assessment or on admission to the ward using the individual assessment tool. Meals suitable for children were provided and drinks of water were available.
- Special diets for both medical and religious needs were provided on request.
- Nursing records we saw showed if clinically required, patient's food and fluid intake was measured and monitored.
- A paediatric dietitian service was available for assessing the needs of children who required special diets and those who had complex medical conditions.
- Specialist milks were available for very young children and babies. Specialist feeds were provided by the dietitian service and pharmacy if required.

Patient outcomes

- Data was collected to help to monitor the performance and outcomes of treatments.
- There were 5754 patient spells spent in hospital from March 2015 to March 2016. This was in line with the England average. A spell is a single period or stay in hospital; this may be one day or more. A second admission with the same condition or a different condition is considered another spell.
- Amongst patients with asthma, 16.8% were admitted more than twice within a 12 month period. This was similar to the England national average of 16.2%.
- Over a 12 month period from January to December 2015, patients with epilepsy had a readmission rate nearly twice the national average. Readmissions were at 50% of patients were against an England average of 29%. However, the numbers involved were very low. Up to September 2016, this had improved, admission rates were lower and the trust was not considered to be an outlier when compared to similar trusts. One senior leader told us that the epilepsy service was preparing a business case to request an epilepsy nurse specialist. This nurse would support patients with epilepsy in the community, to prevent multiple hospital admissions. There was a forward plan for the service that described recruitment of a part time epilepsy specialist nurse to support the paediatric outpatient epilepsy service. As well as planning to establish a local epilepsy support group led by a parent of a patient.
- Patients with diabetes had outcomes similar to the national average. The trust data showed that 22% of patients had their diabetes well controlled against a national average of 20%. An annual work plan was in place to address the continuing development of the diabetic service for patients. However, there was no named responsible individual for ensuring that specific actions that had been agreed were progressed.
- The rate of patients readmitted within two days of a planned admission was lower than the national average. There were 0.6% patients readmitted to the service compared with a national average of 1%.
- The neonatal unit contributed data to the national neonatal audit programme, which compares data nationally across all participating neonatal units. For example, temperature taken within first hour of birth, doses of antenatal steroids administered to the mothers of premature babies, screening for retinopathy (an eye disorder) and premature babies who developed

brochopulmonary dysplasia. The neonatal unit at Watford scored at least as well as other units nationally and in some indicators better than other units, both locally and nationally.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job. Consultants revalidated their registration in line with the general medical council requirements. We saw that the trust monitored that this was happening.
- The trust was a teaching hospital and therefore the trainee doctors within the service were supported locally and at the university by tutors. Training was overseen by a regional deanery.
- Junior doctors had supervision by a consultant as well as a tutor. Supervision sessions were an opportunity for learning and discussion of practice. Medical staff told us that they participated in teaching sessions, presented cases and led audits in the service.
- Three practice development nurses worked in the service. They were responsible for assessing individual competencies and the development of teaching programmes. Regular agency staff had completed similar training to that completed by the trust's corporate training programmes.
- Agency and bank nurses were required to undertake a local induction in the area they were working. These nurses keep their own record of induction; none were kept at the hospital. We did not speak to any bank or agency staff at Watford General Hospital so we were unable to ascertain if all bank and or agency staff had done this.
- Nurse managers were responsible for carrying out appraisal on nurses. Annual appraisals helped to identify any learning or development needs. From April 2015 to March 2016 64% of nursing staff had received an up to date appraisal. The trust provided us with updated information after our recent inspection that showed that they were on track to meet the target for 2016/2017.
- Each level of nurse was supervised and mentored by a more experienced professional. A specialist matron supervised the neonatal unit. Another matron managed the children's wards, the children's emergency department and outpatients. The human resources department supported managers who were managing poorly performing staff. Clear plans were in place for supervision and learning as required.
- Dedicated practice development nurses who had strong links with universities supported nurses with their individual learning plans. They also developed learning requirement plans for the service. This helped make sure that staff were up to date with their clinical skills and had support in their professional development. Also the service had the appropriate level of skills required available.
- Staff had training available to them on the sepsis 6 pathway. This is a treatment pathway for identifying and treating a patient with sepsis with anti-microbials and fluids at the earliest possible opportunity. Extra training needs were identified after a serious incident in the hospital.
- Three nurses were trained in either European paediatric life support or advanced paediatric life support. (EPLS/ APLS)
- All staff were trained in paediatric basic life support and paediatric immediate life support (PILS) as in line with trust mandatory training requirements and national guidance.
- Throughout the service, there was always at least one member of nursing staff on duty who held the APLS qualification. Cover was provided from the children's emergency department (CED) to the wards and children's outpatients as required. In addition, consultants in the department had APLS training.

Multidisciplinary working

- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering patients' care and treatment.
- Three medical hand overs took place each day at the ward status board on Starfish ward; these were at 8.30am 4pm and 8.30pm. They were attended by the doctors and the nurse in charge. Nursing staff handed over at 7am and 7pm.
- Paediatric physiotherapists and occupational therapists were available during the week to provide services to patients on the wards. There was an on call reduced provision at the weekends.
- Play therapists were closely involved with the patients using the service. However, there were not enough play specialist hours to cover the service at all times. This was listed as a risk on the trusts risk register. It stated that there were insufficient funds to support additional play therapist hours.

Services for children and young people

- An art therapy student was attached to the service. We were told that this was the first placement of its kind nationwide.
- A close working relationship existed with the local mental health trust to support children with mental health needs.
- Liaison psychiatry was practiced as defined by the Royal College of Psychiatrists. This was a monthly joint clinical and psychiatric clinic. It was held so that children with conditions such as chronic fatigue could be reviewed and managed.
- A monthly multidisciplinary meeting took place with colleagues from education, health support and psychiatry to discuss children with complex mental health needs requiring a multidisciplinary approach. This was a unique service offered by the children's and young people service in Watford. When patients needed more than one specialist service or consultant, their care was coordinated on an individual basis with consultants and other multidisciplinary team members liaising as required.
- Other children with a diagnosis requiring input from mental health were seen and initially assessed by the community children's assessment team (CCAT) on the ward or in the children's emergency department and were then managed by the local child and adolescent mental health service (CAMHS) within Hertfordshire.
- There was no policy for transition of children and young people to adult services. However, senior leaders of the service told us that when a patient moved between the children's and adult services the process was discussed up to two years before the transition was made. There was liaison with the relevant specialities as required. Leaders told us that transition services for children were well established in specialities such as diabetes, cystic fibrosis, neurology and rheumatology. A new consultant had started to lead on gastroenterology and was developing a pathway of care for children requiring transition into adult services.
- A dedicated paediatric pharmacist was available during normal working hours. Pharmacy needs were covered by the on call pharmacist out of hours.
- Several safeguarding ward rounds took place. These included a psychosocial ward round every Friday. This was a multi-agency meeting attended by hospital staff, child and adolescent mental health services and the crisis assessment and treatment team.
- The special care baby unit (SCBU), part of the neonatal unit, completed psychosocial ward rounds every Tuesday. This was a multi-disciplinary meeting attended by SCBU staff and the safeguarding team. Patients on the unit were discussed, with plans and actions clearly defined.
- The children's emergency department had a child protection meeting every Wednesday. This multi-disciplinary meeting reviewed all referrals made to children services the preceding week. The review process ensured that all referrals were dealt with appropriately, with information shared effectively to protect children.
- The consultant responsible for the care of a patient was identified on the ward status board so that all staff could clearly see who was responsible for the patients' care. However, in the neonatal unit there was no notice above cots to detail who had overall responsibility for that patient's care.
- When a child was discharged from the hospital, a letter was sent to the patient's GP providing details of any completed or ongoing treatment required and of future appointments.

Seven-day services

- There was seven day access to diagnostic services such as x-ray, ultrasound, computerised tomography, magnetic resonance imaging, echocardiography, endoscopy and pathology.
- In patients had access to on call physiotherapists at weekends.
- Mental health services were available at weekends.
- The out of hours on call service for pharmacy was provided by the pharmacy service, not necessarily a specialist paediatric pharmacist.

Access to information

- Information needed to deliver effective care and treatment was available most of the time to relevant staff in a timely and accessible way. This included care and risk assessments, care plans, case notes and test results.
- Technology and equipment was used throughout the service to help to enhance the delivery of effective care and treatment.

- Information technology problems and failures could limit access to information. The trust was aware of this problem and there were plans in place to provide an updated system.
- When patients moved between teams and services, including at referral, discharge, transfer and transition, all the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols.
- The service did not routinely ask parents or carers of patients for their Personal Child Health Record, referred to as red books, and included recognised growth charts. Parents/guardians were not required or encouraged to bring these books to each hospital appointment or admission, but the service relied on parents and carers to produce these books. They could be used to keep a personal record of hospital admissions, which could be shared with the multidisciplinary team, for example health visitors and GPs.
- GPs were able to contact the specialist registrar on call 24 hour a day seven days a week through the switchboard bleeps system. GPs could discuss patients who may have required access to the service.
- There was access to the trust wide computer system. The safeguarding team also had use of a community based information system. The use of information technology helped the clinical team access patient's information across different services, as well as view x-rays and tests results.
- The community information system was able to provide up to date and multidisciplinary records between hospital and community services. This allowed the safeguarding team to make full assessments of children who may have been at risk, as well as liaise with health and social care professionals as required.
- If a patient was to be seen by the community children team (CCN), the parents were given the CCN office phone number so that they could make direct contact should they need to, following discharge.

Consent

- The service did not provide beds for young people between the ages of 16 and 18 years. However, the trust treated 16-18 year old in the adult wards and departments.
- There was a comprehensive consent to treatment policy which described how young people (under the age of 16) might be deemed as being Gillick competent to consent to treatment. This meant that children who have sufficient understanding and intelligence to enable them to understand fully what was involved in a proposed intervention would have the capacity to consent to that intervention. The consent to treatment policy also included guidance on the procedure to take if parents were not thought capable of providing consent on behalf of their child.
- Senior staff we spoke with understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.
- Staff knew how to make 'best interests' decisions in accordance with legislation.
- Staff knew how to work with social services about ensuring any court orders were complied with in regards to who had authority to consent on behalf of a child.
- Senior staff understood the difference between lawful and unlawful restraint practices.
- Junior staff we spoke with had not received any training theoretical or practical regarding what was lawful and unlawful restraint.

Are services for children and young people caring?

Outstanding ☆

We rated services for children and young people outstanding for caring because:

- Feedback from patients and their families was continually positive about the way staff treated them. Staff consistently provided care that was kind and compassionate and respected patients' privacy and dignity.
- There was a strong, person-centred culture that recognised patients as individuals and respected their preferences and needs. Staff worked in partnership with children and their families and encouraged involvement in their care.
- Relationships between staff, patients and relatives were strong, caring and supportive. Staff regularly went above and beyond for the children and young people who used their services and valued their emotional wellbeing.

- Patients and their families were empowered to have a voice and their views were reflected in how the care was delivered.

Compassionate care

- All staff understood and respected the cultural, social and religious needs of the patients they cared for. Throughout our inspection, we observed positive interactions between staff, patients and parents. In all of the areas we visited staff were kind, courteous and respectful to children and their families.
- Patients' privacy and dignity was respected; staff closed curtains around patients when delivering personal care and side rooms were available to meet the needs of patients requiring isolation or additional privacy.
- We observed staff responding quickly and compassionately to patients who called for assistance.
- Staff used distraction techniques and 'bravery gifts' to promote compliance with treatment and minimise distress to patients.
- Play specialists worked on Starfish and Safari wards from 7:30am to 5:30pm, to ensure patients were not left unsupervised for prolonged periods when they did not have a parent or carer visiting. We did not observe any patients unsupervised for longer than 10 minutes.
- During the inspection, we spoke with 10 relatives and five patients in the department. All spoke positively about their care, stating that their wishes had been respected and they were well informed about treatment. All parents and carers we spoke with felt confident leaving their child in the department.
- Inpatient services for children regularly scored above the England average in the NHS Friends and Family Test. The NHS Friends and Family Test asked people if they would recommend hospital services. In August 2016, 100% of respondents said they would recommend Starfish ward and the neonatal unit, compared to the national average of 95%. However, response rates were variable from January to August 2016, particularly on Starfish ward where they received below the England average response rate of around 25%. Staff acknowledged the response rate was low and were actively encouraging patients and families to leave feedback. Staff also utilised other methods of collecting feedback about the services.
- The Picker survey is a national inpatient survey which measures people's experience with care. In this survey the service was rated at better than average for involving parents in discussing a plan for a child's care.
- Starfish and Safari wards had 'How did we do?' boards where children could write their own feedback. At the time of inspection, all comments were positive and praised the care they received.
- 'You said we did' boards were seen throughout the service that showed evidence of actions taken as a result of feedback. For example, feedback from patients in the children's outpatients department included that there was not enough for older children to do while they waited. As a result, books aimed at young people aged 10 and over had been added to the waiting area and staff were organising the donation of a television from a local company. Another example of this was that carers and parents wanted to have hot drinks by the bedside of their children in hospital. The nursing team had been able to work with parents to find a safe way of this happening by providing disposable cups with lids for hot drinks.
- Staff on Starfish ward regularly gave up their own time and went the 'extra mile' for patients. They were regularly fundraising at weekends and included patients and parents in the events. For example, staff had made a starfish costume that they wore outside the local football stadium to collect donations, one weekend of every month.

Understanding and involvement of patients and those close to them

- Parents and patients were actively involved in care and treatment and their views were considered when planning care. This was evident throughout all departments. Older children were given the opportunity to speak to clinicians without their parent present.
- Play specialists involved children when planning daily activities and had a range of age appropriate options. Activities were set up in the playroom and adolescent room or individual activities could be taken to the bedside if patients wished.
- We saw examples of staff involving children in their care and using play as part of their treatment. This included physiotherapists using blowing bubbles and 'bubble football' as part of chest physiotherapy to improve patients' lung function.

- Patients we spoke with on Starfish and Safari wards were well informed about their care and could explain what was happening. For example, one child could describe their treatment plan in detail and knew what was scheduled for the following few days.
- Play specialists had created a series of books to explain care and treatment in ways that children could understand. Different books were used depending on the age and maturity of the patient. For example, for younger children they had created a range of books including 'Ted goes to hospital' and 'Ted has a scan' that showed photographs of a teddy bear going through each stage of treatment. Play specialists used this and the teddy bear to explain to children what was happening.
- Doctors and nurses worked together with play specialists to minimise distress to patients. We saw evidence of medical and nursing staff pretending to give a blood transfusion to a patient's favourite soft toy to help the patient understand and ease their anxiety.
- Parents and carers were able to escort their children to and from theatre. Those we spoke with said that this had given them comfort.
- Parents of children who had been admitted to Starfish ward could volunteer as part of the 'Carer Support Team' that provided emotional and practical support to families on the ward.
- Staff provided parents with essential toiletries when their child was admitted unexpectedly. The toiletries were bought using charitable donations.
- Parents had the opportunity to speak to multidisciplinary teams and were kept updated throughout their child's treatment. For example, parents told us that a surgeon and anaesthetist had come to tell them what had happened during their child's surgery. Parents also told us that staff on Starfish ward would call them at night to update them on how their child was doing.
- There were examples of staff contacting the hospital's interpreter service to communicate with parents whose first language was not English. For example, staff arranged a telephone interpreter for a mother whose baby was receiving treatment, to ensure that she fully understood what was happening.
- Neonatal services had a Parents Forum where relatives could ask questions, raise concerns or discuss areas for improvement with staff.
- We saw minutes from meetings between staff from the children's department at Watford General Hospital and the children's department at the local mental health trust. The minutes included any issues, feedback and actions to improve care for children with mental health needs. For example, Watford General Hospital was identifying a member of staff to act as 'Champion' for children's mental health care who would be given additional training for the role.

Emotional support

- Staff throughout the department understood the need for emotional support for patients and their families. We spoke with children and their relatives who all felt that staff cared for their emotional wellbeing.
- On Starfish ward there was a group of volunteers called the 'Carer Support Team', who worked from Monday to Friday supporting relatives. Volunteers spent time talking with families on the ward and offered assistance, such as making coffee and playing with children so parents could rest. At the beginning of each volunteer's shift, nurses highlighted families that they thought were in particular need of emotional support.
- Parents we spoke with said that they had been encouraged to contact external agencies for further support outside of the hospital.
- Doctors and nurses would highlight patients who they thought might need additional emotional support from the play specialists. Children and young people could also be referred to the play specialists from the outpatients and emergency departments.
- We saw evidence of staff organising entertainers, storytellers and pantomimes for children on Starfish ward. If a patient or family were going through a difficult time, staff would contact charities to refer patients for 'wish granting', to attend charity-led parties or to see if there was anything else available. For example, play therapists told us about a patient who had received theatre tickets after staff had contacted a charity to say the patient was going through a difficult time.
- Starfish ward had been chosen to launch the new 'Captain Starlight' campaign in the UK. Captain Starlight was a campaign focused on reducing anxiety and lifting the spirits of children and young people in hospital. Patients from Starfish ward had been chosen to be the face of this campaign.
- Staff on Starfish ward were familiar with families of patients who had long-term or complex needs and had

built strong, positive relationships with them. We observed staff setting up the environment according to the family and patient's needs, in preparation for planned admissions. This was confirmed by parents we spoke with. For example, one parent told us that her child was often anxious pre-admission; staff had been aware of this and had prepared the child's room with their favourite toys and things they liked. We also saw beds and bed spaces being adjusted in preparation for the family of a patient with complex needs.

- Play therapists had created individual 'sensory stories' for patients with complex needs. They used items, such as fans to create a wind effect and patches of artificial grass for the patient to feel, while telling them stories. Parents and families were also included in the experience. It was evident that play therapists were enthusiastic about their work and often brought things from home to include in the sensory stories.
- Children and young people who were experiencing mental or emotional distress had access to a child psychologist. There was information for parents on what to expect; this had been developed in collaboration with the Children and Adolescent Mental Health Services (CAMHS) at the hospital.
- There was specialist training for caring for children with mental health conditions for staff in the children and young people's service. This had been developed with input from CAMHS. Parents with babies on the neonatal unit were provided with information about "Bliss", an organisation to support parents of children born prematurely.
- Starfish ward had a 'Bereavement box' for families who suffered a loss. This contained trinket boxes that play specialists had decorated for families to keep a lock of their child's hair and a kit for taking hand and footprints. The box also contained guidance for staff when caring for bereaved families. The guidance included information on a wide variety of religions and beliefs.
- Staff referred patients with life-limiting conditions for additional support at the local hospice that provided services for children and young people.
- Staff could contact the hospital chaplaincy to support parents and relatives of a child who had received bad news and there was multi-faith support available.

Are services for children and young people responsive?

Good

Overall we rated the service as good for responsive because:

- There have been no closures to admissions during April 2016 to August 2016.
- The neonatal unit was monitored continuously for capacity and had good communication with the neonatal network and the maternity unit.
- There were joint working arrangements between the hospital and mental health services which benefitted young people with a mental health problem.
- The children's oncology service provided prompt and individualised care to its patients.

However we also found that :

- There was not a dedicated operating theatre or recovery area that was for the sole care of children and young people. Although we were told there were plans to remodel the operating department to provide this.
- There were high levels of outpatient appointments cancelled, particularly in cardiology, diabetes and general paediatrics.
- Not all complaints, particularly verbal, were documented or reported on the trust's reporting system.
- Written complaints were mostly managed to completion including lessons learned and actions documented.
- Food and drinks provided catered for individual needs.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services are planned and delivered. For example, data collected about increasing demand for services was used to produce business plans to increase staff or clinic numbers. This was seen in the delivery of an increased number of transitional cots based in the postnatal ward. In addition, there were plans to employ another paediatric oncologist to support the service.
- There were plans to develop specialist paediatric services including a paediatric gynaecology service, which was being offered by the adult gynaecologists. Plans were also seen regarding developments in other specialist services such as diabetes and epilepsy.

Services for children and young people

- The local community trust was responsible for children's community services. A liaison health visitor provided a link between children treated at the hospital and community practitioners such as GPs and health visitors.
- A local community nursing service was provided by the community health trust. The community nurses liaised when required with the service to ensure continuity of care of children who may need on going treatment leaving hospital and returning home.
- Services were being developed to reflect the growing demand in the local area. Patients with planned care needs were mostly treated within the 18 week limit. Patients were able to discuss admission dates with the service which provided some flexibility.
- Consultants had sub specialities and often there was just one consultant with specific knowledge to provide care, this limited patient choice. However, this meant that a patient would be seen by the same consultant or registrar at most outpatient appointments.
- A link nurse worked as part of the cystic fibrosis/ respiratory team within the outpatient environment participating in multidisciplinary clinics.
- Links between the hospital and the community staff were robust and if a patient required on going care in the community it was easily arranged.
- In the children's outpatient department, work was being done to manage room occupancy to maximise room availability. This would help provide a greater number of clinics.
- We saw no evidence of a plan to develop the space required for the neonatal unit in line with criteria of the British Association of Perinatal Medicine's (BAPM) 2004 service specification on designing a neonatal unit, or the more recent document Health Building Note 09-03 2013 from the Department of Health – Neonatal Units.

Meeting peoples individual needs

- Accessible facilities were available for patients with disabilities.
- Patients with complex needs such as learning disabilities were cared for on both Starfish and Safari wards. There were play therapists and paediatric nurses available to support with those needs as required.
- Individual rooms were available to be used for children who may require a quieter environment due to individual special needs.
- Patients and their families who were vulnerable and may have found it difficult to access services, were identified on an individual basis by the multidisciplinary team members. The community nursing service supported individuals to access the service as required.
- If a patient required palliative care or end of life care this would be arranged according to the family and patient's wishes. The service worked closely with a local hospice. The community nurses would be available to provide care and there was an end of life team within the hospital all of whom could be involved if required in end of life care of a patient. There was not a dedicated end of life care nurse specifically for children.
- If the patient was a looked after child, this was flagged in the patients notes and by a symbol on the ward status board. Safeguarding nurses would be alerted and all staff would be aware of ensuring that patients were kept safe and visited in accordance with any court orders.
- If referrals were required for any specialist services outside of the acute setting, a referral was made to the specific team needed. Whenever a discharge planning meeting was needed a representative from each stakeholder would attend to ensure all aspects of care required have been suitably discussed and explored.
- Patients' parents and carers were provided with information in written and verbal form at the time of discharge with relevant instructions for use of medication and future appointments. A range of patient information leaflets was made available to them. Languages covered were English, Urdu and Polish. Additional languages could be downloaded as required. Information regarding medications was printed and there were other leaflets provided by the pharmacy team. The parent room had a variety of leaflets on external support agencies that patients and their carers could contact.
- Translation services were available for patients who did not have English as a first language. Translators could be used for face to face translation, translation of documents and for British sign language for patients who had a needed it. The services were available through the patient advice and liaison service (PALS) during normal office hours and could be contacted directly, by staff, out of office hours.
- A meal service was provided centrally, at set points during the day. Meals were brought to the ward and kept hot with a steam system.

- Breast feeding mothers were provided with three meals a day.

Access and flow

- In the period from April 2016 to August 2016 there was a 22% occupancy rate on Safari Ward and a 60% occupancy rate on Starfish Ward. There had been no closures to admissions during that period.
- The transitional care cots were based on the postnatal ward within the maternity department. Transitional care cots are for generally well babies who may need more support than usual before going home. At times, this service is expanded into the general postnatal ward if more cots were required. This was reflected in the transitional care occupancy rates of 120%.
- The neonatal service was part of the regional neonatal network. There were daily monitoring systems within the network to continually assess where cots were available and what level of care was available.
- The neonatal unit was closed on one occasion between October 2015 and September 2016. Following this closure there has been a robust escalation algorithm created that allowed the service to recognise surges in activity and respond appropriately.
- As a district general hospital the service provided consultant led care for children locally for the most common diseases and illnesses. These include diabetes, respiratory, cardiac, kidney and bowel problems. There was a level two oncology service for children. If a patient required more specialist support, there were agreements with other tertiary units.
- There were daily routine operating lists for children and young people in the hospital. We were told that the operating department would communicate with the ward regarding specific times that children would have their operations. This means that they would not be starved longer than necessary. However, there was not a dedicated operating theatre or recovery area for children. There were plans in development for a remodelling of the operating department.
- We were told that children with a mental health illness who required treatment for a physical problem were able to have access to a mental health professional 24 hours a day, seven days a week. If a child needed a specialist mental health nurse to care for them this was arranged through the local mental health services or an agency. There had recently been increased joint working between the services for children and young people at Watford general hospital and the child and adolescence's mental health services that were based on the site.
- In the six months from March 2016 to August 2016 an average of 16% of outpatients appointments for the service were cancelled each month. Cardiology had an average monthly cancellation rate of 25%, dermatology 11%, diabetic medicine 19%, haematology 1%, cystic fibrosis 8%, paediatric endocrinology 12%, epilepsy 27%, ophthalmology 15%, urology 13%, general paediatrics 19%. This means that on average 502 appointments were cancelled each month.
- There were 21 operations cancelled between March and August 2016 for patients aged 16 or under. Although we asked whether the operations were for clinical or non-clinical reasons, this information was not supplied to us.
- Patients have the legal right to start non-emergency NHS consultant led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer. Waiting times from referral to treatment within the service and across all specialities for children and young people, in the period from April to August 2016 were on average within the 18 week period 97% of the time.
- Patients for planned admissions would be referred to the service by their GP or by the children's emergency department (CED) to the most suitable consultant who would see the patient by appointment in the outpatients department. If an admission were then necessary, it would be scheduled for either Safari ward or Starfish ward. Planned patients would have an initial assessment appointment prior to full admission. This appointment would take place on Safari ward. This area was open to the general ward area. Basic information about general health and some measurements were taken at this appointment. There was no privacy in the pre admissions area for a patient or their carers who may have required it.
- Unplanned admissions were seen in the CED by a paediatric doctor. From there they would be transferred if necessary, to Starfish ward or the neonatal unit if less that one month old.
- A children's observation bay in the children's emergency department was used to observe and care for patients if they were assessed as likely to recover enough to return home. If they were to be admitted to the ward, the aim

of the service would be to admit them as soon as possible. We were told that the service did not audit the data around time taken to admit a child to the ward following arrival in paediatric assessment unit, so we were unable to verify the target time or compliance with it.

- If a critically ill child needed to be cared for when there were delays in transportation to a tertiary centre, the patient would be prioritised and the relevant team of doctors, anaesthetists and nurses would be available to support the patient whist waiting.
- Patients who required planned surgery would be seen by a general paediatric surgeon or in certain specialities by a general specialist surgeon who treated both adults and children. For example in orthopaedics. These patients would be seen in a general outpatients department rather than the paediatric outpatients department. These patients would also be reviewed as required on the ward prior to discharge. However, we were told by staff that children could often wait for long periods for specialist doctors, who were not paediatricians to see them on the wards.
- Patients who had suspected cancer had a maximum two week wait for assessment by a paediatric oncologist. From the assessment appointment arrangements would immediately be made for onwards referral to a specialist cancer centre for children and young people.
- If a patient needed urgent or next day care, either they were referred by their GP or could self-refer to the children's emergency department for assessment by a paediatrician. A registrar was always on call to speak to GPs assessing children in the community. If required that registrar would be able to contact the consultant for further advice.
- A discharge summery was given to the parents and another was sent to the GP within 24 hours of discharge.

Learning from complaints and concerns

- There was an information pack available that patients and their carers received on admission about how to raise concerns or a complaint. In addition, there were leaflets in the parents' room and in the paediatric outpatients department. We spoke with parents who told us that they felt able to speak to someone if they were unhappy with the care they had received.
- Complaints were dealt with both informally and formally. This means that a nurse or doctor would resolve low level complaints verbally and as they happened without any recording. If required complaints were dealt with through a formal complaints procedure via the patient advice and liaison service (PALS). There had been 10 formal complaints about the service in the period from September 2015 to August 2016. None of the complaints had been escalated to the health service ombudsman. Of the 10 complaints we reviewed had all been promptly investigated in a timely way. Patients and their carers were involved in the process, if they said they wanted to be, and apologies given in a timely way. Of the 10 complaints, three were yet to be finalised and closed. Two closed complaints had no lessons learned or actions documented.
- There was a leaflet available on Starfish ward that was given to all patients and their families to complete following their stay. However, this was produced for a confident reader with an advanced vocabulary. We did not see a feedback form specifically designed for children. There were 'How did we do?' boards where children could write their own feedback.
- We spoke with senior nurses about the complaints process. We were told that what the staff called "official" complaints were all logged and recorded correctly on the electronic recording system. Informal, verbal complaints dealt with locally would not at all times be recorded. This meant that the service might not be able to recognise themes of complaints which could have been logged and categorised.

Are services for children and young people well-led?

Requires improvement

Overall we found the service required improvement for well led because:

- The leadership of the service identified risks to the service which were not on the service risk register at the time of our visit.
- Some of the governance meetings such as the morbidity and mortality meetings were often cancelled and minutes were not always efficiently circulated.
- The divisional director had multiple managerial and clinical functions with limited local support in the clinical functions.

- There were significant challenges within the culture on the neonatal unit. Consultants were not working well together despite a shared vision.
- There was an inconsistent reporting culture and some junior doctors felt fearful of speaking out.
- Not all staff knew what duty of candour meant.

However we also found that:

- There were clear values, a clear vision and a formal strategy for the service to develop specialty services for children.
- There was a clear governance structure throughout the service.
- There was an internal audit programme aimed at improving patient care, treatment and outcomes. Audit and data were used to inform practice and change within the service.
- Leaders were committed to the development of the service.
- Nursing leaders were committed to their priority of providing safe and excellent care for all their patients. They were highly visible and approachable.
- Staff mostly felt appreciated, supported and valued by service leaders.
- Innovation and service development were monitored and controlled using business cases incorporating benefits to service users as well as cost.
- Staff were actively engaged in professional development.
- Nursing staff felt able to be open and honest and were supported when mistakes were made.
- Efforts were made by the service to engage patients and carers in feedback and forums about the development of the service.
- Outstanding staff were actively sought out for acknowledgement at board level.

Leadership of service

- The divisional director of the service was an experienced paediatrician who had been in post since July 2016. Their responsibilities included maternity, gynaecology and all the paediatric services, including the neonatal services. These were multiple clinical functions and there was lack of support in these at a local level. The capacity of the divisional director to manage the clinical functions without support was recorded on the risk register for the trust and categorised as unsustainable. A case was being developed to expand this service to provide further consultant and nursing support. The divisional director also had responsibility for the management and development of the women and children's services. Some functions, for example, in governance and safeguarding were undertaken by consultant colleagues as well as the clinical director for children's services and the clinical lead for neonatal services. We saw that the divisional director had been through a robust recruitment process.
- The clinical director for children's services was an experienced paediatrician, responsible for the medical care of patients within the children's and young people's services.
- There was a clinical lead for neonates, a paediatrician with a special interest in neonates.
- The head of nursing in children's services had overall responsibility for the nursing services provided within the service. There was a matron for children's services, who was responsible for Starfish and Safari wards, the children's outpatient department and the children's emergency department. There was also a matron for neonates. Both matrons had relevant expertise and experience for the roles to which they were appointed and were committed to providing safe and excellent care for all their patients.
- Job plans are documents which define each consultant's role and responsibilities and how they should allocate their time between their responsibilities. Job plans for each consultant had recently been completed so that each could complete clinical work and administration as well as be on call to cover any unexpected admissions.
- The paediatrics and neonatal services had been split into two sub specialities within the last year.
- Staff told us that the matrons were fully engaged with all their staff at all levels.
- The matrons were highly visible and if required, were able to provide hands on care to patients and support their carers. They were well known to all the staff we spoke with and very well respected.
- Service leaders told us that their main concern was the relationships between the consultants on the neonatal unit. This was confirmed by some junior doctors who told us that they felt conflicting opinions, different styles of management and changes of patient care plans could have a detrimental impact on patient outcomes.
- From November 2014, NHS providers were required to apply the Duty of Candour Regulation 20 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Some staff knew what duty of candour was when we spoke with them. However, one senior nurse and two junior nurses were not able to tell us what that meant. The trust plan for training in duty of candour was on a selective basis, for staff who may be involved in investigating, or reporting on an incident. The responsibility for service training was held by the serious incident team within each service.

Vision and strategy for this service

- The service had a strategic vision to further develop specialty services for children including rheumatology, epilepsy, gastroenterology, diabetes, endocrinology and allergy. In addition, there were plans to offer more children's outpatient services locally including general paediatrics, long term conditions and outreach for children with complex needs.
- The service strategy for the next three years from April 2017 – March 2020 was to:
  - Develop transitional care for babies with extra care needs.
  - Enhance level 2 neonatal care, to reduce the need for babies to transfer out to level 3 units.
  - Enhance support to bereaved families.
  - Review paediatric surgery, whether it met best practice standards and identify whether any surgery would better be provided by a more specialist provider.
  - Develop transitional services.
  - Provide adolescent gynaecology services.
  - Improve the sustainability of the paediatric oncology shared care unit (POSCU).
- One senior leader within the neonatal service told us that the service strategy had been written by the medical director and director of transformation. Consultants with sub specialities such as oncology, endocrinology and neurology and senior nursing staff from Starfish ward told us that they were contributing to the plans for developing the service.
- Senior leaders told us that because the intensive care unit occupancy was 30%, the strategy was to deliver improvements in maintaining nursing skills and to address the nursing shortage on the neonatal unit. Therefore to stay open to admissions. Also, that it was important to be able to care for babies that were being cared for in higher level units sooner. This was to be achieved by working with the network of neonatal units.
- Senior medical and nursing staff we spoke with were aware of the strategy and vision for the service. Through continuous monitoring of services, audit and training they were supporting the development of the service. Most of the senior staff and the leadership team we spoke with told us about submission of business plans to support the development of services such as additional specialist staff, equipment and facilities.
- Senior nurses told us that there was a vision to enhance high dependency provision on Starfish ward; these nurses were involved in developing this part of the service.
- Junior nurses we spoke with were unaware of the service vision or strategy.

Governance, risk management and quality measurement

- There was a non-executive director with responsibility for independent, impartial advice on strategy, performance and risk within children services.
- There was trust wide governance and safety structure in place. This included a named governance and risk lead for the children's service and a named governance lead for neonatal services. Their responsibilities included management of risk, audit, incidents, education, training and continuing professional development, evidence based care and effectiveness, patient and carer experience and involvement, and staffing and its management.
- There was a range of governance meetings arranged across the service. Which included:
  - A divisional quality and safety meeting which was held monthly. This included representatives from all of the women's and children's services as well as infection prevention and control. Items such as complaints, risk (such as environmental factors or staffing issues) and serious incidents were discussed. One senior leader told us there was a real time National Neonatal Audit Programme (NNAP) dashboard presented to the quality and safety meeting. The overall aims of the audit were to assess

whether babies requiring specialist neonatal care receive consistent, high quality care across England and Wales. Also to identify areas for improvement in relation to service delivery and the outcomes of care.

- The monthly paediatric clinical governance meeting was attended by the paediatric and neonatal consultants, nurses, trainee doctors and medical students. The meeting reported on incident trends, the NNAP data and provided updates on serious incidents. Discussions included clinical care. We were told that minutes of the meeting were circulated to all senior nurses and consultants and were sent to all trainees regardless of whether they attended. We saw minutes of six of these meetings that mostly followed the agenda described.
- The perinatal morbidity and mortality meeting was planned to be held monthly. This was a forum to discuss trends in illness and deaths in pregnancy and young babies. The information from this meeting was also presented at the quality and safety meetings. However, we were told that this meeting did not always happen. For example, meetings were not held in March, May or June 2016. We were told that the minutes of this meeting were circulated to all senior nurses, consultants and trainees regardless of whether they attended. However, some junior doctors told us that they had not seen the minutes of this meeting.

- We saw from meeting minutes that systems were in place to identify risks locally and then to report them through the appropriate line manager. The risk would then be discussed at the quality and safety group and then uploaded on to the risk register once agreed.
- There was a process for identifying, recording and managing risks, issues and mitigating actions. These were recorded on a divisional risk register. There were 11 risks that were on the register that were related to environmental hazards in the children's emergency department. Of the risks identified, all had had controls in place to minimise risks to patients. If necessary, divisional risks were escalated to the trust board for management. If required business cases were being developed to present to the board for further resources.
- Service leaders told us their main concern was about divisions between staff in the neonatal unit; however this was not on the risk register at the time of our visit.
- There was a leaflet available to all staff about the individual responsibility they had in risk management and reporting of any perceived risks and incidents.
- There was a service level audit schedule. One senior doctor told us that audits had been successfully used to monitor and positively influence developments. For example, there had been an audit into resuscitation readiness. This had resulted in in house simulations to support training for all staff. In addition, pre warming of the resusitaire (the area in which a baby would be resuscitated if necessary) was implemented. An additional audit was carried out into the time line with regards to deciding whether a baby should be actively cooled to prevent brain damage. The audit showed that the decision to cool babies was made for 31% of babies within the East of England recommended target time of 6 hours. This means that the decision to cool was not made within 6 hours for 69% of babies. Due to the delay to decide to commence cooling, a business case had been prepared for the purchase of a cot to provide active cooling on the neonatal unit. This was to be presented to the trust in December 2016.
- Data was collected on a range of safety and performance measures and used both at a local level and to feed into wider regional, network and national audit. For example through the national neonatal audit programme and the Children's Cancer Networks.

Culture within the service

- Most nursing and medical staff we spoke with felt respected and valued. On Starfish ward in particular all nursing staff we spoke with were very happy at work and "loved their job". All the nursing staff on the neonatal unit told us that they felt very supported and appreciated by the nursing leadership, matron and sisters. The staff on the transitional care ward, based on the postnatal ward told us that they enjoyed working there and that all their working relationships were good. The senior sisters and matrons in the general paediatric wards had an "open door policy" which meant that any member of staff could approach them at any time with concerns or worries.
- The culture within the nursing staff and on Starfish and Safari wards encouraged openness, honesty and candour. We were given examples of how, that after errors were made, staff felt able to approach their seniors and report the incidents and therefore receive supportive training and skills development.

- Some junior doctors throughout the service told us that they felt uncomfortable speaking out and reporting incidents for fear of blame or punishment.
- On the general paediatric wards, all the nursing and medical staff told us that they worked well together as a team and supported one another. All staff on Starfish ward told us morale was high that the managers were all approachable and visible.
- On Safari ward, some junior staff told us they did not feel supported by all the staff. The matron was aware of the difficulties in this area and had a plan in place to support the staff.
- We saw that nearly all medical and nursing staff delivered care and treatment with the patient being at the centre.
- The culture, particularly on the neonatal unit, had some significant challenges. We were told by nurses, consultants and junior doctors that there was a significant division of staff within the unit which some felt may have an impact on patient care. The service had commissioned an external thematic review of the unit to investigate and report on the culture and offer recommendations.

Public and staff engagement

- Developing local engagement was mentioned in the diabetes strategy as a part of the 2016 plan. There were significant attempts on Starfish ward to engage service users and their carers to provide feedback and suggestions for the way services were delivered. However, despite a senior sister taking an active lead to encourage responses there was still a low response rate to requests for feedback.
- Children and young people were involved in the development of the adolescents' room on Starfish ward. Parents were listened to and cups with lids were provided so that hot drinks could be taken to the bedside.
- There was a patient feedback form on Starfish ward, which was aimed at parents as it used sophisticated language which a young child would not be able to understand. We did not see a child friendly feedback form. However, children were encouraged to use post it notes on a "did we sink or swim?" board to provide feedback of their care.

Innovation, improvement and sustainability

- Service leaders were responsible for making business cases to apply for funding for developments. This meant that they would need to demonstrate how an application for funding would be used to generate income, as well as improve the service. Business cases included, cooling equipment for the neonatal unit, nursing posts to support the children's oncology and epilepsy service and development of the high dependency unit in Starfish ward.
- The clinical lead in the children's emergency department had developed the situational awareness for everyone "SAFE" project, to include the "druggle" a way of sharing information and learning around prescribing and administering medication safely.
- There were regular opportunities within the trust to nominate colleagues for good practice, innovation or care. There were mentions in the newsletter of achievements of staff on Starfish ward. There was a monthly award for outstanding members of staff presented from board level.

End of life care

Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

West Hertfordshire Hospitals NHS Trust provides end of life care to patients with progressive life-limiting conditions including cancer, advanced organ failure, such as heart and renal failure and neurological conditions.

The hospital reported 1279 in-hospital deaths from 1 March 2015 to 29 February 2016.

There are no dedicated wards for the provision of end of life care at Watford Hospital. This is delivered on most wards in the trust.

The hospital reported that from April 2015 to March 2016, its specialist palliative care team (SPCT) saw 781 patients. 53% of all patients seen, had cancer.

The SPCT supports patients, giving advice on symptoms such as pain control, sickness, and poor appetite. The team also offers emotional and psychological support, and helps families and carers in all settings. There are 4.3 whole time equivalent (WTE) clinical nurse specialists (CNS) in palliative care, based at Watford hospital. The service has three consultants who provide 0.8 WTE. The SPCT nursing team provided a Monday to Sunday 9am to 5pm face to face palliative care service at Watford Hospital. One CNS was on duty at Watford General Hospital on Saturday and Sunday to see inpatients with complex needs and any urgent new referrals.

The trust employs two chaplains who provide chaplaincy support to the trust 63 hours a week (1.18 WTE) who, with the support of approximately 40 volunteers, cover all Christian denominations. The chaplaincy team has access to contacts in the community for support for other religions. In addition to the chaplaincy team, the bereavement office provides support to relatives after a loved one's death.

There are five full-time mortuary staff, one mortuary manager, one deputy manager and three trainees Anatomical Pathology Technologists (ATP). The mortuary is staffed by the APT's from 8am to 4pm. Out of these hours the mortuary could be accessed via the senior operational team. The viewing area and access for relatives was open seven days a week.

During our inspection, we spoke with two patients and two relatives. We also spoke with 39 members of staff, including the palliative care team, mortuary staff, chaplaincy, nursing, medical staff, a resuscitation officer, a porter, an operations manager and patient affairs staff. We observed care and treatment, and looked at care records and 36 do not attempt cardio-pulmonary resuscitation (DNACPR) forms. We visited wards across the hospital, the mortuary, the chapel/the multi-faith room. We received comments from people who use the service and we reviewed the trust's performance data.

End of life care

Summary of findings

We rated end of life care services as good for safe, caring, responsive and well led and requires improvement for effective. We found that:

- Staff within the end of life care service understood their responsibilities for ensuring patients were protected from the risk of harm. The service had systems in place to recognise and minimise patient risk. There was evidence that learning from incidents had been implemented within the service.
- The trust had safety precautions and systems in place to prevent and protect patients and staff from a healthcare-associated infection. Trust infection control guidelines were up to date and reflected national guidance.
- There were sufficient SPCT CNS at Watford hospital. The staffing levels were above National Institute of Clinical Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.
- The service carried out an audit on preferred place of death for patients known to SPCT. The service used the audit to evaluate the quality of the information collated in the care plan and tailored training needs.
- The trust had a replacement for the Liverpool care pathway called individualised care plans for the dying person (ICPDP). The ICPDP was embedded on all wards across the trust.
- The SPCT provided seven-day face-to-face access to specialist palliative care.
- Patients were supported and treated with dignity and respect.
- Feedback from patients and those close to them was positive about the way staff treated people.
- The service was collecting information on the percentage of patients who died in their preferred location. 82% of patients had died in their preferred place of death.
- There was joint working between the SPCT and the medical teams at the hospital to support non-cancer patients.
- The hospital had leaflets available for example coping with dying and procedures to be undertaken after the death of a patient for relatives or friends. The leaflets were available in a number of different languages and formats.
- A chaplaincy team provided spiritual and pastoral care and religious support for patients, relatives and staff across the trust.
- There had been no complaints about end of life care from July 2015 to July 2016.
- The trust had executive and non-executive board representatives for end of life care that provided representation and accountability for end of life care at board level.
- The trust had a three-year end of life care strategy; the strategy was presented to the trust board in July 2016. The strategy was realistic to achieve the priorities and delivering good quality care.

However:

- Patients did not have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. There was no formal mental capacity assessment of the patient's ability to understand this decision. The DNACPR form did not prompt staff to complete a capacity assessment as part of the decision making process.
- The temperatures of treatment rooms where medicines were stored were consistently above the recommended storage temperature of 25°C and the trust were not following their own policy of reducing the expiry dates of medicines in line with the increased temperatures.
- When medicines were prescribed to patients, who required them to be administered via a syringe pump the prescription did not always include an infusion solution (diluent) either on the prescription or on the administration records.
- There was sufficient consultant in palliative care provision at the trust. The consultant in palliative care staffing levels met the National Institute of Health and Care Excellence (NICE) guidelines,

End of life care

commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.

- Bereaved relatives' views and experiences were gathered through the trust's bereavement questionnaire. The service used these views to shape and improve the end of life care service. However, the response rate was low at 10%.

Are end of life care services safe?

Good

We rated this service as good for safety because:

- The staff within the end of life care service understood their responsibilities for ensuring patients were protected from the risk of harm. The service had systems in place to recognise and minimise patient risk. There was evidence that learning from incidents had been implemented within the service.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) records had been signed and dated by appropriate senior medical staff and there was a clear documented reason for the decision recorded, this included relevant clinical information.
- Care records we reviewed were maintained in line with trust policy.
- Most wards had a palliative care champion who acted as the connection to the SPCT. They had quarterly training sessions that helped them stay up-to-date and competent. The trust expected them to share relevant knowledge, processes and skills with their ward teams.
- Equipment, for example syringe drivers, were visibly clean and fit for purpose.
- The trust had safety precautions and systems in place to prevent and protect patients and staff from a healthcare-associated infection. Trust infection control guidelines were up to date and reflected national guidance.
- There was a triage system for SPCT referrals.
- There were sufficient SPCT CNS at Watford hospital. The staffing levels were above National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.

However:

- When medicines were prescribed to patients, who required them to be administered via a syringe pump

the prescription did not always include an infusion solution (diluent) either on the prescription or on the administration records. This was not in line with trust policy.

- There was insufficient consultant staffing in palliative care provision at the trust. The staffing levels were below the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.

Incidents

- There have been no never events or serious incidents relating to end of life care from July 2015 to July 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- Staff we spoke with understood their responsibilities to raise and record safety incidents, concerns and near misses using the trust's electronic reporting system to collect and report incidents.
- During the inspection, we saw the trust shared information with the SPCT about incidents that had occurred in other services. These incidents were discussed at the weekly multi-disciplinary meeting and we saw evidence in meeting minutes. Staff we spoke with told us when incidents had occurred in the past, they received direct feedback relating to incidents.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. While the SPCT, chaplaincy team and mortuary team had not recorded any incidents, staff we spoke with were aware of their responsibilities and principles with regard to duty of candour regulation. They were aware they would be required to inform the patient or their relatives of the incident, make an apology and explained how the trust should respond to any incidents.
- At the last inspection, we saw that naloxone was prescribed for a patient that had been using long-term opiate prior to their admission, despite a recent alert produced by the trust. The trust informed us that there was no policy in place regarding administration of this medication. Since the last inspection, we saw a policy and guidance on naloxone use had been produced and ratified in February 2016. The policy and guidance was available on the intranet. Naloxone is a medication that blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness

Cleanliness, infection control and hygiene

- The service ensured that after death, the health and safety of everyone that came into contact with the deceased person's body was protected. The trust had safety precautions and systems in place to prevent and protect patients and staff from a healthcare-associated infection. Trust infection control guidelines were up to date, reflected national guidance and were available in the mortuary and on the intranet. There was a standard of practice document for the receipt of bodies (suspected infection) on the intranet and in the mortuary. Staff were able to direct us to policies necessary for their practice. Mortuary staff and porters told us about the procedures they followed and equipment they used, which assured us they were able recognise, assess and manage risks.
- Ward staff we spoke with were aware of the procedures to be taken when performing last offices, in order to minimise infection risks.
- Standards of cleanliness and hygiene were maintained in the mortuary and viewing areas. These areas were visibly clean and well ventilated. The mortuary staff informed us a designated member of staff cleaned all areas. Cleaning schedules for each area were completed routinely and in a timely manner, which provided assurance that the areas were cleaned regularly and within a specified time scale.

- There were sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage in the mortuary.
- SPCT wore clean uniforms we saw staff complied with the WHO Five Moments of Hand Hygiene and the trust's infection prevention and control policies. This included being 'arms bare below the elbow', hand washing before and after every episode of direct contact or care, and correct use of protective personal equipment (PPE) such as disposable gloves and aprons..
- We saw staff in the mortuary area wearing the correct PPE, such as gloves, aprons and over shoe protectors as per trust protocol. We observed PPE to be accessible throughout the department.
- Porters we spoke with said that they were aware of the personal protection equipment (PPE) protocol for the mortuary and said they were able to access the necessary equipment.

Environment and equipment

- Staff told us and we saw syringe pumps, used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner. The trust provided a comprehensive education programme for all nursing staff on the use of the syringe pump. All new nursing staff received training on this equipment as part of their induction. On-going training was provided to maintain competence and confidence in using the equipment. Nurses who used the equipment regularly told us they felt confident and competent in using this equipment. Nursing staff, who did not routinely use this equipment, knew where to gain advice and support to enable them to use the equipment confidently. We saw evidence the syringe pumps were maintained and used in accordance with professional recommendation.
- The Watford site provided cold safe storage for adults, children and babies who had died at Watford General Hospital and had the facility for the family and next of kin to view their deceased relative. The mortuary was equipped to store 59 deceased patients, 54 in fridges and five in long-term storage. Staff told us these facilities were usually sufficient to meet the needs of the hospital and local population. An additional storage facility had been purchased since the last inspection. The trust used this during time of high demand, for example, during bank holidays.
- There were five spaces for bariatric patients; there were specific storage trolleys and large fridges to accommodate them.
- The temperature of the mortuary fridges was checked and recorded twice daily and we saw these were within acceptable limits. The mortuary department had a 24-hour seven-day, service level agreement (SLA) should urgent repair be required. Audible alarms would sound if fridges were not maintaining temperature. The alarm was linked to main reception out of hours, to alert staff that maintenance was required.
- Equipment in the mortuary was maintained. We saw test stickers on equipment which ensured us the equipment maintenance schedule was timely.
- The mortuary viewing area was clean and was suitably decorated with comfortable chairs.
- Some staff we spoke with thought that the trolley used for transporting bodies to the mortuary was in a poor condition and was due for replacement. We found the trolley to be in a poor state of repair. This had been reported to the support services, and a new trolley had been ordered and was due for delivery in October 2016.
- Arrangements for managing clinical waste and specimens kept people safe and were in line with the trust's infection control policies.
- At the last inspection, we saw the palliative care team at Watford General Hospital had an office base away from the main hospital in a separate block. Although this block was only accessed by staff, the walls in the corridor had damp marks and mould present. Plaster had fallen away due to ingress of water. On this inspection, we saw the team had been allocated a new office and the team planned to move to the new office by the end of September 2016.
- Staff told us and we saw patients had access to appropriate equipment, such as pressure relieving mattresses and syringe drivers, to keep them safe and comfortable.

Medicines

- The specialist palliative care nurses worked closely with ward based medical and nursing staff and pharmacy staff to support the prescription of anticipatory medicines. The pharmacy department had a link pharmacist who provided support to the SPCT and reviewed patients with palliative and end of life care needs.

End of life care

- Medicines were readily available to patients requiring treatment for palliative care and they were stored securely but the temperatures of treatment rooms where these medicines were stored were consistently above the recommended storage temperature of 25°C. The trust were not following their own policy of reducing the expiry dates of medicines in line with the increased temperatures. This was raised with the trust at the time of inspection. Immediate actions were taken by the chief pharmacist, deputy chief pharmacist, heads of nursing and the deputy director of governance. The policy for the monitoring of room temperatures where fluids and medications were stored was reviewed and updated and necessary action was taken.
- At the last inspection, we reviewed a medication chart that had naloxone prescribed for a patient who had been on opiates prior to their admission. We reviewed the trust's policy on prescribing naloxone and saw that the patient's prescription was in contradiction with it. We were concerned that this medication chart had been reviewed by a member of the palliative care team and this risk had not been identified. When we highlighted this to staff they told us that an admitting junior doctor had prescribed the naloxone and the palliative care consultant was contacted to advise on correcting the prescription to make sure the patient received the correct medicines. This meant that patients were at risk of receiving unsafe treatment, despite patient safety alert information being issued by the trust. Since the last inspection, the trust told us and we saw a policy and guidance on naloxone use had been produced and ratified in February 2016. The policy and guidance was available on the intranet.
- During the last inspection, we saw that the authorisation form for administration of anticipatory medicines in the community stated that it was a prescription. This did not legally constitute a prescription and therefore could not be used in that format. Staff did not know how the form came into use, or what the process for renewing and for checking forms in use was. This meant that the trust did not have a robust process reviewing system in place. On this inspection, we saw there were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. We saw that anticipatory end of life care medication was appropriately prescribed. Medical staff we spoke with said they felt confident in this practice. However, when medicines were prescribed to people who required them to be administered via a syringe pump (by injection through the skin), the prescription did not always include an infusion solution (diluent) either on the prescription or on the administration records. It is important that the diluent is specified, as some medicines need to be diluted by specific diluents. The trust policy says that the name and volume of the infusion solution (diluent) must be specified.
- Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were not disposed of in line with Home Office advice and the Safer Management of Controlled Drugs: a guide to good practice in secondary care 2007 (Department of Health). Controlled drugs that were not used or partially used were not denatured (rendered irretrievable) at ward level before being placed into pharmaceutical waste containers.
- Controlled drugs that had been brought in by people were not handled in a way to ensure they were safe and secure until they needed them again. Patient's own drugs were not always being checked alongside other CDs every 24 hours. Staff were not always following procedures and there was inadequate controls in place to prevent misuse. This was raised with the trust at the time of inspection. Immediate actions were taken by the chief pharmacist, deputy chief pharmacist, heads of nursing and the deputy director of governance. The policy for the management of patients own CDs was reviewed and necessary actions were taken.

Records

- Medical records were stored in lockable cabinets. The cabinets were locked when we visited the wards, which reduced the risk of people who did not have appropriate authority accessing the notes.
- The care records and individual care plans we looked at were written in line with trust policy. In medical notes for patients approaching the end of their lives, we saw clear descriptions of their conditions and of the rationale behind the decisions to stop active treatment, whilst still supporting the patient and their families.
- We saw staff completed mortuary records following trust protocol that provided an audit trail.
- The do not attempt cardiopulmonary resuscitation forms (DNACPR) forms were stored at the front of the patients' notes. This meant the forms were easy to find.

End of life care

- We saw some improvement in DNACPR documentation since the last inspection. At the last inspection, four (36%) of the eleven DNACPR forms we reviewed were not countersigned by a consultant. On this inspection, we reviewed 36 DNACPR forms across all ward areas. We saw thirty four (94%) were countersigned by senior clinician. Two (6%) that were not countersigned were highlighted to the ward sister and countersigned before the end of the inspection.
- The trust had carried out regular annual audits of DNACPR forms. The audit results from March 2016 showed the rust had looked at 100 forms: 97% had been signed by senior clinician, 78% had patient details completed, 93% were dated. 28% had been discussed with patient. 66% had been discussed with relatives. Following the audit, a training package was designed and provided to all staff.
- On the current inspection, we reviewed 36 forms; we saw an improvement in practice since the trust audit. We found all (100%) forms were dated, signed and had patient details completed. Seventeen (47%) of forms had the summary of communication with patient competed. 67% of forms had the communication with patient's relatives or friends section completed. In all cases, the decision had been discussed with either the patient or the relative.

Safeguarding

- There had been no reported safeguarding concerns relating to patients receiving end of life care from April 2015 to March 2016.
- There was some evidence arrangements were in place to safeguard adults and children from abuse. Staff we spoke with told us they understood their responsibilities and adhered to safeguarding policies and procedures. Staff were able to tell the inspection team what signs of abuse were, and how to locate the trust policy. In addition, staff were able to identify their responsibilities with regard to reporting safeguarding concerns. However not all staff were compliant with safeguarding training. The service did not meet the trust target of 90% for all safeguarding training.
- We found all of the SPCT team, were compliant with their safeguarding children levels 1 and 2 and safeguarding adults level 1 and 2 training. This met the trust target of 90%.
- All the mortuary staff were up to date with their safeguarding adult level 1 and 2 training and safeguarding children level 1 and 2 training.
- We found 100% of the chaplaincy staff were up to date with their safeguarding adult level 1 training. However, 67% chaplaincy staff safeguarding adult level 2 and safeguarding children level 1 and level 2.

Mandatory training

- We saw 100% of the SPCT and chaplaincy team of the mortuary team and were up to date with their mandatory training. Mandatory training included equality and diversity, health and safety, fire safety, moving and handling. The service could be assured most staff had the necessary knowledge in these areas.
- The SPCT provided an awareness training session on end of life care for all staff as part of their induction training.
- At the last inspection, we saw the trust did not provide education for staff on the care of dying patients as part of mandatory training although the service had made this recommendation in its response to the National Care of the Dying Adult (NCADH) in 2013 to 2014. The current quality improvement plan identified the trust needed to develop an e-learning package for DNACPR, MCA and deprivation of liberty standards (DoLS) and roll out via a new mandatory training web-link to relevant staff. Care of the dying patient training was in place as core skills training had been in place since April 2016. The trust had e-learning package available for MCA / DOLS. The service was in the process of recruiting an e-learning programme lead to develop further e -learning including end of life care.

Assessing and responding to patient risk

- We saw evidence of a triage system for SPCT referrals. The SPCT clinical nurse specialists held daily review meetings to discuss new referrals, review their workload and discuss patients seen and allocate new referrals. The team also held weekly multidisciplinary meetings where caseload would be reviewed and allocated appropriately between clinical nurse specialists. During the meeting, the team discussed diagnostic challenges, management options and any other pertinent issues relating to their current patients.

End of life care

- The trust report that 81% of patients referred to the palliative care team were seen within 24 hours in January 2016. We saw 100% patients were seen within 48 hours.
- There was a system in place to monitor patients' risk of clinically deteriorating, including those patients receiving end of life care. The trust used the National Early Warning Score (NEWS) assessment tool for ensuring that deteriorating patients were identified and treated appropriately. The assessment tool scored each patient according to their blood pressure, pulse, respirations and conscious status. It prompted staff to follow clear procedures, should a patient's vital signs fall out of expected parameters.
- We saw that risk assessments, such as moving and handling, risk of falls and tissue viability were effectively completed and filed in patients' notes. We saw actions were documented to take place where risks were identified, for example, a specific mattress requested and a referral to dietitians for a patient with tissue viability issues.
- Intentional rounding was in place on the wards to monitor peoples' needs. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. Care needs such as changes required to medication or the need to commence mouth care was monitored by staff during these checks.

Nursing staffing

- There were sufficient SPCT CNS at Watford hospital. The SPC team consisted of funding for 5.43 whole time equivalent (WTE) clinical nurse specialists (CNS). At the time of the inspection, there were 5.13 WTE CNSs in post and a team leader. The staffing levels were above National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK. The guidance recommends 1.0 WTE hospital specialist palliative care nurse per 250 hospital beds. Watford Hospital has 521 beds, which would require a just over two specialist palliative care nurses.
- The SPCT nursing team provided a Monday to Sunday 9am to 5pm face to face palliative care service at Watford Hospital. One CNS was on duty at Watford General Hospital on Saturday and Sunday to see inpatients with complex needs and any urgent new referrals. This met the recommendation from the NICE guidelines for 'End of life care for adults', which states "Palliative care services should ensure provision to: Visit and assess people approaching the end of life face-to-face in any setting from 9am to 5pm, seven days a week".
- We observed a nursing handover; it was well structured and informative. Handover included a review of all current patients. Care and treatment was assessed and planned and workloads were allocated.
- At the last inspection, staff told us that the palliative care team did not have an effective system in place to cover sickness. On the current inspection, staff told us there were no ongoing issues or concerns. At the time of inspection, the team were not using bank or agency staff.
- There were nominated champions for end of life care on most wards across the trust. These link staff were provided with quarterly training to inform their practice and maintain their skills

Medical staffing

- There was sufficient consultant in palliative care provision at the trust. The trust employed three palliative care consultants who provided 30 hours per week (0.8 WTE) cover. There was palliative consultant cover at Watford Hospital two days a week. The staffing levels were below the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK.
- We did not see any evidence of use of locum staff in the palliative care team at the time of the current inspection.

Other staffing

- The trust employed a resuscitation team that comprised one whole time equivalent (WTE) senior resus officer and three part time resus officers. The team provided

the basic life support and immediate life support training on site. They attended emergency calls within the hospital where resuscitation was likely to be required.

- There were five WTE staff working in the mortuary. A mortuary manager, a deputy manager and three trainee anatomical pathology technologists. This was an improvement of the mortuary staffing at the last inspection where we saw staffing in the mortuary was at 40% of its full staffing capacity, and there were three newly recruited trainees, who could not be left unsupervised. At the recent inspection, we saw all staff had completed necessary training and could be left unsupervised. At the time of the last inspection, we saw the trust was using a high number of locum staff to cover the 60% of shifts, which were not covered by permanently employed staff. At the recent inspection, we saw permanent staff were in place reducing the need for locum staff.
- The trust employed two chaplains who provided chaplaincy support to the trust 63 hours a week (1.18 WTE). The chaplains had the support of approximately 40 chaplaincy volunteers.
- The SPCT had a full time administrator who supported the team.

Major incident awareness and training

- Porters in the trust received training in the use of the fridges and the alarm systems and they followed a procedure to alert mortuary staff if there were storage or other issues relating to the mortuary.
- The trust had a major incident plan in place. There were clear instructions for staff to follow in the event of a fire or other major incident. SPCT and mortuary staff we spoke with were aware of this.
- The mortuary had storage contingency plans. The mortuary had increased their storage capacity by 24 since the last inspection. The additional storage was provided in a stand-alone refrigeration unit, which could be used in time of high demand. There was also additional foldable racking system available on site that could be used to increase storage facilities. The manager told us that the hospital had arrangements with local funeral directors in the case of a major incident if more capacity was required.

Are end of life care services effective?

Requires improvement

We rated this service as requires improvement for effective because:

- Patients did not have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice.
- There was no formal mental capacity assessment of the patient's ability to understand this decision regarding DNACPR
- DNACPR forms did not prompt staff to complete a capacity assessment as part of the decision making process.

However:

- The service carried out an audit on preferred place of death for patients known to SPCT. This showed 82% of patients known to the SPCT had died in their preferred place of death. The service used the audit to evaluate the quality of the information collated in the care plan and tailored training needs.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015. The trust achieved five of the eight organisational key performance Indicators (KPI's). The trust scored better than the England average in two of five of the clinical audit KPIs.
- The service had produced a robust action plan to address the shortfalls and issues raised by the NCDAH 2014-2015. The action plan was monitored and reviewed on a monthly basis.
- The trust had a replacement for the Liverpool care pathway called individualised care plans for the dying person (ICPDP). The ICPDP was embedded on all wards across the trust.
- Standards of practice for the mortuary were based on national guidelines.
- Pain relief medicines were prescribed following the trust formulary, which was in line with NICE CG140 Opioids in Palliative Care.
- The SPCT provided seven-day face-to-face access to specialist palliative care.

End of life care

- The end of life care team at Watford Hospital had arrangements in place for supporting and managing staff. The appraisal rate for SPCT was 100%.

Evidence-based care and treatment

- The SPCT had carried out an audit on preferred place of death for patients known to SPCT. Care records of patients known to the SPCT who had died at the hospital from January 2016 to March 2016 had been reviewed, 82% had died in their preferred place of death. The service used the audit to evaluate the quality of the information collated in the care plan and tailored training needs.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015. The results were published March 2016. The trust achieved five of the eight organisational key performance indicators (KPI's). The trust did seek bereaved relatives' or friends' views during the last two financial years (from 1 April 2013 to 31 March 2015).
  - The trust provided formal in-house training which included communication skills training for care in the last hours or days of life for medical staff,
  - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life nursing staff registered.
  - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life for non-registered nursing staff.
  - The trust provided access to specialist palliative care for at least 9am -5pm Monday to Sunday.
- However the trust could not demonstrate there was documented evidence that:
  - Formal in-house training included or covered specifically, communication skills and training for care in the last hours or days of life for allied health professionals.
  - The trust had one or more end of life care facilitators as of 1 May 2015.
- The trust scored better than the England average in two of five of the clinical audit KPIs. The trust could demonstrate:
  - There was documented evidence, within the last episode of care that it was recognised the patient would probably die in the coming hours or days.
  - There was documented evidence within the last episode of care, there was health professional recognition the patient would probably die in the coming hours or days and imminent death had been discussed, with a nominated person important to the patient.
- However the trust could not demonstrate their was documented evidence that:
  - The needs of the person important to the patient were asked about.
  - A holistic assessment of the patient's needs regarding an individual plan of care had been carried out in the last 24 hours of life.
  - The patient was given an opportunity to have concerns listened to.
- The service had produced an action plan to address the shortfalls and issues raised by the NCDAH 2014-2015. The SPCT monitored and reviewed the action plan on a monthly basis at the team meeting and every two months by the compassionate end of life care panel.
- Since the audit, the trust had appointed a non-executive director on the trust board with a responsibility for end of life care and agreed funding and appointed an end of life educator (or facilitator) which addressed two of the organisational key performance indicators the trust had previously not met.
- The trust had a replacement for the Liverpool care pathway called Individualised Care Plans for the dying person (ICPDP). At the last inspection, we saw the document was not yet in use and was in the process of being approved by the trust. However, on the recent inspection, we saw the ICPDP was embedded across the hospital. The ICPDP was in line with the recommendations published June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), NICE QS13 End of Life Care for Adults and NICE CG140 Opioids in Palliative Care. It provided individual care plans for patients believed to be dying. This was used to communicate care and treatment.
- The recent quality improvement plan (QIP) identified the trust had completed the roll out of the ICPDP in all ward areas including the intensive care unit in September 2016. The QIP identified the need for teaching and support to continue for all ward staff in the areas where the care plan had been implemented. Staff we spoke to told us they were aware of the ICPDP.
- Standards of practice for the mortuary were based on national guidelines. We saw and staff told us there was an evidenced based standard of practice (SOP)

procedure for transferring deceased patients from the ward to the mortuary. The SOP provided staff with necessary guidance. Staff we spoke with were confident in this practice.

- There were 'rose symbol' resource box files on each ward. These box files were easily identifiable with the rose symbol on the front side, contained information such as:
  - information on completing the ICPDP, flow charts for the end of life care process, information on five priorities of care (a document outlining national guidance from the leadership alliance June 2014)
  - anticipatory prescribing guidance
  - syringe driver policy
  - relevant infection control guidance
  - contact numbers of SPCT including out of hours contacts.

Staff told us that they found this information and resource useful.

- Spiritual needs resource boxes were also available on all wards. These boxes contained:
  - Information about relevant considerations following death for various religions such as Jehovah's Witness, Islam, Judaism and Sikhism.
  - Items of spiritual comfort such as a book of Jewish prayers, Bhagavad Gita a 700-verse Hindu scripture, a rosary, crucifix, compass for showing direction of Qibla. Staff said they found these resources useful. Staff alerted the chaplaincy team if a patient asked to see them or patients could refer themselves.

Pain relief

- We saw medicines were prescribed following the trust formulary, which was available on the intranet. The guidance was in line with NICE CG140 Opioids in Palliative Care and core standards for pain management in the UK 2015.
- The service used comprehensive prescription and medication administration record charts for patients. These charts facilitated the safe administration of medicines. Specialised prescription charts supported prescribers to follow the agreed protocols for patients who had medicines administered via syringe pumps. We saw most medicines delivered via syringe pumps were prescribed appropriately. However, we saw when medicines were prescribed to be administered via a syringe pump the prescription did not always include an infusion solution (diluent) either on the prescription or on the administration records. There was a risk medicines would not be diluted by specific diluents. This was outside the trust policy, which stated the name, and volume of the infusion solution (diluent) must be specified.
- The SPCT reviewed pain control of the patients known to them daily. This ensured that as required medication was prescribed to manage any breakthrough pain. This is pain relief that is given in between regular, scheduled pain relief. We did not see any evidence of complaints about lack of pain relief while we were on inspection.
- Pain relief was included in the hourly intentional rounding check.
- We did not see evidence of the SPCT carrying out a pain relief audit. An audit of pain relief was not included on the SPCT audit plan or the quality improvement plan
- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. We saw that anticipatory end of life care medication was appropriately prescribed

Equipment

- Staff and the relative we spoke with told us patients had access to appropriate equipment, such as syringe drivers, pressure-relieving equipment such as mattresses and hoists to keep them safe and comfortable.

Nutrition and hydration

- We saw the ICPDP prompted staff to review patients' nutrition and hydration. This was an improvement from the last inspection where documentation to replace the Liverpool Care Pathway had not yet been implemented, so there were no care plan prompts for staff specifically around nutrition and hydration for dying patients.
- Patients risk of malnutrition was routinely assessed using the Malnutrition Universal Screening Tool (MUST). Nutrition charts we reviewed were thorough and summarised accurately.
- Medical staff we spoke with were aware of the GMC guidelines for nutrition and hydration in end of life care.
- Staff accurately completed and reviewed fluid balance charts
- We saw referrals were made to the dietitian, and the dietitian visited the ward to assess and support the patient with their nutrition needs.

End of life care

Patient outcomes

- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015. The results were published March 2016. The trust achieved five of the eight organisational key performance Indicators (KPI's).
  - The trust did seek bereaved relatives' or friends' views during the last two financial years from 1 April 2013 to 31 March 2015).
  - The trust did provided formal in-house training which included communication skills training for care in the last hours or days of life for medical staff,
  - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life for registered nursing staff.
  - The trust provided formal in-house training, which included communication skills training for care in the last hours or days of life for non-registered nursing staff.
  - The trust did provide access to specialist palliative care for at least 9am -5pm Monday to Sunday.

However the trust could not demonstrate there was documented evidence that:

- Formal in-house training included or covered specifically communication skills training for care in the last hours or days of life for allied health professionals.
- The trust had one or more End of Life Care Facilitators as of 1 May 2015.
- The trust scored better than the England average in two of five of the clinical audit KPIs. The trust could demonstrate:
  - There was documented evidence, within the last episode of care, it was recognised, the patient would probably die in the coming hours or days.
  - There was documented evidence within the last episode of care, there was health professional recognition the patient would probably die in the coming hours or days and imminent death had been discussed, with a nominated person important to the patient.

However the trust could not demonstrate there was documented evidence that:

- The needs of the person important to the patient were asked about.
- A holistic assessment of the patient's needs regarding an individual plan of care had been completed in the patients' last 24 hours of life.
- The patient was given an opportunity to have concerns listened to.
- The service had an audit plan in place for 2015-16 which included:
  - Audit of time taken from referral to review by specialist palliative care team.
  - Audit of DNACPR form completion. The service used the audit to evaluate services and used the information obtained to target training needs.
- At the time of the inspection the service were not working towards an independent palliative care accreditation standard for example the gold standards framework (GSF) or contributing to the minimum data set (MDS). GSF accreditation programmes provide guidance to generalist frontline staff to provide a gold standard of care for people nearing the end of life. The MDS for Specialist Palliative Care Services is collected by National council for palliative care on a yearly basis, with the aim of providing an accurate picture of hospice and specialist palliative care service activity.

Competent staff

- The end of life care team at Watford Hospital had arrangements in place for supporting and managing staff. The appraisal rate for SPCT was 100%. Records also demonstrated that 100% of mortuary staff had received an appraisal in the last 12 months however, 67% of chaplaincy staff had an appraisal in the last 12 months which was below the trust target.
- The trust and staff told us all staff members in the end of life care team received clinical supervision. Supervision was provided four to six weekly by an external professional for SPCT. The trust were not able to provide a percentage of staff who had attended supervision, they told us compliance was high as duty rotas were planned ahead to ensure staff could attend.
- The SPCT had regular minuted team meetings where staff were updated on changes within the trust and caseload reviews were carried out.
- All SPCT staff were trained to degree level or were undertaking a degree in a relevant subject. All staff had undertaken additional training relevant to their role in palliative or end of life care.

End of life care

- We saw evidence the SPCT consultant and the SPCT clinical nurse specialists were up to date with revalidation.
- Staff that accompanied bereaved relatives for viewings and assisted relatives following a bereavement had received advanced communication training facilitated by the local hospice.
- At the last inspection, staff told us that staff training and development for end of life care could be improved. The current quality improvement plan (QIP) had identified the trust needed to develop an e-learning package for end of life care, mental capacity act (MCA) and deprivation of liberty (DoLS) and roll out via new mandatory training web-link to relevant staff. The time scale for this was identified as January 2017.
- On this inspection, we saw the trust were working towards ensuring staff had the right qualifications, skills, knowledge and experience to do their job or when they start their employment. Staff had e-learning package available for MCA / DoLS. They were in the process of recruiting an e-learning programme lead post to develop further e-learning including end of life care. The SPCT nurses provided palliative and end of life care training to care staff across the trust. The training included basic end of life care, symptom control, and CPR decision-making.
- The trust had completed the roll out of the individualised care plans for the dying person (ICPDP) and necessary training had been completed on all wards (by September 2016). The service had completed training of staff and roll out of the ICPDP in the intensive care unit.
- The SPCT were continuing to teach and support ward staff in the areas where the ICPDP had been implemented.
- End of life core training was in place for all new starters at trust induction.
- There were no non-medical prescribers at the trust at the time of inspection however SPCT staff told us training was being considered for the SPCT clinical nurse specialists.
- There were 'rose symbol' resource box files and spiritual needs resource boxes available on all wards. These boxes contained information such as relevant guidance to support staff who were receiving end of life care. Staff told us that they found these resources useful.
- The SPCT nurses provided palliative and end of life care training to care staff across the trust. The training included basic end of life care, symptom control and Cardiopulmonary resuscitation (CPR) decision-making.
- The mortuary team provided guidance and advice to the wards and departments across the trust and supported the pathologists and the training on junior Pathologist in Post Mortem techniques

Multidisciplinary working

- We saw evidence of joint working to support non-cancer patients. The SPCT consultant attended weekly cardiology multidisciplinary team meetings and provided support for patients with end stage heart failure. We saw evidence of integrated work with the respiratory team. The new chronic obstructive pulmonary disease (COPD) pathway included a mandatory referral to SPCT for review of symptom control.
- The SPCT team had established close links with other providers in the local area of end of life care including the local hospice, primary care providers and community nurses. The aim of this was to improve patients' experience as they moved between care settings. We saw documented evidence of a multidisciplinary approach to care.
- The SPCT attended weekly multidisciplinary team (MDT) meetings at the local hospice, with the community teams, to ensure continuity of care of the patients moving from Watford Hospital to the community or the hospice.
- Medical staff told us they sought guidance and acted upon advice from the specialist palliative care team.
- We reviewed 15 sets of notes and we saw documented examples of communication of planned care between health care professionals.
- The SPCT held a weekly palliative care MDT meetings. The SPCT regularly attended the specialist teams' MDT meetings such as respiratory care and cardiology to provide support and guidance.
- Referrals to the SPCT came from a wide source of wards across the hospital. The SPCT told us they had a good working relationship with all ward teams. They told us staff on all wards had been supportive of end of life care.
- The chaplaincy team had access to contacts in the community for support for all religions. We saw

evidence of clear liaison processes in place for when patients transferred to the community. The chaplains maintained phone contact with patients' own community spiritual leaders.

Seven-day services

- The SPCT provided a seven-day face-to-face access to specialist palliative care. The team was available from 9am to 5pm, Monday to Sunday. Outside these hours, specialist palliative care advice was available from the local hospice 24-hour advice line. The staff in the hospital accessed the on call doctors if a patient required a review on an evening or weekend when members of the palliative care team were not available. A consultant palliative care doctor was available two days a week. Outside of these two days, staff called local hospice doctors for support, or spoke with the palliative care specialist nurses.
- The mortuary was staffed by the anatomical pathology technologist's (ATP) between 8am and 4pm. Out of these hours the mortuary could be accessed via the senior operational team. The viewing area and access for relatives was open seven days a week.
- The patient affairs office was open from 9am until 4pm Monday to Friday and 10am until 4pm on Sundays. The service told us in exceptional circumstances, arrangements could be made to issue death certificates out of hours on the grounds of religious or cultural needs. The senior operational team coordinated this.

Access to information

- Trust policies, procedures and guidelines were available to nurses, doctors and support staff on the intranet. They were able to access them when necessary.
- SPCT referrals documents and information about five priorities of care and information for patients and relatives were available on the intranet. All staff had access to this information 24 hours a day, seven days a week. Staff we spoke with on the wards were able to direct us to this information and stated that they used it to support their practice.
- The DNACPR forms were at the front of the patients' notes, allowing easy access in an emergency. We saw that forms stayed with the patients, following them into the community and back into hospital.
- At the last inspection, the palliative care team told us that there were plans to implement a computer system so that all health professionals involved in the care of patients had access to up to date records. This was not in place at the time of the recent inspection. Staff did not know the timescales for implementation of this new electronic record system.
- There was currently no end of life register in the trust, or countywide information technology system between the trust, mental health services, GPs and primary care teams. There was a risk some information would not be shared effectively. The risk had been mitigated by SPCT staff maintaining phone contact with the patients' GPs, ensuring appropriate referrals were made and use of individual care plan for the dying person between services.
- The SPCT had their own database of patients referred to the service care teams.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not see robust evidence of mental capacity assessments being carried out and recorded regarding the decisions about CPR. We saw evidence that all of the chaplaincy team and all of the SPCT had attended training on the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). Staff we spoke with told us they had a good understanding of their responsibilities regarding the MCA and knew what to do when patients were unable to give informed consent. We saw mental capacity assessments for decisions around general care and treatment and blood transfusion in medical notes. However, we did not see mental capacity assessments for the patient's ability to understand a decision regarding DNACPR.
- The trust's DNACPR form did not prompt staff to carry out a formal assessment to establish if the patient had mental capacity to make and communicate decisions about CPR, as recommended by Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2015). On the current inspection, we reviewed 36 DNACPR forms across all ward areas. In seven cases we saw that decisions had been made about patient's capacity where there was no evidence of formal assessments used in the decision making progress or information documented in progress notes. This meant that staff who obtained consent of people who use the service did not follow the principles and codes of conduct associated with the Mental Capacity Act 2005.

End of life care

- We saw the trust had carried out regular annual audits of DNACPR forms. The trust provided us with the audit results carried out in March 2016. The trust had looked at 100 forms. 97% had been signed by senior clinician, 78% had patient details completed, 93% were dated. 28% had been discussed with patient. 66% had been discussed with relatives. Following the audit, a training package was designed and provided to all staff as part of the trust's mandatory training.
- Staff we spoke to understood the Deprivation of Liberty Safeguards (DoLS). We saw evidence of assessments in patients' notes. Staff were able to explain the process they would follow if they felt a patient was at risk of harm to themselves or others.

Are end of life care services caring?

Good

We rated care by end of life care services as good because:

- Patients were supported, treated with dignity and respect.
- Feedback from patients and those close to them was positive about the way staff treated people.
- Patients were involved as partners in their care; they were communicated with and received information in a way that they could understand.
- Patients we spoke with understood their care, treatment and condition.
- We observed patients being treated with dignity, respect and kindness during all interactions with staff.
- Staff responded compassionately when patients needed help and support to meet their basic personal needs.

However:

- National care of the dying audit of hospitals 2016 data showed the patients were not always given an opportunity to have concerns listened to.

Compassionate care

- Staff understood and respected people's personal, cultural, social and religious needs. All staff had access to multidisciplinary care records, which provided a care plan, which specified the patients' wishes. Individualised care plans (ICP) for the dying patient were in place for patients who were in their last days or hours of life. The ICP specified patients' wishes regarding end of life care. Records we saw on the wards indicated the patients' preferred place of care and place of death. Staff had documented the wishes and preferences of patients and their families. We saw and relatives told us staff provided care in line with patient wishes.
- Staff took the time to interact with patients and those close to them in a respectful and considerate manner. We saw staff carrying out care with a kind, caring, compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity by asking for consent to proceed with tasks. However, NCDAH data showed the trust did not achieve the clinical KPI that the patient was given an opportunity to have concerns listened to.
- Staff responded to patients compassionately and responded appropriately and in a timely way when patients experienced physical pain, discomfort or emotional distress. The trust did not carry out an audit of the effectiveness of pain management. However, we did not see any complaints about management of pain relief.
- The trust had implemented a "Rose symbol" to promote dignity, respect and compassion at the end of life across our hospitals. The symbol was developed by the bereavement and compassionate end of life care group. A rose symbol was displayed on wards when a person was expected to die in the next few hours or when a person has just died. The symbol was to alert staff and to encourage an atmosphere of quiet and respect at this significant time. This piece of work was shortlisted for the Florence Nightingale Foundation Conference Poster Competition in 2015. We saw the symbol in use on the wards during the inspection, staff did follow the principles.
- The mortuary staff and porters told us that they did not have any concerns about the way ward staff cared for patients shortly after death. There was a last offices policy. The term last offices relates to the care given to a body after death. A process demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements. Nursing staff were provided with training regarding how to perform procedures respectfully.
- Mortuary staff were observed to handle bodies in a professional and respectful way.

End of life care

- The chaplaincy team arranged and delivered an annual remembrance service for those whose babies and children have miscarried or died. We saw a wide range of people attended this.
- The chaplaincy team had planned a non-religious remembrance service for families and friends of adults who have died in the trust's hospitals for November 2016.
- The trust did not have facilities in the mortuary for honouring spiritual and cultural wishes of the deceased person and their family and carers whilst preparing the body for transfer however, this could be arranged at the funeral directors premises.
- The trust had processes in place to honouring people's wishes for organ and tissue donation.

Understanding and involvement of patients and those close to them

- Patients' notes we looked at and patients we spoke with told us staff communicated with them so that they understood their care, treatment and condition. We reviewed 15 sets of notes, each demonstrated people were kept actively involved in their own care, and relatives were kept involved.
- The SPCT and the chaplaincy team provided support for patients and those close to them at end of life. Patients we spoke with stated that the care they received was very good, that the staff communicated with them in a way that helped them understand their care and they felt involved in their care.
- The results of the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 (published in March 2016) showed that 86% of patients had been recognised as dying at the end of their life and this had been discussed with the patient's nominated individual. This meant that in most cases there was documented evidence that a professional had informed a relative that the patient was expected to die in the coming hours or days. The trust scored better than the England average of 79%.
- The trust had held a bereavement focus group for families and carers to feedback their experiences in June 2016; a second was planned for November 2016. The bereavement focus group provided the trust the opportunity to ask relatives about their perceptions, opinions, beliefs, and attitudes towards end of life care services at the trust. The service told us they aimed to use the information obtained to measure the effectiveness and outcomes of the service and to identify where it needed to make improvements. At the time of the inspection, an action plan from the results of the meeting had not been completed.
- We saw staff had recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enable them to access this.
- The trust provided us with information from their last review of bereavement questionnaires returned between April 2015 and April 2016. The bereavement service shared the information with the SPCT who discussed it within their MDT to see if improvements to services could be made and to identify needs for future end of life care training they provided to hospital staff to ensure lessons were learnt.134 surveys had been returned approximately 10% response rate.
  - 30% respondents agreed that the patient had been given spiritual, pastoral or emotional support.
  - 69% agreed as a friend or relative they were well informed of the patient's condition
  - 63% agreed as a friend or relative they were given enough opportunity to ask questions and provide important information about the wishes of the patient.
  - 62% agreed as a friend or relative they were asked how and when they would like to be contacted if there was a patient's condition.
  - 75% agreed as a friend or relative they were given support at the time of death.
  - 84% agreed the patient was treated with dignity and respect following their death.
  - 70% agreed as a friend or relative they were treated with dignity and respect.
  - 75% agreed as a friend or relative they were guided on what registering the death and making funeral arrangements.
  - 51% agreed as a friend or relative they were advised of where further support could be obtained.

Emotional support

- Staff understood the impact that a patients care, treatment or condition had on their wellbeing and on those close to them emotionally. The SPCT told us emotional, psychological and bereavement support and advice for families was an important component of the service.

End of life care

- The chaplaincy team offered spiritual support to patients of all or no faiths.
- Patients we spoke with told us the SPCT and chaplaincy team had provided them with emotional support.
- At the inspection in April 2015, we saw the trust did not provide effective bereavement services and staff delivering information to bereaved people did not receive training in this. During the inspection in September 2016, we spoke to the staff that provided bereavement information to patients and their carers in the patient affairs office. The patient affairs staff told us that whilst they were not trained in counselling, they had received support and training from a local hospice in having difficult conversations, and recognising distress. Staff told us their role was to signpost people to further services such as the local hospice or bereavement support charities.
- We did not see evidence of assessments of patients for anxiety or depression, although staff told us that they would signpost people to the hospice team for support services such as bereavement counselling. Bereavement questionnaires surveys returned from April 2015 to April 2016 demonstrated that 51% of respondents agreed as a friend or relative they were advised of where further support could be obtained.

Are end of life care services responsive?

Good

We rated responsiveness by end of life care services as good because:

- The service was collecting information on the percentage of patients who died in their preferred location. 82% of patients had died in their preferred place of death.
- 81% of patients were seen within 24 hours of referral from April 2015 to March 2016.
- There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life.
- We saw evidence of joint working between the SPCT and the medical teams at the hospital to support non-cancer patients.
- While there was no designated overnight accommodation facilities on site, wards provided recliner chairs or made their day room available for relatives for those who wished to remain at their relatives' bedside.
- The hospital had leaflets available for example coping with dying and procedures to be undertaken after the death of a patient for relatives or friends. The leaflets were available in a number of different languages and formats.
- A chaplaincy team provided spiritual and pastoral care and religious support for patients, relatives and staff across the trust.
- There had been no complaints about end of life care from July 2015 to July 2016.

However:

- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 published in March 2016. The trust scored worse than the England average in three of five of the clinical audit key performance indicators (KPIs). The trust could not demonstrate the needs of the person important to the patient were asked about a holistic assessment of the patient's needs regarding an individual plan of care was carried in the last 24hours of life. Or that the patient was given an opportunity to have concerns listened to.
- The trust did not collect effective information on the percentage of patients who were discharged to their preferred place within 24 hours. This had not improved since the inspection in 2015.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team (SPCT) saw 781 patients from April 2015 to March 2016. 53% of all patients seen, had cancer.
- 81% of patients were seen within 24 hours of referral from April 2015 to March 2016. Patients who were identified as requiring palliative care such as symptom control in end of life care were referred to the SPCT by individual consultants or ward staff. 100% of patients were seen within 48 hours.
- The hospital did not have any designated beds for end of life care, the staff delivered end of life care in most wards with support from the SPCT.
- Staff told us they tried to allocate side rooms to patients who were receiving end of life care in order to offer quiet

and private surroundings for the patient and their families. However, they also said that often patients at the end of life had to be cared for on open wards, as the use of single rooms were prioritised for patients who required isolation.

- The SPCT were part of the Bedfordshire and Hertfordshire specialist palliative care group and attended regular quarterly meeting with the clinical commissioning group, they used these groups to bench mark their services and review how their services reflected the needs of their local population.
- The trust had a rapid discharge process. This was an improvement since the last inspection, as at the previous inspection, the trust did not have rapid discharge policy for patients to their preferred place of death. However, on this inspection, the service was not able to tell us how many patients had been discharged home using the rapid discharge process. Staff told us delays in discharging a patient home could occur because of the lack of available community care packages, particularly in the more rural areas. The palliative care team planned to implement further research into the needs of local people now they had recruited the staff to complete the team and enabled their resources to allow further audit and implementation of the action plan. We saw that this was documented in the action plan for development of the service.
- Staff and relatives we spoke with, told us there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient.
- The hospital did not have designated overnight accommodation facilities on site, however wards provided recliner chairs for those who wished to remain at their relatives' bedside. Some wards made their day room available for relatives to use on such occasions.
- Reduced parking fees for relatives of patients receiving end of life care could be arranged by staff, to enable relatives to spend the maximum amount of time with their relative.
- The SPCT team had established close links with other providers in the local area of end of life care including the local hospice, primary care providers and community nurses. The aim of this was to improve patients' experience as they moved between care settings. We saw documented evidence of a multidisciplinary approach to care. The SPCT attended weekly multidisciplinary team (MDT) meetings at the local hospice, with the community teams, to ensure continuity of care of the patients moving from Watford Hospital to the community or the hospice.

Meeting people's individual needs

- The trust scored better than the England average in two of five of the clinical audit KPIs. The trust could demonstrate:
  - There was documented evidence, within the last episode of care, it was recognised, the patient would probably die in the coming hours or days.
  - There was documented evidence within the last episode of care, there was health professional recognition the patient would probably die in the coming hours or days and imminent death had been discussed, with a nominated person important to the patient.

However the trust could not demonstrate there was documented evidence that:

- The needs of the person important to the patient were asked about.
- In the last 24 hours of life, a holistic assessment of the patient's needs regarding an individual plan of care had been carried out.
- That the patient was given an opportunity to have concerns listened to.

- The hospital had leaflets available for example coping with dying, which outlined the changes that may occur in patients in the hours before death for people that are important to them. We also saw leaflets explaining procedures to be undertaken after the death of a patient for relatives or friends.
- We saw leaflets were available in a number of different languages including Polish and Urdu. Staff also told us they had access to translator services. The Patient Advice and Liaison Service (PALS) could book professional interpreters for patients.
- Leaflets could be provided in large print, braille and in an audio format.
- The trust's website informed patients that they could translate most pages of this website, using a search engines translation service. Information could be translated in to more than 50 languages by the patient clicking the 'translate' link at the top of the page and selecting their language.

End of life care

- There was a multi-faith room, a wudu (washing facility) and a chaplaincy team at Watford hospital.
- The chaplaincy team provided spiritual and pastoral care and religious support for patients, relatives and staff across the trust. Staff alerted the chaplaincy team if a patient asked to see them or patients could refer themselves. For patients who wished to take communion, but could not attend the chapel, the chaplain or an authorised member of the team brought communion to their bedside. There was a book for people to write their prayer requests in. The multi-faith room was open 24-hours a day and were used by patients, relatives, carers and staff. There were also regular services held in the chapel.
- The chaplains attended to anyone asking for support. Support from a specific faith was provided through local religious leaders who could be called. The team had a group of voluntary visitors, from across the community, who visited patients to offer spiritual support.
- A bereavement focus group was held in June 2016. A second event was planned for September 2016. The bereavement focus group provided the trust the opportunity to ask about their perceptions, opinions, beliefs, and attitudes towards end of life care services at the trust. The service told us they aimed to use the information obtained to measure the effectiveness and outcomes of the service and to identify where it needed to make improvements. At the time of the inspection, an action plan from the results of the meeting had not been completed.
- The patient affairs staff were available from Monday to Friday 9am to 4pm, and Sundays 10am to 4pm with a telephone message service outside of these hours. They arranged visits to the chapel of rest, liaised with relatives about death certificates, provided relatives with information such as how to register a death, cremation papers and the coroner's office. They also returned property to family and carers.
- There was information accessible in the mortuary viewing area produced by the trust for relatives. One booklet provided a guide through the practical tasks that need to be tended to during the early stages of bereavement. The viewing facility was available for relatives' viewings on an appointment only basis, usually between Monday and Friday. However, out of hours viewings could be arranged by the manager on call. Viewings were arranged by the patient affairs team, relatives were accompanied by the chaplains or on occasions when the chaplains were unavailable, the patient affairs team would accompany relatives.
- The patient affairs staff liaised with bereaved families and coordinated the issue of the medical certificates, so that the death could be registered and the funeral arranged.
- At the previous inspection, staff told us that they were planning on improving the family rooms as staff had raised this due to the current rooms in a poor state of repair. We saw that most ward had access to a quiet room where staff could hold sensitive conversations with relatives. There was a newly refurbished suitable room in main reception the patient affairs could meet with relatives following a bereavement.
- The trust has a MacMillan information centre in the main reception at Watford General Hospital. The information centre offered a team of experts and trained volunteers to answer questions and information such as local support groups and help for the financial problems cancer may create. Patients and those close to them were able to access booklets, leaflets and other sources of information free of charge.
- Information about patients preferred place of care and advance care plan was held with the individualised care plan for the dying person (ICPDP). The ICPDP was accessible by all staff working with the patient.
- Language interpreters were available and we saw information leaflets in a number of different languages including Urdu and Polish.
- The trust provided canvas bags with a rose symbol on for returning the deceased person's possessions to the relatives in a sensitive caring manner.

Access and flow

- The SPCT collected information on preferred place of death for patients known to SPCT. Care records of patients known to the SPCT who had died at the hospital from January 2016 to March 2016 had been reviewed. 82% had died in their preferred place of death.
- The trust had a Marie Curie discharge liaison nurse based at the hospital. We saw and staff told us the trust had a rapid discharge protocol for when a patient was identified as being within their last few days or short weeks of life and wished to die at home or in a care home. Patients who required rapid discharge were

referred to the Marie Curie discharge liaison nurse or to the SPCT who facilitated a timely, safe discharge in conjunction with the ward staff and other providers. The service was not able to tell us how many patients had been discharged home using the rapid discharge process at the time of the inspection.

- We saw the SPCT had a triage and prioritising system for referrals. 81% of patients were seen within 24 hours of referral between April 2015 and March 2016. We saw 100% patients were seen within 48 hours.
- Patients were referred directly to SPCT on their ward visits or via telephone referral system. Ward staff told us the SPCT were responsive. All ward staff we spoke with could identify the SPCT clinical nurse specialists and consultant.
- The SPCT clinical nurse specialists picked up referrals and phone messages for the SPCT each time they went back to the office. Staff told us and we saw patients who required end of life care were identified at daily ward rounds. Once identified, the ward team would refer the patient for specialist care.
- There were no formal agreements with the local ambulance service. However, we were told staff on the wards were asked when booking transport for transferring end of life patients to highlight that the patient was at the end of life.
- The results of the National Care of the Dying Audit for Hospitals 2014-15 published in March 2016 showed that 81% of patients had been recognised as dying at the end of their life. This meant that in most cases there was documented evidence, within the last episode of care, by at least one health professional, that the patient was expected to die in the coming hours or days. The trust scored slightly below the England average of 83%.
- Porters told us that they were able to respond promptly to requests to transfer deceased patients to the mortuary. This was usually within 15 minutes and they were able to prioritise accordingly. We spoke with ward staff who told us they did not have concerns about response times.

Learning from complaints and concerns

- There have been no complaints about end of life care from July 2015 to July 2016.
- At the previous inspection, the palliative care consultant told us that they did not always receive information about complaints that are passed to the Patient Advice and Liaison services (PALS) so they regularly have to ask for these so that they are able to review the services provided by the palliative care team. At this inspection, SPCT told us they were now provided with complaints from other services, where the patients had received end of life care. The SPCT had access to the investigations and identified learning. The SPCT reviewed these incidents and complaints and discussed within their MDT to see if improvements to services could be made and to identify needs for future end of life care training they provided to hospital staff to ensure lessons were learnt.
- Patients we spoke with told us they knew how to make a complaint or raise concerns if it was necessary.

Are end of life care services well-led?

Good

We rated well led as good because:

- The trust had executive and non-executive board representatives for end of life care that provided representation and accountability for end of life care at board level. End of life care services received coverage in board meetings and in other relevant meetings that reported to the board.
- SPCT and ward staff we spoke with told us end of life care was a high priority for the trust.
- The trust had a three-year end of life care strategy; the strategy was presented to trust board in July 2016. The strategy was realistic to achieve the priorities and delivering good quality care. The strategy was reviewed every other month by the team at the compassionate end of life care panel.
- There were effective plans in place to address outcomes of audits such as the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 published in March 2016.
- We saw evidence of lessons learned.
- The trust did have end of life care champions on most wards

However:

- Bereaved relatives' views and experiences were gathered through the trust's bereavement questionnaire. These views were used to shape and improve the end of life care service. However, the response rate was low at 10%.

End of life care

Leadership of service

- The trust had an executive and a non-executive director on the trust board with a responsibility for end of life care. The chief nurse was the board representative for end of life care, they with the non-executive director provided representation and accountability for end of life care at board level.
- Staff we spoke with told us that there was good leadership of the SPCT. The service was covered by a consultant for two days a week. Staff we spoke with felt the service lead had the capacity, capability, and experience to lead effectively. The managers were visible and approachable. Staff knew who they could ask for support when their line manager was not at the hospital. Changes had been made to the reporting structure for the palliative care team in the 17 months prior to inspection. Palliative care and cancer services had been moved to the surgery division. The Clinical lead for End of Life, an orthopaedic surgeon, who started in post two months prior to the inspection, had provided a valuable fresh view on the service's development needs.
- All staff we spoke with were aware of who their immediate managers were and knew the roles of the senior management team.
- The chaplain, mortuary team and bereavement service told us that they felt supported and listened to by their line management.
- All of the ward staff we spoke with knew who the leads were for end of life care.

Vision and strategy for this service

- SPCT and ward staff told us end of life care was a high priority for the trust.
- At the previous inspection, there was no clear vision for end of life care that staff could describe consistently. On the current inspection, we saw the trust had a three-year end of life care strategy; the strategy was presented to the trust board in July 2016. The strategy aimed to assist staff to provide good care for the dying patient by giving "the very best care for every patient, every day." The strategy set out the aims and objectives for the SPCT, prompted the SPCT to carry out surveys and audits to identify where they needed to make improvements. The SPCT felt the strategy had provided them with a clear vision to improve and develop high quality end of life care across all specialisms.

Governance, risk management and quality measurement

- In April 2015 the SPCT moved to the surgical division and was well established. The team felt they were well placed for the support required.
- The clinical lead for end of life care was an orthopaedic surgeon. They, working with the lead SPCT nurse and lead Macmillan nurse acted as improvement leads for end of life care at the trust.
- At the previous inspection, we saw risk register was not representative of the service's risks. Outcomes on the risk register were also out of date and not reviewed or updated within the trust's stipulated time frame. We saw that the service had not responded promptly to safety matters, which put staff and visitors at risk of harm, this meant that systems and quality checking procedures were not adequate to identify and rectify risks. However, at the current inspection we were assured the service had a robust arrangement for identifying, recording and managing risks, issues and mitigating actions. We saw the compassionate end of life care panel had taken on responsibility for the trust-wide risk register for end of life issues. The risk register was up to date and being monitored.
- The compassionate end of life care panel provided a forum to address complaints and queries raised relating to end of life care through PALS and investigate and report on incidents in line with trust policy. Numbers and themes of complaints were reported and monitored.
- The local end of life care quality improvement plan (QIP) which incorporated the NCDAH action plan and strategy progress was monitored through the compassionate end of life care panel. The panel reported into the quality and safety group, which in turn reported to the quality and safety committee and on through to the trust board. This ensured the service had a governance framework and management systems that regularly reviewed its' progress.
- The service had local audits in place to measure the effectiveness and outcomes of the service. The trust had developed a care-planning tool to replace the Liverpool Care Pathway, which had been removed however, this had been implemented an embedded.
- We saw evidence of issues around end of life care raised at board meetings.

End of life care

- The trust had end of life care champions based on most wards. The champions attended quarterly training session to support their learning and maintain their skills.
- The multidisciplinary care record document and the associated training ensured that end of life care services were assessed, monitored and managed on a day-to-day basis and reviewed regularly.
- The SPCT were part of the Bedfordshire and Hertfordshire specialist palliative care group and attended regular quarterly meeting with the clinical commissioning group, they used these groups to bench mark their services and review how their services reflected the needs of their local population.
- The SPCT had monthly team meetings where governance and risk issues were discussed. For example shared learning from incidents in other directorates and information form the bereavement survey.
- The compassionate end of life care panel provided a forum to address complaints and queries raised relating to end of life care through PALS and investigate and report on incidents in line with trust policy. Numbers and themes of complaints were reported and monitored. The compassionate end of life care panel also monitored the local end of life care quality improvement plan (QIP) which incorporated the national care of the dying audit for hospitals (NCDAH) action plan and strategy progress was monitored through the compassionate end of life care panel. The group reported to the quality and safety group.
- The service had a QIP in place. The aim of the QIP was assist the service to self-assess their performance in delivering a quality end of life care service and plan future improvements. The QIP was a live action plan document that brought together planning and operational delivery documents, ensuring that they all worked together. Each action had an identified timescale and lead. The QIP was monitored through the compassionate end of life care panel.

Culture within the service

- At the previous inspection, staff told us that a lot of changes had happened in a short period of time, which did not give them time to fully embed the changes. A member of staff told us that it was “very difficult to whistle blow” about issues around short staffing and safety of patients. They told us that they had called the whistleblowing line twice, and did not feel that the issue was dealt with. This meant that we could not be sure that the trust followed up and investigated incidents where staff followed the whistleblowing procedure.
- On the current inspection, we did not receive any concerns from staff about whistleblowing procedure. Staff told us, they felt respected and valued. Staff felt the trust were committed to provide safe and caring services. Staff we spoke with were passionate about the care they delivered.
- We observed staff providing care in a respectful manner, they maintained patients’ dignity, there was a person centred culture. We saw staff responding to patients' wishes.

Public engagement

- Bereaved relatives’ views and experiences were gathered through the trust’s bereavement questionnaire. The service used these views to shape and improve the end of life care service. However, the response rate was low. The trust provided us with information from their last review of bereavement questionnaires surveys returned from April 2015 to April 2016. 134 surveys had been returned which was approximately a 10% response rate.

Staff engagement

- The SPCT held monthly team meetings where information and learning from safety and quality audits was shared.
- The trust carried out staff satisfaction surveys, although these did not specifically identify end of life care results.

Innovation, improvement and sustainability

- We saw evidence that leaders and staff strived for continuous learning and improvement of lessons learned. The team used feedback from bereavement questionnaires, training feedback and complaints to improve the service and target training needs.
- At the previous inspection, we saw that projects had been put into place to improve the awareness of end of life care, however a project to introduce “end of life champions” on each ward had not been successful, although the trust was not able to tell us how this was implemented, or the progress managed and audited. Since the last inspection, regular (quarterly) training sessions had been established for the champions. Training had been supported by a local hospice.

End of life care

- Since the last inspection, the trust has been part of a network wide working party to develop an end of life individualised care plan for the dying person (ICPDP) post the Neuberger report published in July 2013. An ICPDP was now embedded across the trust.
- The "Rose symbol" had been developed to promote dignity, respect and compassion at the end of life across the hospitals. The symbol was be displayed on wards when a person was expected to die in the next few hours or when a person had just died to encourage an atmosphere and of quiet and respect at this significant time. This piece of work was shortlisted for the Florence Nightingale Foundation Conference Poster Competition.
- The trust were successful in a bid to Macmillan in 2015 for two year pump primed money for a Macmillan end of life care educator and this post had being recruited to. The staff member was due to join the team in November 2016.
- The trust end of life care strategy was presented to the trust board in July 2016.
- The trust held their first bereavement focus group in June 2016; another one was planned for September. The bereavement focus group provided the trust the opportunity to ask about their perceptions, opinions, beliefs, and attitudes towards end of life care services at the trust. The service told us they aimed to use the information obtained to measure the effectiveness and outcomes of the service and to identify where it needed to make improvements. At the time of the inspection, an action plan from the results of the meeting had not been completed.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Outpatient clinics are provided at Watford General Hospital and two other sites within the West Hertfordshire Hospitals NHS Trust, the other two sites being Hemel Hempstead Hospital and St Albans City Hospital.

Outpatient services includes all areas where patients are referred for investigations and diagnosis or for follow up care. Some patients are listed for admission following their visit to outpatients or they may have to return to allow their condition to be treated and monitored over time.

We inspected a number of areas where patients are seen in clinics including the main general outpatient department which is used by a range of surgical and medical specialties. We also visited the cardiology, ophthalmology, dermatology and fracture clinics which were managed separately to the main outpatient department. The diagnostic imaging department included x-ray, ultrasound scanning, magnetic resonance imaging (MRI), CT scanning and nuclear medicine.

The general outpatient department was managed within the trust's medical division. There are 24 consultation rooms in the main outpatient department.

Some clinics such as the ophthalmology clinics were managed by the surgical division. Patients attended cardiac clinics located on the floor above general outpatients for electrocardiography, echocardiology and lung function tests. Rapid access clinics were provided for patients thought to have had trans ischaemic attacks (TIAs), chest pain and heart failure. A fracture clinic was located adjacent to the accident and emergency department.

The diagnostic imaging department carries out routine x-rays, CT scanning, magnetic resonance imaging (MRI) nuclear medicine and fluoroscopy.

Rapid access clinics are also provided in gynaecology, care of the elderly and there is an urgent treatment centre within ophthalmology outpatients.

We spoke with 25 patients and their relatives and 20 staff, including consultants, radiographers, nursing and reception staff. We observed the care patients received and reviewed 18 sets of records. In addition to this, we reviewed local and national data and performance information about the service.

There were 279,332 outpatient attendances at Watford General Hospital in the 12 months between March 2015 and March 2016

There was a separate outpatient department for children. Children were also seen in the ophthalmology clinics.

Outpatients and diagnostic imaging

Summary of findings

Overall we rated the out patients and diagnostic imaging service at Watford Hospital as requires improvement because:

- At our previous inspection in 2015 we found that patients' records were not securely stored in the cardiology and ophthalmology outpatient departments which meant there was a risk of unauthorised access to personal, clinical information or of clinical information being lost. At this inspection we found patient records were securely stored in lockable cupboards in cardiology and lockable trolleys in the ophthalmology clinic areas.
- Outpatient services had responded to many of the environmental issues identified at our previous inspection. Work was underway to provide new accommodation for cardiac patients and a new reception area had been built in the ophthalmology reception and waiting area.
- Two treatment rooms in the dermatology department were not clean and the air conditioning in both rooms had not been working for some time. Staff were unable to evidence any progress on resolving this.
- Nursing staff in outpatients were not auditing staff's compliance with good hand hygiene practice and we did not see staff routinely using hand sanitisation gels in the ophthalmology outpatient department.
- Endoscopes were cleaned before each use in the outpatient department. However, the equipment was not returned to the endoscopy department for checking and cleaning at the end of the clinic in line with best practice, as described in Health Technical memorandum 01-06 (HTM 01-06) Guidance on the Management and Decontamination of Flexible Endoscopes.
- Treatment rooms in the ophthalmology outpatient department were fitted with locks during our inspection. However, we observed one door which led to a room where intraocular injections were being administered, was propped open, and there were no signs on the door to indicate when a patient was receiving treatment.
- The system in place for maintaining medical equipment was not effective. Staff described frustration about equipment being not being adequately maintained.
- Patients' records were not always available for clinics. The trust was monitoring the situation and there had been an improvement since our last inspection. Information provided by the trust indicated that 94% of notes were available for clinics; however staff told us notes were often not available or arrived late.
- There was a 25% vacancy rate for nursing staff in the main outpatient department and the turnover rate was 17% which was considerably higher than the other sites in the trust. The trust's target for staff turnover was 12%.
- Guidance had been developed for radiology staff to administer a medicine, Hyoscine Butylbromide prior to treatment without a prescription. A patient group direction was in place (PGD). This meant that radiographers were aware of the risks and contraindications, when patients should not be given the medication as it could cause them harm.
- PGDs were in place for nurses in the ophthalmology department who were able to administer medicines without a doctor's prescription.
- There was evidence that staff were following national clinical guidelines and participating in national audits.
- Nursing staff completed local induction training when they joined the outpatient department. We saw the training programme which included training on the use of equipment within the department and a medicines competency assessment. Induction programmes were developed to meet the needs of different staff groups for example for trained nurses and healthcare assistants.
- Clinic letters provided patients with very little information about the clinics or what to expect. Patients told us they would have appreciated more information about the clinic and about the difficulty parking, which many patients found frustrating.
- Nursing staff told us there were good working relationships amongst the nurses but working relationships between medical and nursing staff was

Outpatients and diagnostic imaging

not always effective. They described how the poor communication culture meant they could not pass information on to patients if, for example, the clinic was running late.

- Some services, for example, the diabetic service, had developed joint clinics with partners in primary care to support women who had developed diabetes in pregnancy. There were other examples of combined working in renal clinics and links with podiatry services. The service used videoconferencing to provide virtual clinics with community partners.
- The trust was making improvements to the organisation of outpatient clinics. However, clinics still frequently over-ran and some patients told us they had experienced long delays. The length of time patients waited to be seen was not monitored. The trust's patient administration system had no facility for recording when patients were seen and the information was not collected manually.
- During our previous inspection in March 2015, we found that clinics were being cancelled at short notice. This was still happening, although staff told us that the clinical divisions were getting better at providing medical cover. The trust's overall target for cancelled clinics was 8% and was 5% for clinics cancelled with less than six weeks' notice. The overall cancellation rate for clinics had peaked in April 2016 at 14% which was a 3% increase on the mean of 11% over the previous 12 months. This improved in June 2016 reducing to 11.0%. The number of clinics cancelled at short notice had also improved to 3.9% in June 2016.
- Staff told us communication between the clinics, consultants and their secretaries was poor and described examples of patients arriving for clinics that staff knew nothing about. In addition, clinics were cancelled at the last minute because there was no medical cover in place.
- Data for September 2016 showed that the trust had fallen below the national 93% target that all suspected cancers should be referred to a consultant and seen within two weeks; only 89.4% of patients were seen within this time period. For breast cancer, for the year to date only 76% patients had been seen within two weeks.
- Diagnostic imaging waiting times were good. The standard set by the trust was that 99% of patients referred for 15 diagnostic tests for example, ultrasound or a CT scan should wait no longer than six weeks. This standard, which was better than the national position of 98.2%, had been reached since April 2015.
- A comprehensive information dashboard which included a range of performance indicators was under development but had not been rolled out for clinical and managerial use. Operational managers within the outpatient department were aware the information dashboard was being developed but were not aware of what this meant for the service.
- The leadership of outpatient services was not clear. Responsibility for outpatients was shared between the clinical divisions and the outpatient department but there was no overarching management structure.
- In radiology, staff told us medical staff and radiography staff worked well together. Staff spoke highly of their managers.
- The trust recognised the need to make improvements to outpatient services and had set up an improvement programme which had achieved some positive changes.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

Overall we rated safe as requires improvement because:

- Treatment rooms in the dermatology department were not clean. The air conditioning had not been working for some time. Staff were unable to evidence any progress on resolving this.
- There were no audits in place to measure staff's compliance with good hand hygiene practice. We did not see staff routinely using hand sanitisation gels in the ophthalmology outpatient department
- Endoscopes were cleaned before each use in the outpatient department. However, the equipment was not returned to the endoscopy department for checking and cleaning at the end of the clinic.
- Treatment rooms in the ophthalmology outpatient department were fitted with locks during our inspection. However, we observed one door which led to a room where intraocular injections were being administered, was propped open and there were no signs on the doors to indicate when a patient was receiving treatment.
- There was an ineffective system in place for maintaining medical equipment. Staff described frustration in equipment not being adequately maintained.
- Records were not always available for clinics. The trust was monitoring this situation, however, staff told us notes were often not available, or arrived late.
- There was a 25% nursing staff vacancy rate in the main outpatient department. Turnover was 17%, which was considerably higher than the other sites in the trust. The trust's target for staff turnover was 12%.

However we also found:

- Outpatient services had responded to many of the environmental issues identified at our previous inspection in March 2015. Work was underway to provide new accommodation for cardiac patients and a new reception area had been built in the ophthalmology reception and waiting area
- Guidance had been developed for radiology staff to administer a medicine, Hyoscine Butylbromide, prior to treatment without a prescription.
- Patient group directions (PGDs) were in place for nurses in the ophthalmology department who were able to administer medicines without a doctor's prescription.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and to report them internally and externally.
- Nursing staff told us they reported incidents using the trust's electronic reporting system. They described how the senior sister in the department investigated incidents and the results of lessons learned were fed back to staff during departmental meetings. The minutes of staff meetings showed incidents had been discussed.
- We saw an analysis of incidents reported for the period April 2015 to May 2016. There had been 114 incidents reported in total. 102 resulted in no patient harm, nine resulted in low harm and three resulted in moderate harm. The largest number of incidents, 27, related to administrative problems for example with organising appointments. There were 21 incidents relating to patient documentation and disruptions to the service as a result of problems with the environment, equipment or staffing
- The minutes of departmental meetings showed that incidents were discussed. For example, a baby was treated in ophthalmology outpatients with a medicine recommended for infants aged 18 months or over. The baby was younger than 18 months and the medicine had been administered in error. The incident had been investigated and was due to be discussed within the surgical division to prevent a similar mistake occurring.
- Staff told us about an incident in general outpatients where a patient had become unwell in one of the clinics and staff had difficulty finding a glucometer to measure the patient's blood sugar levels. As a result, glucometers were provided for all clinic areas.
- No 'never events' were reported for this service during the period July 2015 and June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the

potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- One serious incident had been reported between July 2015 and June 2016. The serious incident related to the Radiology Information System (CRIS) breaking down. This resulted in a backlog of 2000 patient images, which had to be reviewed and reported manually.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended.' trust policy, and how to access it. Senior staff were aware of their responsibilities to report radiological incidents involving unnecessary exposure of radiation to patients to the Care Quality Commission (CQC). Five CQC reportable incidents had been reported appropriately between March 2015 and March 2016. Three incidents were the result of errors by the referrer and the remaining two were the results of errors within the radiology department.
- A further incident was reported to CQC in April 2016 which involved the referrer failing to cancel a request. The patient had already had a computerised tomography (CT) scan and received a second CT scan which was unnecessary
- The minutes of the Watford General Hospital Radiation Protection Committee from January 2016 showed staff had discussed the importance of informing patients about any radiation incidents and discussed an example of an incident.

Duty of candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Senior nursing staff we spoke with about the duty of candour were well informed about the trust's policy but said they were guided by their manager about responding to complaints particularly those likely to where harm had occurred. Staff had access to information through their managers and on the internal website.
- Managers and section heads understood their responsibilities under the duty of candour legislation. The majority of staff we spoke with familiar with the term duty of candour but were not sure how it operated in practice. They said they would seek guidance from their manager if they were unsure.
- Staff received training on the duty of candour requirements as part of the trust's induction programme and a duty of candour section was included on the electronic forms staff used for completing incident reports.

Cleanliness, infection control and hygiene

- The main outpatient department was visibly clean. Senior nursing staff showed us the cleaning schedules used by housekeeping staff but said communication was difficult because clinic staff left before domestic staff arrived and messages were usually relayed by leaving notes.
- We observed staff were adhering to the trust's arms bare below the elbow.
- There were 'I am clean' stickers on equipment which indicated equipment was clean and ready for use.
- There was a departmental link nurse for infection prevention and control who attended infection control meetings and kept staff up to date with the trust's infection control policies.
- Personal protective equipment such as disposable gloves and aprons were readily available and we saw staff used these when caring for patients.
- Staff in outpatients adhered to the trust's arms bare below the elbow policy. Supplies of personal protective equipment such as disposable gloves and aprons were available and we observed staff using these.
- The results of infection control audits were displayed on a notice board in the radiology department.
- The minutes of the sisters' meeting in June 2016 showed that the need for hand hygiene audits had been discussed. This had not been implemented and audits had not being carried out by the date of our inspection. Staff and managers in the ophthalmology clinics told us they were not undertaking hand hygiene audits.

Sanitising gels were available for staff to use between each patient but we observed nursing staff entering and leaving treatment rooms without using the gel or washing their hands
- Waste was appropriately segregated and needles were disposed of in sharps disposal bins units which were signed, dated and were not overfilled.
- We observed endoscopes being used in the outpatient clinic, which were cleaned in the department between patients. We asked if these were returned to the endoscopy department for checking and cleaning at the end of the clinic. Staff were cleaning the scopes with disinfectant wipes. Staff told us they were responsible for checking and cleaning the equipment on a daily basis. This does not comply with best practice as described in HTM 01-06 guidance on the management and decontamination of flexible endoscopes
- We saw the results of infection prevention and control audits for endoscopy equipment. This showed 100% compliance in April and June 2016, and 96% compliance in February and March 2016. The audit checked that cleansing solutions were available and staff on the endoscopy unit were aware of the process for decontaminating the equipment.
- When we visited the dermatology outpatient department we found the air conditioning in the dermatology treatment rooms was not working. This meant air was not extracted from the rooms where surgical procedures were being carried out. We spoke to the sister responsible for infection control within the department who told us they were unsure how long this had not been working. The blinds in the treatment rooms were dirty and broken. During our announced inspection we re-inspected the department and found some improvements had been made. The air conditioning had been repaired, the rooms cleaned and the blinds removed
- At our previous inspection in March 2015, we found the couches in the fracture clinic were ripped and represented a potential infection control risk. However, at our inspection in September 2016, we found that the couches had been replaced.

Environment and equipment

- Electrical equipment we checked in the main outpatient department had been safety tested.
- Staff working in the diagnostic imaging department wore radiation detection badges which meant the level of radiation staff were exposed to was monitored.
- All the rooms in the diagnostic imaging department where imaging equipment was located had secure access. There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- Personal protective equipment (PPE,) lead aprons, were available to staff for use within to protect them from ionising radiation exposure.
- The radiology service carried out risk assessments for all radiological equipment which described any the risks to staff and patients.
- Rooms in the ophthalmology outpatient department, where patients received intraocular injections, had no signs on the doors to indicate when a patient was receiving treatment. Access to the treatment area was through a door on the main corridor in the department, where patients were waiting to be seen. During our inspection locks were being fitted to rooms where patients were being treated. A lock had been fitted to the outer door but not to the treatment room itself. When we returned to the department, we saw this outer door was propped open. We raised this with staff who told us this door would in future always be closed. Staff told us if an injection was being given the member of staff always locked the room from the inside so that they were not interrupted.
- The air conditioning in the ophthalmology laser treatment room was not working. It had been reported as needing repair in August 2013. The outpatient improvement plan showed the service was still waiting for the air conditioning unit to be replaced three years after it was reported. The room had no other source of ventilation and became very hot. Incidents affecting patients' health and safety had been reported but nothing had happened as a result.
- At our last inspection we found that the accessibility and size of the cardiac clinic rooms on level three was insufficient to provide a safe environment for patients using it. Staff told us that should people become unwell in one clinic room, there was not enough room to move patients easily as the corridor was so narrow. A plan to re-provide the accommodation was in place. Building

work to provide new treatment areas was close to completion and staff were preparing to move into the new accommodation. The re-development had been designed to address the accommodation problems in the department. However, there was still a risk to patients until the new facilities were available.

- The resuscitation trolley was checked regularly. The top of the trolley which contained a defibrillator, suction and oxygen monitoring equipment was checked daily. The sealed drawers which contained medicines, equipment and dressings used in emergencies were checked weekly. We saw records which evidenced this. The resuscitation trolleys all carried equipment which was appropriate for treating children in an emergency.
- During our previous inspection staff in the outpatient department told us they had experienced difficulty in getting equipment repaired. At this inspection they told us there had been a small improvement but there were still problems. We saw a report prepared in May 2016 by the trust's internal auditors following a review of the management of medical equipment used, to ensure services were safe and equipment complied with national standards. The audit concluded there had been some improvement in the maintenance of equipment. The responsibility for managing equipment was clearer, however further work was still required.
- The trust's medical equipment was managed by the clinical engineering and pathology departments. They were responsible for maintaining an accurate record of the equipment used and to manage maintenance schedules. There had been difficulties maintaining equipment and the trust had developed a plan for improving this process. There was no monitoring of rental equipment, for example, bariatric equipment and fall prevention beds. The trust's report highlighted that trolleys, couches and beds were not managed by anyone in the trust.
- The diagnostic imaging department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were available for staff to refer to. It was the responsibility of the radiation protection supervisor (RPS) to supervise work and observe practices to ensure compliance. We found the service was complying with the regulations. A radiation protection supervisor (RPS) worked across all three sites in the trust ensuring the local rules were followed to protect, patients, the public and staff from the risks of working with ionising radiation.

Medicines

- There were arrangements in place in diagnostic imaging for managing medicines, medical gases and contrast media. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- Medicines were stored securely in locked cupboards. The outpatient sister held the keys. We checked a sample of medicines and found these were being stored correctly and were all in date. There were no controlled drugs (CDS) kept in the outpatient departments or radiology when we visited. There were no controlled drugs used in radiology.
- Fridge temperatures were checked and recorded ensuring medicines which required refrigeration were being stored at the correct temperature. Staff contacted the pharmacy department if fridge temperatures were outside the recommended temperature range.
- There was a pharmacy on site, which provided an outpatient dispensing service. This service was available Monday to Friday from 9.00am to 5pm. Clinical pharmacists worked over all three trust sites, and were available for any dispensing queries.
- FP10 prescription pads were kept in a locked cupboard. Staff ensured prescription pads were issued sequentially which meant prescription numbers could be traced, should this be necessary. Staff checked these had been issued sequentially and that there were no gaps in the prescription pads. We were not made aware of any audits that were undertaken on prescription pads.
- Nursing staff within the ophthalmology outpatient department were able to administer eye drops without a prescription from a doctor. This was done via a patient group direction (PGD). A PGD is a document authorised by the trust which describes medicines that can be used for specific clinical conditions. We saw several examples of PGDs which were in use, for example Fluorescein sodium 2% eye drops. The PGDs had been approved by the trust's medicines and safety panel in April 2016. The

document included the signatures of all the nurses authorised to administer the eye drops. The document demonstrated that nursing staff's competency to administer the medicine had been assessed.

- At our previous inspection we found that radiology staff were administering a medication, Hyoscine Butylbromide, prior to treatment with no prescription or PGD in place. Radiographers were not aware of the contraindications, when patients should not be given the medication, as it could have caused them harm. At this inspection we found a document had been developed which described how this medicine should be administered, which included the risks and contraindications. The document had been signed by 43 members of staff who had been trained to both administer the medicine and had been assessed as being competent to do so.
- The diagnostic imaging department had three administration of radioactive substances committee) (ARAC) (certificate holders who worked across all three sites; they ensured good clinical practice was carried out in the nuclear medicine department. The certificates evidencing this, were checked during inspection and were in date.

Records

- We reviewed eight sets of records in the ophthalmology clinic and ten sets of records in the main outpatient department and found these were comprehensive, signed and were up to date. We found the records in the main outpatient area that extended to several volumes, which had not been summarised. They contained old information, which had not been secured in the folder adequately. This meant that there was a risk that some essential information could be lost.
- Staff told us patient records were stored at St Albans Hospital and were transferred between sites when required. Staff told us notes often arrived late contributing to delays in patients being seen. An electronic tracking system was in place but staff told us notes were not always effectively tracked. Notes had been removed from storage, but the system had not been updated.
- When we spoke with the outpatient managers about the availability of notes they told us they had been working hard to improve the situation. They described how clinic preparation teams on all sites checked for late additions to clinic lists and requested the notes as soon as possible. If notes were not available 24 hours before the clinic a set of paperwork including the last clinic letters, recent test results, patient labels and a clinic outcome form was created and sent to clinic in the absence of the full record. If the full medical record became available on the day of the clinic they were provided for the consultation and the temporary records were securely destroyed. They said consultant medical staff decided whether they were willing to see the patient without their full health record. Outpatient nurses worked closely with the clinic preparation teams to keep them informed of missing records and completed incidents reports when notes were not available.
- At our previous inspection in March 2015, we found patient records had been stored in piles on the floor in the room where the patient had seen an orthoptist. At the inspection in September 2016, we saw the records had been removed. Staff confirmed and we saw that these records were now being stored securely.
- Improvements had also been made to the storage of notes in the cardiac department. Previously notes had been stored on the floor. New lockable cupboards had been installed in the administration offices and we saw these were well organised and locked when not in use.
- Patient information in radiology was stored electronically. We reviewed six patient records and found radiology staff had carried out safety checks, for example on women of child bearing age who may have been pregnant.

Safeguarding

- Arrangements were in place to safeguard patients from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures.
- Staff were able to access the trust's safeguarding policy, copies were available in the outpatient department and radiology. However, some staff in the outpatient department were unsure if they could access the policy on the trust's intranet but radiology staff were all familiar with where to find the guidance.
- Clinical staff should complete level three training if children are being seen and assessed This is in line with national guidance from the Royal College of Paediatrics and Child Health (2014).

- Staff told us they had completed level one and level two training in safeguarding adults and children. None of the staff in general outpatients or ophthalmology outpatients had completed level three safeguarding training.
- All of the nursing staff working in the inpatient department had completed level one adult safeguarding training, 83% had completed level two adult safeguarding training.
- 90% of nurses working in the main outpatient department had completed level one safeguarding for children, 100% had completed level two. 78% of eligible administration staff in the main outpatient department had completed level one training for children, 78% had completed level two training.

Mandatory training

- All staff were expected to attend mandatory training. This was delivered via e-learning and face to face. The trust's target for completion of mandatory training was 90%. Staff compliance with mandatory training was as follows:

Nursing staff:

- Adult basic life support: 79.3%
- Conflict resolution:90%
- Equality and diversity: 92%
- Hand hygiene: 81.6%
- Health and safety: 90.4%
- Information governance: 90%
- Infection control: 77.2%.
- Moving and handling: 90%
- Non patient moving and handling: 81.3%

Allied health professionals:

- Basic life support: 85%
- Conflict resolution training: 100%
- Infection control: 93.4% for.
- Patient moving and handling: 94.6%
- Equality and diversity: 92%

- Allied health professionals are a group of staff which includes radiographers, physiotherapy and other therapists. We were not given separate figures for the diagnostic imaging department. Administration and clerical staff working in the outpatient or diagnostic imaging departments were not shown separately, so this data relates to these staff at the Watford site.

Administration and clerical staff:

- Basic adult life support: 87%, had completed training, had completed
- infection control 77.4%
- information governance training 88%
- Health and safety training: 99.7%
- Staff told us they were supported to complete mandatory training but it was sometimes difficult to be released to attend training courses.

Assessing and responding to patient risk

- Risk assessments were carried out, where appropriate, in both radiology and outpatients. There were procedures in place in radiology when staff found something unexpected, for example a mass seen on an image. There were clear protocols in place if a patient's condition deteriorated. Staff in radiology and the outpatient department followed these protocols, which included using the National Early Warning Score (NEWS) system to assess what interventions and actions were required. In addition, nursing and medical staff accessed advice from the medial assessment unit. Patients were admitted to the hospital, if their condition required the level of care which could only be provided on a ward.
- There were illuminated signs on display throughout the radiology department informing patients and staff when machines were working and where there was a risk of radiation exposure. The MRI room was locked when not in use to prevent unauthorised access.
- The radiology protection supervisor worked across all the sites in the trust. Radiology staff told us they were always available by telephone and spent some days working in each department. There was a designated radiation protection advisor, staff reported they were easily accessible.
- Diagnostic reference levels were audited by the radiological protection advisor.

- The World Health Organisation (WHO) or 5 steps to safer surgery surgical checklist was being used in the radiology department as a safety check for all procedures that took place in the department. Compliance with the WHO checklist was audited. At our previous inspection in March 2015, compliance with the

checklist was inconsistent. The last audit was completed in December 2015 showed there was 100% compliance with the process. The audit checked the process was being followed.
- The patient's records we reviewed in the outpatient department included an assessment of risks, including falls, moving and handling and Malnutrition Universal Screening Tool (MUST) score.
- Staff in radiology carried out safety checks, for example on women of child bearing age that may have been pregnant. Royal College of Radiologists guidelines emphasise the importance of women of child bearing age being asked about the possibility of being pregnant.
- We observed the 'pause and check' system used in CT, x-ray and ultrasound. This is a clinical imaging examination IR(ME)R checklist for ensuring the correct procedures were always performed. Staff checked the patient identification details were correct, checked that the test was justified, the anatomical area to be imaged, system and equipment settings were all correct and that the radiation dose had been recorded.
- Staff in outpatients who were specialists in diabetes care, kept in contact with patients regularly by telephone to provide advice and support. A 'pause and stop' procedure was used in the diagnostic imaging departments. This ensured the right patients were getting the right scan, at the right time. We saw evidence of this used in practice.

Nursing staffing

- The outpatient department sister planned staffing levels to ensure sufficient numbers of staff were available to support the clinics. His was based on the number of clinics, the number of appointments offered and in consultation with the medical staff. When we spoke to the sister in charge they told us they did not use a staffing acuity tool.
- Staffing levels for registered nurses were 17% below planned levels and 21% for healthcare assistants in May 2016. The figures for registered nurses were similar for the two previous months, 17% less hours than planned. 19 posts (25%) were vacant in the main outpatient department and turnover was 17% which was considerably higher than the other outpatient sites in the trust. The trust's turnover target was 12%.
- There was a recruitment plan in place; the manager told us staffing levels had improved. The trust was actively recruiting to fill the vacant posts. In the meantime, agency staff were used to cover vacancies.
- Agency staff received an induction when they joined the outpatient department to explain the department's policy and procedures.

Medical staffing

- The clinical directorates were responsible for providing medical cover for clinics. The directorates identified the grade and number of medical staff required based on the number of patients who needed to be seen.
- Locum medical staff were used to provide cover on occasions, but the senior sister told us medical teams were relying less frequently on locums and providing cover within their own teams. Consultants supported by junior medical staff led most clinics.
- An additional two cardiac consultants had been recently appointed which had contributed to an improvement in waiting times.

Major incident awareness and training

- There were plans in place to deal with major disruptions to outpatient services which meant patients could continue to be seen in the event of a major service breakdown.
- Staff were aware of the trust's major incident policy but none of the staff we spoke with had received training and none were aware of any scenarios that may have taken place.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the service for effective.

- There was evidence that radiology services were following national clinical guidelines and participating in national audits.
- In outpatients a number of audits took place, but there was no evidence of action planning to effect improvements.
- Nursing staff completed local induction training when they joined the department. We saw the training

programme which included training on the use of equipment within the department and a medicines competency assessment. Induction programmes were developed to meet the needs of different staff groups for example for registered nurses and healthcare assistants.

- Clinic letters provided patients with very little information about the clinics or what to expect. Patients told us they would have appreciated more information about the clinic and about the lack of parking which many patients found frustrating.
- Nursing staff told us there was good working relationships amongst the nurses but working relationships between medical and nursing staff was not always effective. They described how communication was sometimes poor which meant they could not, for example pass information on to patients if the clinic was running late.
- Some services, for example, the diabetic service, had developed joint clinics with partners in primary care to support women who had developed diabetes in pregnancy. This was in addition to joint renal clinics and links with podiatry services for all patients with diabetes. The service used videoconferencing to provide virtual clinics with community partners.

Evidence-based care and treatment

- Each patient had a proforma, based on NICE guidance, which was specific to each clinic. It was completed by the consultant or clinical nurse specialist, who indicated what investigations or referrals the patient may need next. In addition there was a section for clinical coding, although this was rarely completed. Copies of the protocols were available in the sister's office and on line.
- Clinics were usually well organised and delivered effective assessment and treatment. Staff delivered evidence based care and followed National Institute for Health and Care Excellence (NICE) guidelines where relevant. For example pathways in the cardiac department were based on NICE guidelines for cardiac ablation and catheterisation. The diabetic service was following diabetes in pregnancy guidance and the ophthalmology service used national guidance for the glaucoma pathway.
- The trust participated in the National Cardiac Benchmarking Collaborative. This is a UK-wide collaborative of specialist cardiac centres to enable them to benchmark and compare the services they provide against their peers, in order to help improve quality and efficiency.
- Patients were able to book follow up appointments before they left clinic. Reception staff used these to organise patient's future care.
- The diagnostic imaging department followed Royal College of Radiology and other national guidelines. Staff could access guidelines on line and staff met weekly to discuss any changes to clinical practice.
- We saw the trust's policy for ensuring that accidental or unintentional exposures to ionising radiation were reduced as far as practicably possible. The policy was up to date and reflected the latest guidelines.
- Dose levels were recorded in a dose record book in each diagnostic imaging room for patients and staff, in line with ionising radiations regulations (IRR) 1999. These were audited and reported on annually in the radiation protection advisor's report

Pain relief

- Medical staff prescribed pain relieving medicines in outpatient clinics if required. Patients could collect pain relieving medicines from the pharmacy before leaving the hospital.
- Patients attending fracture clinic had their pain assessed and staff were trained to give Entonox for patients with severe pain.
- We saw examples of pain assessments recorded in patients' notes in the outpatient department. Patients could be referred to the pain management service provided by the trust.

Nutrition and Hydration

- Nutrition and hydration needs were not routinely assessed as part of the outpatient process.
- There was a café adjacent to the main clinic area where patients could purchase hot and cold drinks and sandwiches.
- Water dispensers were available in waiting areas. Our inspection took place during warm weather. Some patients and carers had been waiting for over an hour to be seen but staff did not offer people drinks. A relative organised drinks for patients in one of the clinic waiting areas.
- Staff offered patients in radiology a drink and snack following their procedure.

Outpatients and diagnostic imaging

Patient outcomes

- Information about outcomes of people's care was not always collected and routinely monitored.
- A number of audits had been carried out in outpatients, for example, compliance with the British Committee for Standards in Haematology guidelines, infection prevention and control and cleanliness. However, there were no associated action plans to effect improvement.
- The follow up to new patient attendance ratio was 1:5 which was slightly below the England average.
- Following a patient safety alert and local audit the diabetes service had introduced a new medicine chart to improve insulin administration in the outpatient department.
- Procedures and the outcome of consultations were coded but administrative staff told us the codes were not always entered on to the computer system. This meant the treatment provided for patients could not always be retrieved using the codes.
- A full audit cycle had been completed for retinal vein occlusion which conformed to the Royal College of ophthalmology requirements.
- The imaging department did not participate in the Imaging Services Accreditation Scheme or the Improving Quality in Physiological Service. These help imaging services manage the quality of their services and make continuous improvements.
- If a patient did not attend for two consecutive clinic appointments, they were referred back to their GP. Medical staff checked patients' notes to ensure there were no outstanding issues before the patient was returned to the care of their GP.
- There was a backlog in radiology reporting. The trust outsourced reporting to an independent company. The radiology department double reported 10% of radiology reports including those undertaken externally. This was used as a quality control process to check the quality of radiology reporting.

Competent staff

- Nursing staff completed local induction training when they joined the department. We saw the training programme which included training on the use of equipment within the department and a medicines competency assessment. Newer nursing staff, recently joined the trust, told us they had completed an induction programme which provided them with information about the organisation's policies for example how to report incidents.
- Induction programmes were developed to meet the needs of different staff groups for example nurses and healthcare assistants.
- Induction programmes were in place for radiographers. Supervision for radiographers was provided by the superintendent radiographer.
- One member of staff told us they had completed their nursing re-validation. They said managers in the trust had been very supportive.
- 90% of staff in the general outpatient department had received an appraisal within the last 12 months. The trust's target for annual appraisals was 90% and was therefore being achieved.
- 94% of radiographers had received an appraisal in the last 12 months and 100% of nurses working in radiology had been appraised.
- We asked staff about supervision meetings with their manager. None of the staff we asked said they had regular one to one meetings but they said they felt supported by the organisation and their manager. Managers in the main outpatient and ophthalmology clinics told us they had prioritised staff appraisal, but said work pressures made it difficult to meet staff on a more formal basis, as often as they would like. Radiology staff's competency levels were assessed and recorded in folders maintained within the department.

Multidisciplinary working

- Some staff told us there were good working relationships amongst the nurses but working relationships between medical and nursing staff were less effective. They described how interactions between some groups of staff, was poor, which meant effective communication with patients, if for example the clinic was running late, was affected. Therapy staff such as physiotherapists contributed to assessments in clinic when required.
- A one stop clinic had been developed for treating patients with glaucoma. This meant patients received all their treatment at one visit.

- Specialist nurses supported patients in outpatient clinics for example when they had received a distressing diagnosis. Specialist nurses were able to provide additional information about the condition and provide emotional support.
- The diabetic service had developed joint clinics with partners to support women who had developed diabetes in pregnancy. There were also joint renal clinics and links with podiatry services for all patients with diabetes.
- Videoconferencing was used to provide virtual clinics with community partners.
- The diagnostic imaging staff had access to any scans and x-rays from other hospitals in the trust, and communicated with staff at other sites if needed, to discuss a patient's previous images. This ensured that patients did not receive unnecessary radiation.
- Multidisciplinary meetings were held to discuss new cancer diagnoses. Oncologists, radiologists, pathology staff and surgeons attended these.

Seven-day services

- The outpatient department was open from 8.30am until 5pm on weekdays. Additional clinics were organised in the evenings or on Saturdays if waiting times were not being met.
- A consultant radiologist based in the acute admissions unit reported on urgent inpatient MRI and CT scans and carried out urgent ultrasound examinations between 8am and 8pm Monday - Friday and 7am – 1pm at week-ends and bank holidays.
- During the week the diagnostic imaging working day was from 8am to 8pm. Outside of these hours CT scans were reported by an external company. The service monitored the use of external CT reporting.
- There was a consultant radiologist on-call out of hours to provide advice and for urgent ultrasound requests.

Access to information

- The trust audited the availability of notes. The most recent audit was carried out in June 2016. The audit found that 10.3% of notes were not available on the three days that had been audited. Data supplied by the trust indicated that 6% of patients at Watford General Hospital were seen without their full medical record being available. On two occasions whilst we were in clinic we observed clinic staff requesting a copy of the patient's GP referral letter because the notes were not available.
- Examples were seen of clinic letters patients had received inviting them to clinic. They informed patients about the time and location of the clinic but there was no additional information about the hospital or the service. Three patients we spoke with said they would have appreciated more information about what to expect and about car parking. They all said they found it difficult to park particularly because of the re-development work which was taking place that had reduced parking spaces.
- The printers used to print appointment letters were not functioning, therefore, letters were printed on a device which was also used as a photocopier. There was a risk that some appointment letters could have got lost, when staff used the photocopier. The device had no local memory and printing from the appointment system was halted whilst the member of staff completed their photocopying. This was recorded in the service's risk register. The problem been identified three months ago. Staff we spoke with were not aware of any progress with resolving this problem.
- There was a backlog sending clinic outcome letters to GPs following outpatient consultations. This was highlighted on the divisional risk register. For example the backlog in the cardiology department was three to four weeks. The trust were monitoring the situation and trying to reduce the length of time it took to inform GPs about the outcome of patient's outpatient consultations. The service was reducing the backlog with staff working overtime.
- Medical and nursing staff had access to computer terminals in clinic for accessing test results
- Patient information was recorded on outcome forms which patients returned to the reception staff which enabled any follow up appointments to be organised
- The diabetic service had implemented a new information system which enabled staff working in the hospital to share information with community staff and GPs.
- GPs received a letter informing them about their patient's clinic attendance.
- Diagnostic imaging results were scanned onto the electronic patient system so that they could be

accessed by staff throughout the trust as required. Diagnostic imaging staff could access test results from other providers immediately through an electronic system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with, in both outpatients and radiology, understood the relevant consent and decision making requirements. process
- We saw examples of valid, completed consent forms and observed consent being obtained for two patients in outpatients. The tests and investigations were explained and the patients were invited to ask questions or clarify anything they were unsure about before they agreed to the procedure.
- In radiology written consent was also obtained, prior to the procedure taking place.
- We saw examples of four mental capacity assessments which had been undertaken for patients who were unable to consent to treatment because they had a mental health condition. Staff we spoke with had a good understanding of the importance of recording decisions which had been made in a patient's best interests.
- We saw that a specific consent form was used for procedures in line with the Mental Capacity Act (MCA) 2005. This consent form was specifically for patients who lack the capacity to consent to investigations or treatment in accordance with the MCA 2005.

Are outpatient and diagnostic imaging services caring?

Requires improvement

Overall we rated caring requires improvement because:

- Patients were not always treated with privacy and dignity. Ophthalmology tests and consultation took place in areas where confidentiality could not be maintained and in the dermatology clinic we saw a patient being treated in an area which acted as a reception area and a corridor.
- Patients received treatment for leg ulcers in a corridor that was used as thoroughfare for both patients and staff.

However we also found:

- The majority of patients were satisfied with the care they received. Patients told us staff had treated them with compassion and treated them as an individual.
- There was a quiet room where nursing staff could support patients if they had received bad news.
- Staff were aware of how to support people with a learning disability or dementia.
- We observed staff to be approachable, polite and caring.
- We also observed staff explaining to patients what to expect and offering them the opportunity to ask questions.

Compassionate care

- Patients were not always treated with dignity whilst they received care and treatment.
- We saw a patient's leg ulcers being treated in a corridor area which staff and patients walked through to access other areas of the department. The patient's privacy, confidentiality and dignity was not being respected. We raised this with staff who were aware of the unsuitability of treating patients in this area but told us they were short of space.
- The reception area in the main outpatient department was designed to ensure patients were not overheard when they spoke to the receptionist.
- Discussions and examinations took place in the consultation rooms to ensure privacy. Nursing and medical staff used curtains and around the examination couch and patients were covered up whilst sensitive or intimate examinations took place.
- Staff told us a chaperone was offered if the patient required examination by a health professional of the opposite sex. We saw notices informing patients that chaperones were available.
- We observed nursing staff comfort and console patients who were emotional or distressed by news they had received in the outpatient clinics. Staff responded discretely and with compassion. We spoke with ten patients in the main outpatient department. One patient had asked to speak to us because they were unhappy about the service. They told us they had attended many different outpatient departments and felt treated as a product not a patient. Other patients we spoke with told us they were satisfied with the service

they had received and that nursing and medical staff were caring and explained things well. One patient said, "Staff are polite and helpful and my experience of coming here is a positive one."

Understanding and involvement of patients and those close to them

- Any treatment that was provided, was explained by the relevant member of staff. Patients told us staff had spoken clearly to them and their relatives, offered to provide further information and encouraged them to ask questions.
- We saw the results of a patient satisfaction survey which had been carried out in April 2016. 79 of the 80 patients who responded said they would be extremely likely to recommend the service to friends and family. An action plan had been developed based on the survey results.
- Nurses informed patients about any delays in the clinics.
- We spoke with a member of the St Albans good neighbour scheme who had driven a patient to hospital for an urgent eye test. There had been a mix up in the appointment time and the patient was waiting to be seen. They said staff had not given them any information about when the patient would be seen. The good neighbour volunteer driver said they had other commitments but would not leave the person at the hospital because they would not be able to get home. When we returned half an hour later we saw they were still waiting. When we spoke with staff they were aware the person was waiting and said they would ensure they were seen.
- Other patients we spoke with told us medical and nursing staff explained their care and they were offered choices and options about the timing of their treatment. Patients and relatives told us they felt able to ask questions and medical staff provided them with the information they needed to address any concerns.
- Staff gave patients sufficient information regarding their next appointments. We observed reception staff offer patients a choice of appointment to suit the patients travel needs.
- Staff we spoke with understood the needs of people who required additional support and were able to access interpreters and specialist advice within the trust if, for example, a patient was living with dementia.
- Areas for seeing and treating patients in the ophthalmology outpatient department did not provide privacy or confidentiality. Patients were seen in cubicles, adjacent to a corridor, rather than private consultation rooms. Conversations could be overheard by other patients and relatives. During our inspection curtains were installed, which provided a degree of privacy.
- At our last inspection in March 2015, we saw two orthoptists in ophthalmology outpatients shared a room where they saw patients. This meant there was no confidentiality for patients whose consultations took place at the same time. We saw that this practice had continued and two patients were still being seen in the same room.

Emotional support

- Patients were supported if they received bad news and needed to discuss their concerns.
- Clinical nurse specialists were available in clinic to provide patients with emotional support. There was a quiet area within main outpatient department where patients could discuss their care in private.
- We observed staff supporting patients following their consultation. There was a quiet area in outpatients which patients could use if they were upset.
- Patients could access spiritual care. Staff knew how to contact the chaplaincy service when a patient required this support.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Overall we rated the service as requires improvement for responsive because:

- The trust had achieved the national target 92% incomplete referral to treatment time for five months July to November 2015 but this had fallen to between 89% and 87% in May–July 2016, leading to a year to date average of 88.33% (as at July 2016) and a downward trajectory.
- The national cancer waiting standard requires at least 93% (non-admitted pathway) of patients urgently referred by their GP with a suspicion of cancer should wait no longer than two weeks to be seen. The trust met

this target for the period from April 2015 to April 2016. However, the position had deteriorated, falling to 81.3% in July 2016, leading to a year to date average of 89.4% and a downward trajectory.
- The trust missed the non-admitted national cancer wait target for patients with breast lumps. 93% of these patients were required to be seen within two weeks. However, the trust's performance was consistently lower that this, May 87.4%, June 75.1%, July 45.9% YTD 76.0% again, a downward trajectory.
- The length of time patients waited to be seen was not monitored. The trust's patient administration system had no facility for recording when patients were seen and the information was not collected manually.
- Clinics were still cancelled at short notice although staff told us clinical divisions were getting better at providing medical cover. The overall cancellation rate for clinics had peaked in April 2016 at 14% which was a 3% increase on the mean of 11% over the previous 12 months.
- Staff told us communication between the clinics, consultants and their secretaries was poor and described examples of patients arriving for clinics staff knew nothing about or clinics cancelled at the last minute with no medical cover in place.
- Patients were not kept accurately informed of waiting times. Information was written on a board but the waiting time increased but we did not see that the waiting time on the notice board was changed. In other areas patients did not know how long they might have to wait.
- Some patients we spoke with told us how unhappy they were about the car parking arrangements and lack of information.

However we also found:

- All patients who were urgently referred by their GP with a suspicion of cancer who were subsequently diagnosed with cancer should wait no longer than 62 days to start treatment. The trust performed better than the 85% national standard from April 2015 to April 2016, with consistently more than 85% of patients waiting less than 62 days. The trust's figures were between 85% and 89%, which was better than the England average of 82%
- The Trust continued to meet the target from April 2016 with 97% of patients waiting no more than 31 days to start treatment.
- The trust had set a target of 5% for clinics cancelled at short notice. Over the past 12 months the number of clinics cancelled at short notice was below less than 5%
- Diagnostic imaging waiting times were within trust targets. The standard set by the trust was that 99% of patients referred for 15 specified diagnostic tests should wait no longer than six weeks. The standard had been achieved since April 2015 and was better than the national position of 98.2%.
- The radiology service measured the time patients waited before undergoing their procedure. Data provided by the trust showed patients waited 34 minutes on average to be seen for the period January to June 2016

Service planning and delivery to meet the needs of local people

- A range of outpatient and diagnostic imaging services were provided to meet patient's needs. This included routine clinics and specialist services.
- Waiting areas were comfortable and large enough. Water was available.
- There was a children's play area in the ophthalmology clinic but not in the main outpatient department.
- Patients waiting for blood tests waited in the main corridor close to the main entrance of the department.
- The ophthalmology service had developed a one stop macular degeneration clinic.
- The diabetic team worked closely with local clinical commissioning groups to plan and co-ordinate the care people with diabetes received.
- All the patients we spoke with who had travelled by car described how difficult it had been to park. Several patients said they were anxious because their clinic was running late and they and their car park ticket had expired. They said they did not want to leave the clinic and risk missing their appointment. We observed staff reassuring some patients. They were able to contact colleagues in the car parking department to explain the clinic was running late and give them details of the patient's car to avoid penalties. Not all patients were aware this was possible.
- Clinics were arranged on Saturday mornings to minimise waiting lists.

Access and flow

- At our previous inspection we had concerns about the appointment booking system with evidence of double

booking, frequent cancellation of clinics and a lack of oversight and co-ordination to minimise the impact of patient wait times and cancelled clinics. When we spoke to managers during our recent inspection they described the improvements they had planned. This included creating a new administrative post to coordinate outpatient bookings. The post had been created but had not been filled at the time of our inspection.

- Referral to treatment times had improved in most specialties. Patients close to the 18 week referral to treatment time target were escalated to the specialty divisional manager to expedite treatment. Some clinical divisions had been reviewing their clinic booking rules, others were preparing to review their clinics. A centralised clinic booking team had been created, responsible for booking all first appointments and re-arranging cancelled clinics. A validation team which was managed by the director of performance reviewed all the patient treatment lists to ensure patients were being followed up appropriately.
- The number of patients not attending booked out-patient appointments was still a concern. The number of patients who did not attend (DNA) clinic appointments at Watford General Hospital was in line with the England average since November 2015.
- The trust had introduced a text messaging system to remind patients about their clinic appointments. DNA rates had reduced following this service improvement.
- The trust's policy was to discharge a patient back to their GP if they did not attend booked appointments on two occasions.
- A weekly access meeting was held to discuss waiting times and additional clinics were organised on Saturdays if a specialty was at risk of breaching waiting time targets. A new performance monitoring report had been developed so that managers could monitor and manage the outpatient service more effectively.
- Services which were achieving the national 95% standard were given a 'stretch target' to the next percentage point. This was in an effort to achieve the overall target to compensate for areas, which did not achieve it.
- A slight reduction in short notice hospital initiated outpatient appointment cancellations was achieved in May 2016. In June 2016 3.9% of clinics were cancelled in less than six weeks, compared with 4.4% in May 2016, 5.6% in April. The trust had set a target of 5% for clinics cancelled at short notice. This was achieved or exceeded consistently over the previous 12 months.
- The overall cancellation rate for clinics had peaked in April at 14% which was a 3% increase on the mean of 11% over the previous 12 months. The trust had set a target of 8% for all cancellations. This figure includes clinics cancelled at short notice i.e. in less than six weeks and clinics cancelled further in advance. An analysis of hospital initiated single appointment cancellations, as opposed to whole session cancellations, was underway to identify reasons for these cancellations.
- The national standard for NHS trusts is that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral, was withdrawn in June 2015. The trust performed better than the England average in certain speciality clinics, for example, for dermatology 97%, and geriatric medicine 98%. However, they were slightly below the England average for gynaecology at 95% and urology at 91%. Non-admitted pathways are those patients who started treatment and did not need admission to hospital.
- The trust had achieved the national 95% referral to treatment time target for three months August to November 2015 but this had fallen to between 85.9% and 87.7% in May–July 2016, leading to a year to date average of 87.3% and a downward trajectory.
- The national cancer waiting standard requires at least 93% of patients urgently referred by their GP with a suspicion of cancer should wait no longer than two weeks to be seen. The trust met this target for the period from April 2015 to April 2016. However, the position had deteriorated, falling to 81.3% in July 2016, leading to a year to date average of 89.4% and a downward trajectory.
- The trust missed the national cancer wait target for patients with breast lumps. 93% of these patients were required to be seen within two weeks. However, the trust's performance was consistently lower that this, May 87.4%, June 75.1%, July 45.9% YTD 76.0% again, a downward trajectory.
- The national standard is that 85% of patients should wait no longer than 62 days from urgent GP referral to first definitive treatment for all diagnosed cancers. The trust performed better than the 85% national standard from April 2015 to April 2016, with consistently more

than 85% of patients waiting less than 62 days. The trust's figures were between 85% and 89%, this was also better than the England average which was between 82% and 83%.

- From March 2015 to April 2016, the percentage of patients diagnosed with a cancer waiting no more than 31 days for definitive treatment was consistently higher than the national standard of 96% and generally better than the England average.
- Audits undertaken by the trust indicated that there was a significant number of patient choice breaches adversely affecting performance. Work was ongoing to improve this.
- Improving telephone response rates in the central booking service was one of the pieces of work included in the outpatient improvement plan. The total number of calls connected, the number of abandoned calls and voicemail messages received was monitored weekly between the beginning of October 2015 and May 2016. The data collected by the trust showed that more than 50% of calls were abandoned in October 2015 rising to a peak of 70% for a short period in March 2016 but the level had fallen to 20% consistently for the period between April – May 2016. Managers told us this was an area where they hoped to sustain the improvement, reducing the level even further.
- Staff in outpatients told us all new patients were given a 10 minute appointment time which were often too short. Patients' consultations often took longer and clinics ran late as a consequence. Clinical Divisions were reviewing their clinic booking rules to reduce the frequency of clinics running late
- Staff told us communication between the clinics, consultants and their secretaries was poor and described examples of patients arriving for clinics staff knew nothing about or clinics cancelled at the last minute with no cover in place. Staff told us this had happened the day before our inspection started. The doctor was ill and the clinic had to be cancelled and patients' appointments had to be rearranged.
- A patient told us they were attending the fracture clinic to have a cast fitted. They said they had been waiting but staff had not told them how much longer they would have to wait or how late the clinic was running.
- On average 10% patients per week waited more than 30 minutes to see a clinician. This evidence was taken from a waiting times audit completed in June 2016. The trust did not routinely monitor or audit the length of time patients waited to be seen in clinic.
- 21.2% of clinics at Watford Hospital started later than scheduled which resulted in patients not being seen at their appointment time On the day of our inspection we spoke with several patients an hour after a clinic was due to start. Medical staff had been delayed and the clinic had not started. Clinic staff did not inform patients the clinic had not started. Patients asked staff why the clinic had not started and when medical staff would arrive. Clinic staff were unable to tell patient when the clinic would start.
- The trust told us that ongoing referral demand had been highlighted to the clinical commissioning group (CCG) on a number of occasions, particularly in relation to cardiology and pain. The trust was in discussions with the local clinical commissioning group about reducing the number of new referrals to the trust. The ratio of follow up to new attendances for the Watford outpatient service ranged between 1.5 and 2.5 follow up attendances for every new referral and was slightly below the England average.
- Only 89.9% of general surgery patients were seen within 18 weeks which did not meet the standard but was better than the England average and trauma and orthopaedics was 88.9% which was also better than the England average.
- 80% of patients with a cardiac condition were treated within 18 weeks. The number of cardiac patients treated within 18 weeks had improved in recent months from 77% to 80% however the service was not achieving the standard. The England average was 93.1%. The service had developed an action plan for improving their performance against the standard.
- 90% of urology, 88.6% of ENT and 87.7% of oral surgery patients were treated within 18 weeks.
- The trust's outpatient services improvement plan showed that managers were planning to produce leaflets in the top five languages used locally, to explain how patients could access the patient advice and liaison service (PALs), how to make a complaints and about transport to the hospital and parking. Staff told us they could access interpreting services.
- As part of the outpatient improvement plan all clinical divisions were asked to review their clinic booking rules

to reduce the number of overbooked clinics and update the appointment booking system. We saw from the outpatient risk register, updated in July 2016, that this process had not been completed and that not all clinic delays were being reported on the trust incident reporting system.

- The diagnostic waiting time standard set by the trust was that 99% of patients referred for 15 specific diagnostic tests should wait no longer than six weeks. The standard had been achieved since April 2015 and was better than the national position of 98.2%. 100% of patients requiring magnetic resonance imaging (MRI), non-obstetric ultrasound, diagnostic imaging and barium enemas were all seen within six weeks. A small number of patients requiring a DEXA bone scan waited longer than six weeks. Six patients out of a total of 570 patients waited longer than six weeks during the six months from December 2015 to June 2016.
- Average radiology reporting times for the period December 2015-May 2016 were 4.4 days for routine investigations, 2.0 days for urgent investigation and 2.2 days for patients referred as part of the two week wait process for suspected cancers.
- The radiology service measured the time patients waited before undergoing their procedure. Figures provided by the trust showed patients waited 34 minutes on average to be seen for the period January to June 2016. There was no trust target for this particular wait.
- Patients in radiology were informed about how long they would have to wait to be seen. There was a noticeboard located behind the reception desk, which informed patients of the likely waiting time. The waiting time when we visited was 30 minutes.
- The trust was lower than the England average for diagnostic waiting times for patients waiting longer than six weeks. The diagnostic waiting time standard was that 99% of patients referred for diagnostic tests should wait no longer than 6 weeks.

Meeting people's individual needs

- Outpatient services and diagnostic imaging were organised and provided to ensure patients experienced care designed to meet their needs. The service tried as far as possible to respond to patient's preferences and needs. Staff took account of patient's personal circumstances and other conditions when providing care and treatment.
- One patient told us the waiting area in ophthalmic outpatient had been re-organised. They said there was now more space for patients, but it was more difficult to hear when they were being called.
- The fracture clinic had trolleys which were suitable for transporting bariatric patients. There was a hearing loop for patients who had difficulty hearing.
- There were no information leaflets in other languages other than English. However, the trust's outpatient improvement plan included the development of information leaflets in different languages
- Transport was provided for patients with mobility problems. Patients were assisted with access to transport if they had problems with their mobility. Staff told us patients waited for a long time for transport, often after the clinics had finished for the day. The transport office was located adjacent to the outpatient department.
- Staff were aware of the needs of patients living with dementia or with a learning disability. The trust had developed a resource pack to guide staff supporting people with a learning disability. The department had a link nurse to support both patients with dementia and staff when caring for people with additional needs. There was a specialist nurse to support patients with a learning disability who, in addition, offered advice and support to staff.
- Patients with a learning disability had a purple folder. This alerted staff to patients who might require additional support.
- Inpatients who visited the radiology or outpatient departments, and who were living with dementia had a coloured wrist band which alerted staff to their needs.
- There was a quiet room which patients could use if they had received bad news.
- We spoke with a specialist nurse who provided nurse led clinics in the outpatient department. They provided care for adult patients and young people whose care was transitioning from the paediatric service.
- Notes from a sisters meeting demonstrated that staff had been liaising with transgender groups and were planning an information sharing session with staff about how this group of patients felt being an outpatient, from their point of view.

Outpatients and diagnostic imaging

- We visited the diabetes treatment centre at Sycamore house. The service had developed a kitchen which they used to teach patients about the foods they should avoid to help their condition and to learn how to cook healthier options.

Learning from complaints and concerns

- The outpatient matron and business manager were responsible for managing complaints. There was a complaints policy in place, which staff could access via the intranet.
- Senior staff told us the patients' advice and liaison service (PALS) were responsible for dealing with complaints and they were asked to investigate and respond to the issues raised.
- Staff told us they could ask for advice and guidance from the PALS, which was located close to the outpatient department entrance. Staff knew to direct patients to the PALS and there were leaflets available in the outpatient department explaining how patients could raise complaints and concerns.
- Leaflets explaining the trust's complaints process were available in all the clinic areas we visited.
- The trust's monthly performance report for May 2016 highlighted that the largest number of complaints received related to outpatient appointment delays and cancellations.
- We saw complaints had been discussed at outpatient sisters' meetings and staff told us they were made aware of the outcome of complaints at staff meetings.
- Staff told us the majority of complaints were verbal and they tried to resolve these at the time. We spoke with a group of patients who told us they had spoken with staff about the delays in clinic. Several patients told us there were delays every time they attended and staff seemed powerless to do anything about it.
- Radiology complaints were discussed in staff meetings. The notes of meetings showed staff reviewed complaints and made changes to procedures within the department as a result, for example by checking the correct information was recorded on referrals.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Overall we rated well-led as requires improvement because:

- There was a management structure in place for outpatients. However, responsibility for outpatients was shared between the clinical divisions and the outpatient department. Staff told us it was unclear who was responsible for improving performance in the outpatient departments.
- A comprehensive information dashboard which included a range of performance was under development but had not been rolled out for clinical and managerial use. Operational managers within the outpatient department were aware the dashboard was being developed but were not aware of what it may indicate about the service.
- There were high numbers of clinic cancellations and staff and patients were not always informed.
- Patient surveys were not undertaken.
- Audit cycles were not completed.

However we also found:

- Managers and staff told us medical staff and radiography staff worked well together. Staff spoke highly about their managers.
- The trust recognised the need to make improvements to outpatient services and had set up an improvement programme which had achieved some positive change.

Vision and strategy for this service

- The trust recognised the need to improve outpatient services and had made changes to strengthen the management structure and established an improvement programme overseen by an outpatient improvement board.
- We saw posters in the outpatient department promoting the trust's vision: "The very best care for every patient every day." However, staff we spoke with were unsure what the vision meant for the service they worked in.

Outpatients and diagnostic imaging

- There was not a joint strategy or vision specifically for outpatients or diagnostic imaging to take the directorate forward.

Leadership of service

- A divisional director managed outpatients and diagnostic imaging. They worked closely alongside the superintendent radiographer and the lead nurse for outpatients and had this responsibility for all three hospital sites. Staff in outpatients and diagnostic imaging told us they felt supported by their managers, they were visible and approachable if they had any concerns.
- The day to day management of outpatient services was shared between nursing matrons and administrative staff. The matrons in ophthalmology and general outpatients had recently taken up their posts. Ophthalmology outpatients was managed as part of the surgical division. The diabetes service, cardiac and dermatology were managed within the medical division.
- Staff told us the management of the service had improved since the matrons had been appointed a few months prior to our inspection. They said they could raise issues and the matrons would try to resolve them. The matrons were approachable and visible in the department.
- The trust had created two new leadership roles in outpatients a clinical and nurse lead to strengthen clinical leadership and support and improve staff engagement.
- The day to day management of clinics was the responsibility of individual clinical divisions who met monthly. However, the divisions did not meet together to review the issues around overbooking, cancellation of clinics, long waiting times for patients.
- We saw the cardiac department's improvement plan. A new post had been created to drive improvements forward. As a result, there had been a significant investment in additional medical staff posts and an improvement in waiting times. Managers had developed a business case which the trust had supported. The plan described how the service would achieve national waiting time targets.
- Leadership within the radiology department was clearer. Staff in the radiology department spoke highly about their managers and told us they felt informed and involved in discussions about the quality of the service.
- Leadership of the radiology service was shared between a consultant radiologist and the superintendent radiographer. Managers and staff told us medical staff and radiography staff worked well together. Staff spoke highly about their manager.

Governance, risk management and quality measurement

- Accountability for the management and performance of outpatients was delegated to the divisional director. The divisional director and their management teams had responsibility for oversight and management of performance for outpatient services within their clinical remit.
- The governance of the main outpatient department was included in the medical division's governance processes and structures.
- The director of performance oversaw the performance of outpatients. The outpatient matron worked across all three sites in the trust. We asked managers how decisions were made, for example setting up a new clinic in the general outpatient department. They told us decisions were made by mutual agreement between the outpatient department and clinical divisions. However, staff told us that occasionally, clinicians on arrived to hold a clinic without the outpatient's staff knowledge. In addition, staff were not always informed when clinics were cancelled. During our inspection, some patients made us aware that they had been waiting in clinic for over an hour, the consultant had not arrived and staff were not able to tell patients when they would arrive.
- In radiology, incidents, the results of audits and new national guidance, was discussed at departmental governance meetings which were held monthly. An ionising radiation safety policy was in place which described the governance arrangements in diagnostic imaging
- We saw a programme of audits which had been carried out in outpatients for example an audit of interruptions during outpatient clinics and dermatology surgical lists, and an audit of GP referrals to general medicine. We were not shown the results or any associated action plans for these audits. This meant the departmental leaders could not assure themselves that there were improvements in standards within the department.
- Managers were familiar with recent guidance which had been aimed at reducing the number of patient incidents

related to invasive procedures, including those undertaken in the outpatient department. A plan for addressing the standards had been developed but was not yet fully in place.

- The trust's risk register was seen to be discussed in the divisional governance meetings and plans drawn up on the improvement plan against the risks. There were eight risks specific to outpatients at Watford Hospital on the medicine's division risk register. Most related to the lack of capacity for follow up outpatient appointments and the inadequacy of the outpatient environment for patient consultations.
- Risk management was not undertaken comprehensively. Staff we spoke with were not clear how risks were escalated within the trust and if the identification of risks resulted in any action being taken.
- We asked managers if they discussed how to improve the performance of clinics. Senior nurses within the outpatient clinics told us there were no regular mechanisms for reviewing the performance of clinics. They told us the outpatient improvement project board was the forum for discussing improvements. An improvement plan had been developed following the last CQC inspection, to review the clinic's performance, but staff told us that progress had been slow and they were not always informed about the actions planned or the reasons for delays.
- The outpatient programme board had agreed key performance indicators including managing loss of productivity caused by patients who did not arrive for their appointments, short notice cancellation rates and clinic utilisation. These had been incorporated in to a comprehensive information dashboard which also included the ratios of new patients to those who were being followed up and first appointment waiting times. The dashboard was still under development, it had not been rolled out for clinical and managerial use. Operational managers within the outpatient department were aware the dashboard was being developed but were not aware of what it indicated about the service. The dashboard was due to be fully rolled out by the end of September 2016.
- Meetings were held twice a week where issues, incidents and concerns could be discussed. All grades of staff attended the meetings. Staff within the department received an email informing them of the outcome of the meeting including any decisions made.

Culture within the service

- Leaders were reported to be visible and approachable.
- We observed managers in the outpatients, and diagnostic imaging departments supporting staff. Staff told us team working had improved and the matrons were working hard to involve staff in changes to the service. However, staff told us the service was under pressure and they struggled on occasions to ensure the patient receive a good experience.
- Fracture clinic staff worked at the Watford site told us they were working towards integrating working practices with the St Albans site. Staff told us they welcomed the opportunity to work more closely with colleagues at the other sites.
- Team working between the medical and nursing staff was reported to be suboptimal due to lack of communication, for example when a clinic was cancelled.
- Sisters from all three main outpatient departments met monthly with the lead nurse to discuss departmental performance, operational performance, staffing including training, service improvement. Issues discussed at these meetings would then contribute to the operational and strategic management of the division.
- Nursing staff told us they felt communication with medical staff could be improved. They said clinics were still cancelled or reduced without clinic staff being informed and they had to deal with patient's frustration.

Public and staff engagement

- There was some evidence that patients who used outpatients were engaged and involved in decision-making to improve the service.
- A patient communications project had included reviewing appointment letters were fit for purpose. Patients' opinions had been sought. The new letters were aimed at improving the rates where patients did not arrive for their appointments and reduced complaints relating to appointment letters.
- Based on feedback from patients the diabetes team had developed a patient care plan. This was document retained by the patient and information about the patient's condition to help them manage their own care. In addition it enabled information to be shared for example with community health staff

- Information for staff included meetings and a weekly trust e-bulletin. Staff told us they felt they had been kept informed about changes, both trust wide and within their department.

Innovation, improvement and sustainability

- An outpatient service improvement plan had been developed. This included plans for improving appointment letters and reducing the length of time to answer the telephone in the central booking office. There were plans for collecting data on the length of time taken to answer calls and the number of abandoned calls.
- Text messaging was being introduced. Messages were sent to patients to remind them about appointments. This was in an effort to try to reduce the number of appointments where patients did not attend and had shown some improvement in non-attendances.
- Work had started on agreeing how many overbooked appointments could be made for each clinic. These were the number of additional appointments which could be added to a clinic for patients who needed to be seen urgently for example if the patient had been unable to attend or a clinic had been cancelled.
- An analysis of hospital initiated cancellations within six weeks of the clinic taking place was also planned, to reduce the number of cancelled clinics.
- A one stop clinic had been developed for patients with macular degeneration. This meant patients could receive all their tests and treatment in one visit

Outstanding practice and areas for improvement

Outstanding practice

- The set up and management of the children's emergency department was outstanding.
- Excellent MDT working was observed with acute medical services, stroke services, intensive care, children's services and the elderly frail unit.
- That the trust has Hospital Standardised Mortality Ratio (HSMR) rates lower than expected, sustained for 18 months.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Ensure that care for patients with mental health issues in the emergency department by ensuring that they are cared for in a safe environment, that their safety is risk assessed, and that staff are suitably trained to meet their needs, as well as keep staff safe from harm.
- Ensure governance quality systems, including the reporting of incidents, duty of candour, completion of local audits, learning from incidents and complaints and ensuring the risk register is up to date.
- Ensure that observations of patients who could be acutely unwell are undertaken appropriately and in a timely way.
- Ensure the timely completion of patient records.
- Ensure that patients who have been in the emergency department for more than six hours are reviewed by a senior clinician and are risk assessed.
- Ensure that there is a provision for the offering of regular drinks to patients during their time in the emergency department.
- Ensure that there are appropriate systems in place to track the patients and the expiry of those being treated under a deprivation of liberty safeguards.
- Ensure that staff completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms where a person lacks capacity to make an informed decision or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that all staff caring for patients less than 18 years of age has completed safeguarding level 3 training.
- Ensure the safe management of medicines at the hospital complies with Home Office 2016 guidelines on the security of controlled medicines. This includes patients' own medication.
- Ensure that there are procedures in place for the safe management of temperatures within treatment rooms and areas where temperature sensitive medications are stored.
- Prescriptions for syringe pumps must comply with the trust's prescribing standards.
- Ensure that mandatory training compliance meets trust targets of 90%, including blood transfusion training.
- Devise an action plan to address the shortfall between appraisal rates and the trust target and make sure that the trust target is reached.

Action the hospital SHOULD take to improve

- Review the arrangements for the collection of blood samples from the emergency department.
- Provide training to staff in dementia awareness, learning disabilities and complex needs.
- Review the escalation plan for the emergency department and make this effective in practice.
- Review staff training and knowledge on the Mental Capacity Act and DoLS.
- Review ambulance offload and handover times in the emergency department.
- Consider learning and outcomes from complaints.
- Consider developing a vision and strategy for the future of the emergency department.
- Consider lack of staff engagement across the emergency department and work towards improving this.

Outstanding practice and areas for improvement

- Reduce the number of patient moves out of hours within admissions and ward areas.
- Consider undertaking a risk assessment in relation to the lack of a dirty utility area in the emergency surgical admissions unit.
- Ensure that venous thromboembolism risk assessments are consistently completed and repeated according to trust policy and that the proforma used to complete assessments is fit for purpose.
- Consider further training for staff around Deprivation of Liberty safeguards to ensure that all staff are aware of when it is appropriate to consider an application to meet patients' needs and protect their rights when necessary.
- Ensure patients are discharged from the critical care unit within four hours of the decision to discharge to improve the access and flow of patients within the critical care unit (CCU).
- Ensure the trust meets the needs of patient requiring admission to CCU at all times.
- Ensure a microbiologist has daily input to the ward rounds on CCU to review patients care in line with the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- Take actions to reduce the incidence of single sex breaches in the critical care unit.
- The trust should ensure that all medicines are administered and documented in accordance with trust policy and national standards.
- The trust should ensure that modified obstetric early warning score observation charts are completed and acted on in accordance with trust policy.
- The trust should ensure they take the required actions to meet the 62 day referral to treatment time for patients with suspected gynaecological cancers.
- Within end of life care, the service should collect effective information on the percentage of patients who were discharged to their preferred place within 24 hours.
- The trust must ensure staff in outpatients comply with the trust's hand hygiene policies.
- The trust must ensure treatment rooms where invasive procedures take place are clean.
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This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Staff completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms did not comply with the Mental Capacity Act 2005 and the Code of Practice. Systems were not in place to assess, monitor and mitigate the risks relating to non-compliance with the Mental Capacity Act 2005. Seven out of the 36 DNACPR forms we reviewed stated that the patients did not have mental capacity. However, there was no evidence of mental capacity assessments being completed.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The safe and proper management of medicines. There was not proper and safe management of medicines in place and the hospital and hospital management had not taken reasonably practicable actions to mitigate any such risks. There was no standardised approach to the management of patients own controlled medication, with wards using different systems to store medicines brought into hospital. Patients own controlled drugs were not reconciled adequately. Patients in the emergency department for extended periods of time were not reviewed by a senior clinician.

This section is primarily information for the provider

Requirement notices

The mental health room in the emergency department contained hazards which could be used by patients to self-harm.

Observations of patients who could be acutely unwell were not consistently undertaken appropriately or in a timely way.

Prescriptions for syringe pumps did not comply with the trusts prescribing standards.

Medications were stored in treatment rooms where temperatures exceeded recommended levels. During inspection, there was limited evidence that this had been reviewed or escalated appropriately.

Pain relief was not being routinely checked or provided to patients. Patients who were clinically deteriorating were not being undertaken consistently. Records were not being completed consistently.

Staff in outpatients were not complying with good practice or with the trust's hand hygiene policies.

Treatment rooms where invasive procedures take place were not clean.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Safeguarding service users from abuse and improper treatment- A service user must not be deprived of their liberty for the purpose or receiving care or treatment without awful authority. Patients were appropriately referred to the deprivation of liberty safeguards team for assessment, which

This section is primarily information for the provider

Requirement notices

enabled an initial period authorisation whilst awaiting external assessment. The DoLS applications were not tracked to identify expiry dates and not reapplied for when the initial assessment period expired.

Locally wards had insight of patients treated under DoLS; however, there was no central monitoring or tracking in place.

Medical and nursing staff within the service did not have safeguarding children level 3 training, a requirement for all staff caring for 16-18 year olds in line with the Royal College of Paediatrics and Child Health Intercollegiate document 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: Regular fluids were not provided or offered to patients despite the department temperature regularly being above 28°C during the course of our inspection.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes for governance were not embedded or robust in all areas.

This section is primarily information for the provider

Requirement notices

The trust did not have oversight of incidents as all were not being reported therefore learning opportunities were missed.

In addition, in some areas the culture did not allow an open style where this could be done.

There was a lack of local audit activity in the emergency department.

Records were not always completed in a timely manner.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. How the regulation was not being met: Not all staff who were responsible for assessing, planning, intervening and evaluating children, were trained in safeguarding to level 3. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2104) which stated safeguarding level 3 training should be provided for clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns'. Appraisal rates were below the trust target. There was no action plan in place to ensure that appraisals took place in an effort to reach the trust's target.

This section is primarily information for the provider

Requirement notices

Compliance in mandatory training across the service was not in line with trust targets which may place patients at risk.